References

Drug Therapy for Hypertension
To the Editor: The review of hypertension by Dr. Kerr in the recent issue of JABFP 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 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. 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

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 is the most important article in the entire literature on the subject, and I have reviewed it previously in The Family Practice Newsletter. 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

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
sequence of a missed mitotic lesion, this modality is
to insensitivity to support its use as a substitute for
the 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

References
1. Moy JG, Realini JP. Guidelines for postmenopausal pre­
ventive hormone therapy: a policy review. J Am Board Fam
2. Dorum A, Kristensen GB, Langebrenke A, Sornes T, Skaar
O. Evaluation of endometrial thickness measured by endo­
vaginal ultrasound in women with postmenopausal bleed­

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 re­
ceiving estrogen therapy.

In our policy review we noted that this technique “appears to be quite useful in distinguishing endo­
mtrial 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 perfor­
ance 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 endo­
mtrial malignancy were known to have been present
with an endometrial thickness less than 5 mm on vagi­
nal ultrasound. This new study suggests that the abil­
ity of vaginal ultrasonography to rule out endometrial
hyperplasia and cancer might be less than previously
thought.

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

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

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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, 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 es­
trogen 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. Given the conse­
quence of a missed mitotic lesion, this modality is

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

without doubt, “obstetrics is too important to be
left to the obstetricians”11 and “just too darned im­
portant 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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Kissimmee, FL

1. Moy JG, Realini JP. Guidelines for postmenopausal pre­
ventive hormone therapy: a policy review. J Am Board Fam