These new goals were reflected in the new Canadian Hypertension Education Program recommendations published in the July issue of *Canadian Family Physician*.[2] On the subject of lifestyle modifications, the group states the following: "Unfortunately, after a diagnosis of hypertension few Canadians improve their lifestyles; however, simple and brief interventions by health care professionals increase the probability of patients making lifestyle changes."[2]

We advocate providing all hypertension patients with a prescription for sodium, which should say, "Read the label! SODIUM—200 mg per serving for a total of 1500 mg per day."

This would have several advantages as a brief intervention:

- it would provide clear concise directions (200 mg/serving, 1500 mg/d);
- it would introduce the term *sodium* (some patients know they should reduce their salt intake, but are confused by sodium use);
- it would provide numbers and units of measure that precisely reflect current terminology, helping with label reading; and
- it would only require a prescription pad or a prescription printed from an electronic medical record. Family physicians would not need another pamphlet to add to the numerous tear-off sheets, requisitions, referral forms, application forms, and report forms that fill up office space.

—Adam Steacie MD MSc FCFP
Brockville, Ont
On behalf of the Health Promotion and Primary Prevention Subcommittee of the Ontario Stroke Network

References

1. Blood Pressure Canada. *Policy—sodium*. Calgary, AB: Blood Pressure Canada; 2007. Available from: **www.hypertension.ca/bpc/wp-content/uploads/2007/10/bpc-sodium-policy-with-endorsements-clean.pdf.** Accessed 2009 Sep 29.
2. Canadian Hypertension Education Program. 2009 Canadian Hypertension Education Program recommendations. An annual update. *Can Fam Physician* 2009;55:697-700.

How tight is too tight?

Regarding the debate on tight glycemic control published in the June issue of *Canadian Family Physician*,[1] I think it might be worthwhile to look at the hemoglobin (HbA_{1c}) levels the studies referred to actually achieved and reported, rather than what their targets were.

The achieved levels of HbA_{1c} for the UKPDS (United Kingdom Prospective Diabetes Study) follow-up were 8.5% (conventional) versus 7.9% (intensive) in the insulin-sulphonylurea group and 8.9% (conventional)

versus 8.4% (intensive) in the metformin group. There were better cardiovascular outcomes in the intensive groups, meaning those who achieved HbA_{1c} levels of 8.4% in the metformin group or 7.9% in the insulin-sulphonylurea group. This does not mean that going below 7.9% will result in better outcomes—we simply do not know.

The HbA_{1c} levels achieved in the ADVANCE (Action in Diabetes and Vascular Disease: Preterax and Diamicron MR Controlled Evaluation) study were 6.5% versus 7.3%. The decrease in end points was mainly driven by improvements in nephropathy.

In the VADT (Veterans Affairs Diabetes Trial), achieved HbA_{1c} levels were 6.9% versus 8.4%. There were no differences in outcomes between the 2 groups.

In the ACCORD (Action to Control Cardiovascular Risk in Diabetes) study, levels were 6.4% versus 7.5%. There was increased mortality in the tight control group.

These studies seem to indicate that better glycemic control improves outcomes—up to a point. Where that point is is open to debate. The average HbA_{1c} level in those studies seems to indicate that an appropriate HbA_{1c} level is somewhere between 7% and 8%. The current average HbA_{1c} level for my practice is 7.5%; if I systematically target patients with levels above 7% for intensification, I will drive my average down. I do not think any of the studies above tell me to do that for my practice. It seems to me that I should make a systematic effort to reduce HbA_{1c} levels in the individual patient level to below 8%; at the practice level, the average level should be between 7% and 8%. I would have to target patients with the highest levels of HbA_{1c}, as they will benefit the most—perhaps leaving those with levels between 7% and 8% alone—to get to results similar to those of the UKPDS.

We can now start to translate evidence from individual patient care to care of a practice population, which is a different way of looking at evidence-based medicine. I do not think clinicians should go beyond the evidence, and right now evidence does not seem to support a goal of having an overall HbA_{1c} practice average of 7% or less. What that means in terms of individual patient goals needs to be reviewed.

We need a very clear and evidence-based definition of what "tight glycemic control" is; authors of guidelines might wish to revisit their current recommendations.

—Michelle Greiver MD CCFP
North York, Ont

Reference

1. Clement M, Bhattacharyya O, Conway JR. Is tight glycemic control in type 2 diabetes really worthwhile? Yes. *Can Fam Physician* 2009;55:580,582 (Eng); 584,586 (Fr).