



TABLE 1—The rate of all strokes in the treatment and control groups (1000 patients years according to the age at the initial screening and the sex of the patients)

Table with 4 columns: Age, sex, Treatment group, Control group, Significance. Rows include Age (years), Males, Females, and Both sexes.

TABLE 11—Types of cases in the treatment and control groups

Table with 3 columns: Treatment group, Control group, and Significance. Rows list various stroke types like Ischaemic, Haemorrhagic, and Cryptogenic.

mortality—due to stroke, coronary artery death, ventricular failure, ruptured aneurysm, and hypertensive nephropathy showed a non-significant reduction in the treatment group.

SMOKING IN RELATION TO STROKE AND MYOCARDIAL INFARCTION

As most of the treatment group than the control group smoked (28% v 21%), the incidence of smoking in those who had strokes and myocardial infarctions was examined in the two groups.

The incidence of all strokes (per 1000 patient years) in smokers and non-smokers was: treatment group—smokers 17.4 (nine patients), non-smokers 10.9 (14 patients); control group—smokers 21.1 (10 patients), non-smokers 20.9 (34 patients).

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There was a significant excess of fatal cancers in the treatment group. Table V. The excess was entirely in cancers of the bronchus treatment group.

Before randomisation 1165 patients were excluded because they were already being treated for hypertension. The mortality of these excluded patients was compared for comparison purposes in the analysis.

The rates per 1000 patient years for total mortality were 23.6, stroke 2.3, coronary artery disease 11.7, and all cardiovascular disease 23.9. These are closely similar to those in the treatment trial—see table IV.

The reduction in stroke rate was similar in men and women and in the two age groups 60-69 years and 70-79 years at randomisation.

It was more evident in non-smokers, however, who showed a 50% reduction in overall stroke rate on treatment. The small number of reported transient ischaemic attacks at treatment.

The absence of an effect on overall mortality was partly due to a non-significant increase in the death rate from cancer in the treatment group. These were mainly cancers of the bronchus.

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The inclusion of patients with low diastolic pressures (systolic only hypertension) might have combined different responses to treatment in subgroups with high and low systolic pressures.

Comparing the patients admitted to the trial with high and low diastolic blood pressure (> 90 mm Hg or < 90 mm Hg) showed a trend for a reduction in cardiovascular death only in patients with raised systolic pressures.

The selection of patients in the trial was based on an attempt to screen all those in the age group on the practice lists.

reorderable events were Drs D G Bevers, G Howitt, and J Mann. Dr Kim McPherson advised on statistical management.

Imperial Chemical Industries, Pharmaceuticals Division, Macclesfield, provided financial support for the study.

References

- 1. Sirtori CR, Rocchini G, Benfante S, et al. A comparison of treatment with the antihypertensive drug, atenolol, with the effect of hypertension on the quality of life. J Hypertension 1982; 1: 102-10.

Appendix 1

These were used by the pilot committee in judging trial endpoints.

Myocardial infarction

- Non fatal: a typical pain with either electrocardiographic evidence of a myocardial infarction or raised cardiac enzymes or both.

Stroke

- Fatal: (a) Death occurring as a result of stroke as defined in (a) or (b) of sudden fatality or (b) sudden fatality as a postmortem examination showed a myocardial infarction or complete occlusion of a coronary artery.

Common artery death

- Myocardial infarction: Death classified as due to myocardial infarction or sudden death.

Non-fatal

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Tamoxifen: acute attack: Focal central nervous system symptoms or signs occurring suddenly and disappearing within 24 hours.

Major stroke: Focal central nervous system symptoms and signs occurring suddenly and leaving only a small deficit after a month.

Minor stroke: Focal central nervous system symptoms and signs occurring suddenly and leaving a substantial deficit after a month.

Case of death: The definition of cause of death took into account the principal cause of death rather than the mode of death.

Appendix 2

Self-administered questionnaire

Please tick (in the appropriate box)

- 1. Are you troubled with headaches? rarely/occasionally/often/sometimes/most of the time

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The mortality from all causes and from principal cardiovascular endpoints in these treated patients was nearly the same as that for patients who were not treated.

The trial was an observation controlled without placebo. The degree to which lack of blinding of observers might have led to bias in the identification of events must therefore be considered.

The biggest difference between the groups was in the incidence of strokes, and as this was mainly apparent in fatal and major non-fatal strokes it is unlikely to be affected by observer bias.

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causes and for major endpoints in the two studies. Mortality from most causes in the European study was at least double that in the trial reported here.

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Good Practice

What is a good GP?

NICHOLAS L BISHOP

The government's consultation document on primary health care, published last April, put forward suggestions for encouraging good practice among family doctors.

Many of my patient referrals are direct from GPs, and so there is ample opportunity to assess the various styles of practice.

Perhaps the most striking and unexplained element of the relationship between the radiologist and the GP is the wide variation in the usage of imaging facilities by practitioners.

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