

Canadian Hypertension Society, Blood Pressure Canada, the Heart and Stroke Foundation of Canada, the Public Health Agency of Canada, the College of Family Physicians of Canada, the Canadian Council of Cardiovascular Nurses, and the Canadian Pharmacists Association) oversee the process.

- Clinical experts work with a Cochrane librarian to systematically identify and review the evidence in each topic area, and a central review committee of 4 methodologists reviews all of the evidence and recommendations prepared by these clinical experts. While clinical experts may receive funding from the pharmaceutical industry for advisory panels, consultants, or speakers bureaus, the members of the central review committee explicitly do not.
- All draft recommendations that are developed by the clinical experts for that topic and the central review committee to meet pre-specified levels of evidence are presented to and debated by the Recommendations Task Force of CHEP (44 unpaid volunteers with academic and clinical expertise in hypertension).
- The potential conflicts of interest of all members are identified, disclosed in writing and distributed at the consensus conference, and members with significant conflicts of interest are asked to abstain from votes on recommendations related to their potential conflicts.
- Only those draft recommendations supported by 70% or more of the Recommendations Task Force members are subsequently accepted.
- Although CHEP does receive funding from multiple sources to cover the costs of developing and disseminating the guidelines, the largest single financial sponsor of CHEP activities in 2005 was the Public Health Agency of Canada.

Although the *CMAJ* editorial suggests that more expensive antihypertensive therapies have been recommended over less expensive alternatives in Canada, we feel it important to point out that diuretics have been recommended as first-line drug therapy for hypertension in every iteration of the Canadian national hyper-

tension recommendations over the past three decades (including a period when international guideline panels had recommended against them). Indeed, in our listing of appropriate choices for first-line therapy, thiazide diuretics are the only drug class assigned a grade A recommendation.<sup>2</sup> Further, the percent increase in prescriptions for diuretics has increased dramatically and more than the increases for angiotensin-converting enzyme inhibitors or calcium channel blockers since the CHEP program started.<sup>3</sup>

### Norm Campbell

Chair  
CHEP Executive Committee  
**Finlay A. McAlister**  
Chair  
Central Review Committee  
Calgary, Alta.

### REFERENCES

- Clinical practice guidelines and conflict of interest [editorial]. *CMAJ* 2005;173(11):1297.
- Khan NA, McAlister FA, Lewanczuk RZ, et al; Canadian Hypertension Education Program. The 2005 Canadian Hypertension Education Program recommendations for the management of hypertension: part II – therapy. *Can J Cardiol* 2005;21(8):657-72.
- Campbell NR, Tu K, Brant R, et al, for the Canadian Hypertension Education Program Outcomes Research Task Force. The impact of the Canadian Hypertension Education Program on antihypertensive prescribing trends. *Hypertension* 2006;47:22-8.

DOI:10.1503/cmaj.106008

### [The editor responds:]

I commend the CHEP for its efforts to reduce bias resulting from financial competing interests when developing guidelines. The steps outlined in their letter lead in the right direction. In our editorial<sup>1</sup> we did not claim, as stated by Campbell and McAlister, that “guideline panels should consist only of non-experts.” Clinical expertise (especially if financially unencumbered) is important, especially in choosing meaningful clinical questions for randomized trials and in selecting endpoints for efficacy and adverse events. Analysis of the resulting data and summations of that data across multiple clinical trials (meta-analyses, evidence reviews of all sorts and guideline recommendations) are much more dependent on methodological expertise. Indeed, recommendations of clinical experts and of guidelines supported by

sponsors with commercial interests are heavily biased toward those interests.<sup>2</sup>

### John Hoey

Editor  
*CMAJ*

### REFERENCES

- Clinical practice guidelines and conflict of interest [editorial]. *CMAJ* 2005;173(11):1297.
- Choudhry NK, Stelfox HT, Detsky AS. Relationships between authors of clinical practice guidelines and the pharmaceutical industry. *JAMA* 2002;287: 612-7.

DOI:10.1503/cmaj.060245

### Corrections

Reference 10 in a recent commentary<sup>1</sup> was incorrect. The reference should have read as follows: Shah T, Casas J, Cooper J, et al. Insight into the nature of the CRP-coronary event association using Mendelian randomisation [abstract]. *Atherosclerosis* 2005;6(Suppl):78.

### REFERENCE

- Lowe GDO. The association between elevated levels of inflammation biomarkers and coronary artery disease and death. *CMAJ* 2006;174(4):479-80.

DOI:10.1503/cmaj.060246


In a public health article on tuberculosis (TB),<sup>1</sup> there was a transcription error in the legend for Figure 1. The caption for TB cases 0–24 should have been cases/100 000 population/year, not cases/year.

### REFERENCE

- Murray S. Challenges of tuberculosis control. *CMAJ* 2006;174(1):33-4.

DOI:10.1503/cmaj.060247

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