LETTERS TO THE EDITOR

To the Editor:—The work by Ganz et al.¹ demonstrates noncompliance with guidelines for warfarin therapy following a thromboembolic event. However, the current extent of the problem is, perhaps, not well addressed by this study, which used patients from 1991–1994. Though the practice of three months of oral anticoagulation has been recommended by Hyers et al. in 1989,² the optimal duration of treatment was not yet fully established in 1994. Indeed, Hyers et al. qualified their recommendation, noting that “sufficient length of treatment may be shorter than three months.” In October, 1992, the Research Committee of the British Thoracic Society published their data in support of three months of treatment rather than four weeks.³ Ultimately, two more studies were published in 1995,^{4,5} which seem to have finally resolved this issue in favor of three months of treatment. Therefore, the compliance problems that have been demonstrated for 1991–94 may have simply reflected some of the uncertainty, which legitimately existed at that time.

Gantz et al. have effectively demonstrated a problem of compliance with guidelines that were, however, evolving at the time of their study. This work establishes the need for further research regarding adherence to current guidelines. Unfortunately, some have now begun to raise concerns that treatment beyond three months for these patients may not be warranted. Such ongoing evolution of guidelines will make evaluation of compliance difficult. — **STUART KEITH SUTTON, MD, FACP**, Consultant in Internal Medicine, Norfolk, Va.

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In Reply:—We agree with the thrust of Dr. Sutton's argument that the ongoing evolution of guidelines, and the

evidence on which they are based, make the evaluation of adherence to such guidelines a difficult task. The American College of Chest Physicians guidelines in effect during the period of our study (1991–1994) recommended three months of oral anticoagulation for treatment of venous thromboembolism, even though some of the definitive studies justifying this recommendation were completed later. The guidelines allowed for a shorter duration of therapy only for “patients whose risk factors can be interrupted, e.g., estrogen use or transient immobilization.”^{1,2} We examined whether such reversible risk factors as recent hip fracture or surgery were associated with less than 90 days' duration of oral anticoagulation, but we did not find any association.³ Similarly, of patients on hormone replacement therapy, none had less than 90 days' duration of therapy. Thus, neither estrogen use nor immobilization adequately explained shorter durations of therapy in our cohort, suggesting that the guidelines available at the time were truly not being followed. We agree with Dr. Sutton, however, that the evidence base was limited at the time.

The purpose of our study was not only to document the extent of adherence to guidelines, but also to look for predictors of poor adherence. Such predictors might provide useful insight into larger problems with the health care delivery system that may not have improved as rapidly as the evidence base on venous thromboembolism. For this reason, our data may provide insight into current issues that need to be addressed. For example, African Americans were more likely to receive a shorter-than-recommended duration of therapy, even after controlling for potentially confounding factors.³ Though our data do not reveal the reason for this finding, it can serve as a stimulus for further investigation.

Most importantly, Dr. Sutton's letter makes clear that measuring adherence to guidelines, like the refinement of the guidelines themselves, must be an ongoing task that is performed recursively, to be sure that as the evidence base in medicine evolves, our practice evolves with it. — **DAVID A. GANZ** and **JERRY AVORN, MD**, Boston, Mass.

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To the Editor:—With great interest, we read the fine article by Knight et al. concerning evidence-based medicine (EBM) in the treatment of hypertension in older patients.¹ The article is very important for decision making about therapeutic strategy in elderly hypertensive patients. However, most elderly patients have other diseases. Thus the effect of antihypertensive agents on other organs is also an important factor influencing the choice of the most suitable antihypertensive drug for elderly patients. On this point, evidence alone may not be enough to decide the best treatment of hypertension in older patients. We and others have reported that angiotensin-converting enzyme (ACE) inhibitors are effective in preventing aspiration pneumonia in the elderly.^{2,3} The increased upper airway reflexes due to ACE inhibitors have some untoward effects on elderly hypertensive patients, but ultimately lead to good results in the patients. Furthermore ACE inhibitors may possess anti-inflammatory capacity. We have reported that ACE inhibitors inhibit the reactive oxygen species in bronchoalveolar lavage cells from chronic obstructive pulmonary disease (COPD) patients.⁴ Thus ACE inhibitors are a possible therapeutic agent for the treatment of oxidant-associated lung disorders in older hypertensive patients.

A beta-blocker would be the drug of choice for most hypertensive patients with a history of myocardial infarction; however, the drug could cause airway hyperresponsiveness in elderly patients with COPD and long standing asthma. Because COPD is increased with advancing age, beta-blockers may not be a good choice of antihypertensive drugs in elderly patients with airway diseases.

Calcium-channel blockers are good candidates for antihypertensive agents of choice for the elderly. Yet these agents have been reported to cause heart attacks,⁵ cancer,⁶ and gastrointestinal bleeding⁷ in older patients. However, many controlled trials have attested to the efficacy and safety of long-acting calcium-channel blockers. Thus the quality of the evidence should be carefully considered.

Based on the currently available evidence for the treatment of hypertension in older patients, a low-dose diuretic should be used more frequently for elderly hypertensive

patients, as suggested by the editorial.⁸ Diuretics are also effective in the treatment of right heart failure in patients with COPD. However, the side effects of all drugs on volume status and electrolytes in relation to digoxin use are often concerns in elderly patients. In geriatric medicine, comprehensive strategies for treatment of hypertension are important for frail older patients with concomitant diseases. Further evidence is necessary to decide the best selection of antihypertensive drugs for elderly patients with other disorders. — **SHINJI TERAMOTO, MD,** and **HARUKI KUME, MD,** *International University of Health and Welfare, Department of Internal Medicine, San-no Hospital, Tokyo, Japan* and **TAKESHI MATSUSE, MD,** *Department of Pulmonary Medicine, Yokohama City University Medical Center, Yokohama, Japan.*

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To the Editor:—I read with interest the article by Jain and Chou¹ regarding “orientation clinics.” Their success serves as an exciting opportunity for future development and collaboration. We conducted a similar clinic for patients and their spouses in the mid-1990s. Patients were scheduled for the orientation session the same day as the primary care visit. Our focus was on prevention and screening measures. We discontinued the clinic, as the no-show rate was unacceptably high. Feedback indicated that patients were willing to come to visit their new primary care provider, but not willing to spend additional time at another presumed unrelated visit. The requirement in Jain and Chou’s model to attend the orientation clinic prior to visiting with their new primary care provider makes sense. In my view attendance at the orientation session is an important predictor for identifying patients who are truly serious about transferring their care to the Veteran’s Health Administration. We know from experience, and this is validated in the literature,² that many patients choose to come solely for the VHA prescription benefit. Over the last 18

months we have telephoned our patients prior to their first primary care appointment. This intervention decreased our no-show rate for first visits to primary care. However, we have not performed health maintenance screening for obvious reasons. Group visits, such as orientation clinics, do present unique systems issues, however, such as coding, documentation, and patients needing same-day urgent care. No doubt Jain and Chou and others in the VHA system have solutions to these challenges as well. — **DAVID A. NARDONE, MD**, *Clinical Director Primary Care, VHA Medical Center, Portland, Ore.*

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