LETTERS

ACE Inhibitors Versus ARBs Versus DRIs: A Systematic Update

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To the Editors:—I read with interest the well-done meta-analysis by Powers and colleagues in the June issue of JGIM that described the limitations of the newer antihypertensive medications in examining long-term cardiovascular outcomes.¹ The article was well summarized in the very clinically useful editorial written by Dr. Smetana.² While I agree with Dr. Smetana that thiazide diuretics remain the mainstay of initial therapy as outlined in the Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7),³ I am concerned that for most practicing physicians, thiazide-type diuretics means hydrochlorothiazide. As Dr. Smetana correctly points out, chlorthalidone (or indapamide) have the most robust cardiovascular outcomes data amongst all antihypertensive agents, but this has not penetrated widely into practice. Approximately 125 million prescriptions were written for hydrochlorothiazide alone or in combination in 2008; yet, unlike previously mentioned, longer-acting thiazide diuretics, there are no data to support hydrochlorothiazide's ability to improve cardiovascular outcomes.⁴

The recent British National Institute for Clinical Excellence (NICE) guidelines published last year suggest that

ACE inhibitors should be the drug of first choice for those less than fifty-five years old, and calcium channel blockers for those fifty-five years or older.⁵ Thiazide diuretics were relegated to third-line medications in these guidelines, but remained ahead of beta-blockers and newer agents. I think all practicing clinicians anxiously await the upcoming JNC 8 guidelines to help wade through this growing controversy.

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