group and 159 in the placebo group. The five-year cumulative stroke rates were 5.2/100 for active treatment and 8.2/100 for placebo. This represents a 36 percent reduction (p = 0.0003) over five years. This is similar to the results in trials of treatment for diastolic hypertension. Stroke deaths were few: 10 in the active-treatment group and 14 in the placebo group. White men and women and black women had a lower incidence of stroke. Among black men there were few events (9 vs 8). The benefit was seen in all age groups. Those subjects who had received prior antihypertensive treatment had a similar decrease in stroke (43 percent), compared with a 31 percent decrease in stroke incidence among those without prior treatment.

The numbers of nonfatal cardiovascular events were also lower with active treatment. Deaths from all causes, all cardiovascular causes, and all coronary causes were lower. The difference in total coronary heart disease deaths was largely due to the decrease in fatal heart attacks (15 vs 26). Benefit from active treatment was also suggested in patients both with and without baseline ECG abnormalities. There was no difference in dementia or depression. Modest changes in biochemical variables (potassium, uric acid, glucose, cholesterol, sodium) were noted in the active treatment, and abnormalities were managed as part of routine patient care.

Effective therapy of ISH in the elderly can make a significant impact on the health of the nation by reducing the risk of stroke and other cardiovascular events, especially coronary heart disease and left ventricular failure. This can be accomplished without significant side effects with low doses of common inexpensive drugs. Physicians should make the results of the SHEP project available to their patients with ISH.

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REFERENCE


Primum Non Nocere

The message in the somewhat brief, yet straightforward, case report by Freiberg and Barnes, which appears in this issue (see page 865), cannot be overemphasized. Is it really possible for something so seemingly innocuous as a peripheral venous catheter to have contributed to a patient’s eventual demise? As concluded by the authors, the answer is a very emphatic yes. This case report serves as an important reminder of some of the basic principles related to peripheral venous catheters: (1) Adherence to aseptic technique should be maintained at the time of placement of an intravenous cannula. (2) When dealing with unruly or uncooperative patients, special efforts must be taken to ensure the security of the catheter. (3) Unplanned or inadvertently removed catheters should be carefully inspected to ensure that fragmentation has not occurred. (4) In the event that an embolized catheter fragment is identified, removal (preferably percutaneously but perhaps requiring an open procedure) should be attempted promptly.

It is an inherent responsibility that we all have as clinicians to ensure that the risk associated with any type of invasive procedure is minimized—including even that of placement of a peripheral intravenous cannula.

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