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 a-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 Ravnkovs 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.

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

References

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” 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” is both encouraging and empowering.

Family physicians delivering babies have been described as “an endangered species” whose extinction was imminent; however, forward-thinking family physicians considered the endangered species “worth
The above letter was referred to the authors of the question 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.

Julie Graves Moy, MD, MPH
Baylor College of Medicine
Houston, TX

Janet P. Realini, MD
University of Texas Health Science Center
at San Antonio

References

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.

W.R. Kiser, MD
Guy Runkle, MD
David D. Ellis, DO
Margaret R.H. Nusbaum, DO
John P. Kugler, MD, MPH
Tacoma, WA