# *Editor's preface*

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Two of the most important risk factors for cardiovascular disease are hypertension and smoking. The pharmaceutical industry has responded by spending enormous resources annually on research and development of new and better drugs for hypertension. In stark contrast, the tobacco industry spends almost nothing on the prevention of smoking, and shareholders make billions of dollars in profits from the sale of the agents of this risk factor. But then, preventing smoking is not the role of the tobacco industry, nor should it be. Such is the role of government and individuals. In an invited editorial, Fred Bass harshly criticizes the federal government's record on smoking prevention, citing both the prime minister's undelivered promises and Health Canada's underfunded and feeble responses (page 61).

Even if effective drugs are available, hypertension cannot be controlled unless patients take their medications. Although study subjects comply with their assigned therapies in tightly controlled and monitored trials, the daily therapeutic vigilance required to manage the silent risk factor and to perhaps prevent a catastrophic event 20 or 30 years later goes far beyond the motivation of many patients. Jaime Caro and colleagues show that about 20% of newly treated hypertensive patients appear to stop all treatment within 1 year (page 31). In a related project, they found that ACE inhibitors, when prescribed as initial therapy, had marginally higher compliance rates compared with other classes of drugs (page 41). Calling for further research, Martin Meyers elucidates why patients don't take their antihypertensive drugs (page 64).

Although experts agree on smoking and hypertension, they disagree on screening for prostate cancer with tests for prostate-specific antigen (PSA). The continuo of academic rumbling over the value of screening has not deterred the choir of patients and physicians from rewriting the score. In an Ontario survey, Peter Bunting and colleagues (page 70) found that 63% of PSA tests ordered were for "screening" in asymptomatic men and an additional 40% were to determine if urinary tract symptoms might be due to prostate cancer. Although some would call such case-finding wasteful because we simply don't know if PSA testing prolongs life expectancy, Murray Krahn and colleagues (page 49) found that the cost of screening a hypothetical cohort of all eligible Canadian men was a relatively trivial part of total health care costs.

Lastly, a word, if we may, about us. A new section, "The Left Atrium" (page 91), makes its debut in this issue with an editorial introduction (page 67). A voice for the "art" of medicine, it will be a regular collection of thoughtful book reviews, visual arts and prose. We welcome contributions. We've also added a human face to the last page of the issue, in another new section, called "Heart and Soul" (page 160). Each instalment will provide a glimpse into the professional life of an ordinary person doing extraordinary work in the practice of medicine or in other areas to improve the well-being of his or her fellow human beings. Finally, we invite you, medical technology buffs and sceptics alike, to submit your papers for this year's global theme issue on the impact of new technologies in medicine (page 66). Along with other journals around the world we will devote most of the pages of a November issue to technology. Papers received before May 1, 1999, will have a better chance of being included.