

Eastside has a “fluctuating population of 10 000 to 25 000 people.” Most community leaders that I talked to agree that the population is from 10 000 to 12 000 if the single family homes in Strathcona are not counted, and from 15 000 to 16 000 if they are. All community leaders agree that the Downtown Eastside has a stable population base. Even residents who move from hotel room to hotel room often do not move out of the neighbourhood.

To label an entire community as “Skid Road” devalues both the local residents and their neighbourhood. When the only thing the media can see is the skid-row image, they cannot see the caring community that exists behind that negative façade.

The article carries an implied tone of contempt for some of the most ill and powerless people in our society and depicts local residents as losers with no redeeming qualities. Without doubt, contempt is the opposite of attention. One thing many residents have in common is poverty, and they live in that stressful condition with a dignity and caring that gives the neighbourhood surprising strength.

I am sure readers would agree with the Downtown Eastside woman who said, “I need to connect with someone who believes in me and helps me believe in myself.”<sup>22</sup>

**Sandy Cameron**  
Vancouver, BC

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## Real-world effectiveness of antihypertensive drugs

James Wright and colleagues reported results of a meta-analysis of data on the effects of various antihypertensive drugs.<sup>1</sup> Their stated purpose was to assist physicians in choosing an initial antihypertensive drug by systematically quantifying the available evi-

dence on efficacy, defined as lowering blood pressure and preventing adverse outcomes. They did not achieve this goal, however, because they focused exclusively on clinical trial data. Although they mentioned the importance of exercising treatment decisions on the basis of the best available evidence, they failed to remind physicians that the real-world effectiveness of antihypertensive therapies is also largely a function of patient compliance. Unfortunately, although Wright and colleagues included data for study withdrawals, they did not consider that real-world compliance cannot be studied under the conditions imposed by trials.<sup>2</sup>

If they had deemed results from studies that investigated compliance with antihypertensive therapies in actual practice as additional evidence worthy of consideration, physicians would also have been informed that class-specific patterns of persistence with initial antihypertensive drug therapy have emerged.<sup>3-6</sup> Persistence with antihypertensive therapy, for example, is generally poor, particularly for initial therapy with older agents such as diuretics and  $\beta$ -blockers. Therefore, to conclude, as the authors have, that physicians should select a diuretic in the absence of contraindications ignores the best available evidence. If the ultimate goal of antihypertensive therapy is to control hypertension and to avoid cardiovascular events, then physicians must consider *all* available evidence. An antihypertensive medication is only efficacious if a patient remains on therapy, and initial choice of antihypertensive therapy appears to be a significant factor in achieving this outcome.

**J. Jaime Caro**  
**Krista Payne**  
Caro Research  
Montreal, Que.

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#### [The authors respond:]

We appreciate the letter by Jaime Caro and Krista Payne; however, we disagree with their conclusion. Before doctors consider choosing a drug on the basis of real-world compliance, they should ask 2 questions. Is the evidence suggesting a difference in compliance likely to be true? If there is a difference, what is the magnitude of that difference and is that magnitude likely to lead to a difference in morbidity and mortality? The answer to both questions in this case is No.

With regard to the first question, 2 studies<sup>1,2</sup> suggest that compliance is better with new drug classes than with old drug classes, and 2 studies<sup>3,4</sup> suggest that there is no difference in compliance. These 4 studies are observational and are subject to bias (i.e., patients prescribed drugs from different classes are not comparable). The most likely bias in the 2 studies claiming a difference is that patients receiving new drugs were more likely to have been given a drug sample in the doctor's office. Old drugs are not available as samples. This sampling would not be captured in the database and would bias the results in the direction seen. The authors should have been aware of this confounder but did not mention it. Lower compliance with the old drugs, thiazides and  $\beta$ -blockers, is highly unlikely to be true; a double-blind randomized controlled trial designed to test this hypothesis demonstrated fewer withdrawals with the old drugs than with the new drugs.<sup>5</sup>

With regard to the second question, in the study by Caro and colleagues<sup>2</sup> the largest absolute difference in non-persistence was between thiazides and angiotensin-converting-enzyme inhibitors: 9% at 6 months and 13% at 4.5 years. Would this small difference in compliance lead to a difference in morbidity and mortality? We believe it is highly unlikely, and randomized controlled trials would be required to answer this question. It is important that doctors not be fooled into thinking that observational studies measuring compliance are a substitute for randomized controlled trials that are designed to be generalizable and to measure clinically important outcomes.

**James M. Wright**

**Cheng-H. Lee**

**G. Keith Chambers**

University of British Columbia  
Vancouver, BC

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### Why aren't we falling for anticoagulant therapy?

In his editorial regarding the reasons why so many eligible patients with atrial fibrillation are not receiving anticoagulant therapy,<sup>1</sup> Stuart Connolly suggests that anticoagulant therapy is contraindicated in elderly patients with a history of falling. A recent study<sup>2</sup> demonstrated that for the risks of anticoagulation to outweigh its benefits, the average elderly person must fall approximately 300 times in 1 year; the study concluded that the risk of falling is not an important factor in the decision about whether to offer antithrombotic therapy to elderly people with atrial fibrillation.

Connolly focuses on patient factors involved in the lack of appropriate use

of anticoagulants, but physician factors may be just as important. Treatment of patients with warfarin is a time-consuming, poorly remunerated aspect of clinical care, requiring multiple phone calls from the laboratory and contacts with the patient to explain dose adjustments. This may help to explain why physicians seek reasons (including a predisposition to falling) not to offer warfarin therapy to eligible patients. Before this care gap can be closed, both patient and physician factors need to be addressed.

**Malcolm Man-Son-Hing**

Geriatric medicine  
University of Ottawa  
Ottawa, Ont.

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2. Man-Son-Hing M, Nichol G, Lau A, Laupacis A. Choosing antithrombotic therapy for elderly patients with atrial fibrillation who are at risk for falls. *Arch Intern Med* 1999;159:677-85.

#### [The author responds:]

Malcolm Man-Son-Hing draws attention to 2 interesting factors related to underuse of anticoagulant