Correspondence

We will try to publish authors' responses in the same edition with readers' comments. Time constraints may prevent this in some cases. The problem is compounded in the case of a bimonthly journal where continuity of comment and redress is difficult to achieve. When the redress appears 2 months after the comment, 4 months will have passed since the original article was published. Therefore, we would suggest to our readers that their correspondence about published papers be submitted as soon as possible after the article appears.

Limits of Technology

To the Editor: Could the riddle be the truth and is the parable irony? In the September-October issue of *JABFP*, Dr. Gayle Stephens writes a thought-provoking piece on the ultimate limits of technology as it consumes even itself and its opponents (Primary Medical Care: A Riddle and a Parable. J Am Board Fam Pract 1992; 5:540-1). At the same time, McBride and colleagues have a juxtaposed editorial about the utility of ambulatory blood pressure monitoring as a new technology in which, "Initial purchase costs of equipment and software are $7,000 to $10,000, and typical charges are $200 to $300 for a monitored session."[p 542]

One of the great ironies of family medicine is our ability to describe accurately the problems confronting medical reform at the same time that we are fascinated by the advances in technology that are directly applicable to our specialty. While ambulatory blood pressure monitoring might indeed one day save costs and lives and improve the quality of those still living, such benefits remain to be proved. Until such time, the benefits to widespread use of this technology might benefit physicians more than society. We need to be careful about feeding the "red bull" in our own backyards.

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Ambulatory Blood Pressure Monitoring

To the Editor: The article by Drs. Ferguson and Shaar in the September-October 1992 issue of *JABFP* (The Effective Diagnosis and Treatment of Hypertension by the Primary Care Physician: Impact of Ambulatory Blood Pressure Monitoring. J Am Board Fam Pract 1992; 5:457-65) was certainly important in demonstrating the usefulness of the ambulatory blood pressure monitor. There are, however, some additional points that should be made about the special need fulfilled by ambulatory blood pressure monitoring.

Because many family physicians provide some element of industrial or occupational medicine in their practice, they are often called on to do Department of Transportation (DOT) physical examinations for truck drivers. There has always been a standard that blood pressure values greater than 160/90 mmHg require special assessment, and they can entirely disqualify the particular driver. It has been our impression, and we have been able to demonstrate it clinically, that certain groups of truck drivers are so concerned about their blood pressure and their ability to make a living that their normal blood pressure becomes elevated — a variant of the classic "white coat" hypertension. We have used ambulatory monitoring to reduce the level of concern for such patients and to qualify them for being able to drive a DOT vehicle.

Special consideration should also be given to using ambulatory blood pressure monitoring when evaluating commercial pilots, because their livelihood might also depend on the ability to control their blood pressure with limited amounts of medication. The proper diagnosis of hypertension or inappropriate use of medication could certainly be a major problem for either of these two patient categories.

I appreciate the practical approach that the *Journal* seems to be taking toward primary care and look forward to each issue.

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Pseudoephedrine in Pregnancy

To the Editor: Anastasio and Harston, in their article on the fetal effects of pseudoephedrine taken by the pregnant woman,[1] have cited and perhaps relied upon an old (1982) textbook reference, which claimed that this drug was "considered safe in pregnancy." Pseudoephedrine has been assigned a risk factor rating of C in a newer summary of drugs,[2] a rating moderately far from the safe classification, and one that bears a warning that drugs ranked there should be given only if the benefit justifies potential risk to the fetus, which is not known for drugs with this rating.

The assertion that any drug is safe for a pregnant woman is becoming more and more difficult in the face of increasing knowledge of subtle and late-appearing ill effects from many apparently "safe" substances, as the article itself well points out. *Williams Obstetrics*[3] summarizes general guidelines for use of drugs in women who are or may be pregnant, advising that any drug that exerts a systemic effect on the mother will cross the placenta and that any advantages of such "must clearly outweigh any risks inherent in its use."

Family practice training centers should take care that reference materials represent the most up-to-date knowledge available.

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