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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[1] 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[2] 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.[3] To choose other drugs on the basis of theoretical rather than clinical benefits might not be in the best interest of our patients.

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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[1] is the most important article in the entire literature on the subject, and I have reviewed it previously in *The Family Practice Newsletter*.[2] Where I disagree with him is about the relative importance of β-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 α-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. β-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 β-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.

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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"[1] 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"[1] is both encouraging and empowering.

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

saving"[3] and suggested measures for "conserving [the] endangered species".[4] An ecologic niche[5] is now believed to exist for this species. Because of this "revival in obstetrics"[6] academic physicians are calling for a "new direction"[7] and new "decisions"[8] concerning the training of family physicians to deliver babies — even suggesting that family physicians be the primary instructors of family physicians learning to deliver babies.[9] Your data would indicate that the future for family practice obstetrics is indeed "bright".[10]

Without doubt, "obstetrics is too important to be left to the obstetricians"[11] and "just too darned important to leave to the technologists."[5] The specialty of family practice and the academic community in family medicine is beginning to awaken to the fact that family medicine without birthing is not family medicine — it's just medicine.

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Transvaginal Ultrasound and Surveillance on Estrogen Therapy

To the Editor: In their review of the recently published guidelines for postmenopausal preventive hormone therapy,[1] Drs. Moy and Realini lend support to the recommendation that transvaginal ultrasound might be an acceptable option to direct tissue sampling as an approach to surveillance of women receiving estrogen therapy. This support is unwarranted.

When compared with the reference standard, transvaginal ultrasound has a sensitivity of 80 percent and a specificity of 60 percent.[2] Given the consequence of a missed mitotic lesion, this modality is too insensitive to support its use as a substitute for periodic direct endometrial sampling in women on unopposed estrogen therapy.

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1. Moy JG, Realini JP. Guidelines for postmenopausal preventive hormone therapy: a policy review. J Am Board Fam Pract 1993; 6:153-62.
2. Dorum A, Kristensen GB, Langebrekke A, Sornes T, Skaar O. Evaluation of endometrial thickness measured by endovaginal ultrasound in women with postmenopausal bleeding. Acta Obstet Gynecol Scand 1993; 72:116-9.

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

To the Editor: Thanks to Dr. Kiser, et al. for their letter with regard to transvaginal ultrasound as an evaluative technique for surveillance of women receiving estrogen therapy.

In our policy review we noted that this technique "appears to be quite useful in distinguishing endometrial hyperplasia and carcinoma." We also noted that this procedure is less invasive than endometrial biopsy. We do mention that experience with this technique is still relatively limited and its performance should be monitored.

We appreciate this new reference provided by Dr. Kiser, et al. At the time the American College of Physicians guidelines were published, no cases of endometrial malignancy were known to have been present with an endometrial thickness less than 5 mm on vaginal ultrasound. This new study suggests that the ability of vaginal ultrasonography to rule out endometrial hyperplasia and cancer might be less than previously thought.

We encourage family physicians whose interests include this topic to continue to study vaginal ultrasonography, office endometrial biopsy, and other techniques so that the optimal technique can be determined and used in clinical practice. The sensitivity, specificity, and predictive value of transvaginal ultrasound should be compared with those of endometrial biopsy in the office, as well as with those of dilation and curettage in the operative setting. Comparative evaluations can only enhance our knowledge and ability to provide appropriate care for patients.

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