

## References

1. Hindman MC. Is exercise tolerance testing indicated for diagnoses and/or screening in family practice? An opposing view. *J Fam Pract* 1989; 28:476-80.
2. Clinical competence in exercise testing: a statement for physicians from the ACP/ACC/AHA task force on clinical privileges in cardiology. *J Am Coll Cardiol* 1990; 16:1061-5.

## Drug Therapy for Hypertension

*To the Editor:* The review of hypertension by Dr. Kerr in the recent issue of *JABFP*<sup>1</sup> was very informative. He made a common leap of faith, however, regarding cholesterol and mortality. Although the Framingham data clearly show a correlation between cholesterol and cardiovascular mortality, that does not imply that pharmacological reduction of cholesterol reduces mortality. In fact, most trials of lipid-lowering therapy (and a meta-analysis<sup>2</sup> of those studies) have failed to show a reduction in mortality. Thus, we don't know that lipid-lowering potential is a valid reason to choose a particular antihypertensive agent.

Two classes of antihypertensive agents, beta-blockers and diuretics, have been shown to reduce mortality.<sup>3</sup> To choose other drugs on the basis of theoretical rather than clinical benefits might not be in the best interest of our patients.

Neal Clemenson, MD  
University of Oklahoma  
Health Sciences Center  
Oklahoma City, OK

## References

1. Kerr CP. Hypertension in the 1990s: a new disease. *J Am Board Fam Pract* 1993; 6:243-54.
2. Ravnskov U. Cholesterol lowering trials in coronary heart disease: frequency of citation and outcome. *BMJ* 1992; 305:15-9.
3. Alderman MH. Which antihypertensive drugs first — and why! *JAMA* 1992; 267:2786-7.

The above letter was referred to the author of the article in question, who offers the following reply:

*To the Editor:* Dr. Clemenson's observations are most astute, particularly on the cholesterol issue. I agree with him generally on the subject of cholesterol. The article he has cited by Ravnskov<sup>1</sup> is the most important article in the entire literature on the subject, and I have reviewed it previously in *The Family Practice Newsletter*.<sup>2</sup> Where I disagree with him is about the relative importance of beta-blockers and diuretics having reduced stroke-related mortality by about 1 event per 500 patients treated per year.

The two main points of my article were as follows:

1. The major clinical hypertension trials have failed to show benefit for heart disease, and epidemiologically, this area is of greatest concern for practicing physicians. In choosing to undertake drug

therapy for hypertension, it is prudent to choose an agent that offers the greatest likelihood of benefiting the heart based on the best available data even though such data do not derive from major prospective controlled trials.

2. When drug therapy is chosen, the physician should opt for a drug that can offer two or more benefits at the same time while avoiding any metabolic harm.

I still prefer an antihypertensive drug that lowers cholesterol, because this effect is free, and we have no reason to avoid lowering cholesterol if it can be achieved in the course of an intervention of proven value. A peripheral alpha-blocker controls the blood pressure just as well as any other drug, will induce regression of left ventricular hypertrophy, if present, improves insulin metabolism, and improves cholesterol metabolism. Beta-blockers, on the other hand, clearly aggravate cholesterol metabolism. Since having read the Ravnskov article, I do not currently advocate any other medication to lower cholesterol. My primary approach to cholesterol is based on a low-fat, high-fiber diet and plenty of exercise.

At the present time the number one goal of all physicians in primary care should be to lower cardiac mortality. In this effort beta-blockers (except following myocardial infarction) and diuretics have clearly failed. Nor does drug-induced lowering of cholesterol appear to be the answer. We are, therefore, compelled to look for other means of achieving this goal and must act, albeit in the face of imperfect data. The best a practicing physician can do right now is to individualize treatment for his hypertensive patient after consideration of those known cardiac risk factors discussed in my article.

Colin P. Kerr, MD, JD, MPH  
Mount Gretna, PA

## References

1. Ravnskov U. Cholesterol lowering trials in coronary heart disease: frequency of citation and outcome. *BMJ* 1992; 305:15-9.
2. Kerr CP. Cholesterol is bunk! *Fam Pract Newslett* 1993; 7:65-6.

## Obstetrics in Family Practice

*To the Editor:* For those family physicians continuing to provide obstetric services to their patients, the information that "The percentage of Diplomates who do no deliveries has decreased from 71.5 percent to 66.7 percent during the past year"<sup>1</sup> and that "The number of recertified Diplomates who deliver from 1 to 25 babies annually has increased from 11.9 percent to 16.7 percent"<sup>1</sup> is both encouraging and empowering.

Family physicians delivering babies have been described as "an endangered species"<sup>2</sup> whose extinction was imminent; however, forward-thinking family physicians considered the endangered species "worth