

# 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.

## Exercise Stress Test Training

*To the Editor:* I read with interest the recent article by Drs. Jacobson and Nuovo entitled "Exercise Stress Test Training in Family Practice Residency Programs" (JABFP 1993; 6:289-91). It is encouraging to see that 52 percent of the 309 responding residency programs are currently providing exercise stress test (EST) training for their residents, albeit most frequently under the supervision of a cardiologist. I fully support the expectations of the authors — as more family practice residents are trained during residency, a higher proportion of future EST training can be provided by qualified family practice faculty.

I want to add to the list of indications for exercise stress testing that were suggested by the authors in their opening paragraph. In addition to performing EST to (1) evaluate chest pain, (2) follow the course of coronary heart disease, (3) assess the severity of coronary heart disease, and (4) offer preventive screening for asymptomatic high-risk individuals, I would add a fifth indication, namely, to increase our security as the primary care provider by offering more complete care for our patients in an optimally cost-effective manner.

My experience performing and precepting hundreds of exercise tests during the past decade has prompted my suggestion of this fifth indication. I have found that in an overwhelming majority of cases the results of the EST have dramatically increased my confidence in selecting the most appropriate, cost-effective management approach for a particular patient. When the EST is negative, outpatient management can almost always be safely continued and exercise prescription more confidently prescribed. When test results are equivocal, extra caution in management is indicated, and the closeness of patient supervision and follow-up is increased as appropriate for the situation. Consideration might be given in such cases to obtaining additional noninvasive testing for clarification (i.e., stress echocardiography, radionuclide studies with thallium, and so on). Finally, when the test is positive — especially when markedly so — referral to a cardiologist can be more confidently made, not to ask "What would you do?" but

rather to refer a patient who definitely needs cardiac catheterization.

Obvious advantages of our increased involvement with exercise testing are greater patient satisfaction (from more comprehensive patient care) and enhanced cost effectiveness (as the need for referral and even cardiac catheterization can often be safely obviated), as well as greater satisfaction for us personally. Despite cost concerns raised in the article by Jacobson and Nuovo, EST is an extremely cost-effective procedure. A substantial portion of the cost quoted in their article should be subtracted from initial financing and setup costs, because a 3-channel electrocardiogram machine and office defibrillator should be included routinely in a family physician's office regardless of whether EST is performed. By sharing this equipment in a group practice, or by obtaining a contract to perform screening, the EST patient volume should increase, which would recoup the cost of equipment needed.

Finally, the criteria for competency should be addressed. The authors acknowledge the mixed opinions about family physicians performing EST. Even though the authors write, "others have stated that ESTs should be the exclusive domain of cardiologists," concrete evidence for this opinion is lacking. If "exercise testing should be performed by physicians with knowledge and special expertise in the cardiovascular response to exercise, and in the diagnostic and therapeutic roles of exercise in individuals at risk for developing or already having coronary artery disease,"<sup>1</sup> interested and appropriately trained family physicians should certainly qualify. The American College of Physicians, American College of Cardiologists, and the American Hospital Association Task Force statement suggests that "the trainee should participate in at least 50 exercise procedures during training."<sup>2</sup> This same task force, however, acknowledges that the number of procedures necessary to ensure competence has not been established by objective criteria, "... and a greater or smaller number of procedures may be deemed appropriate by a local credentials committee." As is the case for achieving competence to perform any procedure, the amount of supervision required is highly variable and not necessarily commensurate with a specified number of procedures arbitrarily decided upon by a board of specialists, who might have an interest in retaining exclusive domain to that procedure.

In summary, Jacobson and Nuovo are to be commended for their article that emphasizes the progress made by family physicians toward incorporation of EST into our active diagnostic armamentarium.

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## 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.

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## 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.

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## 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