

Out-of-office BP measurement vital

The excellent Canadian Hypertension Education Program update published in the July issue of the journal¹ demands some comments:

In family practice, where we follow patients for many years, it seems that our choice of drugs in the treatment of hypertension is essentially a game of “spot the adverse drug reaction.” We choose drugs based on what remains after calcium channel blocker-related edema, angiotensin-converting enzyme inhibitor cough, β -blocker fatigue, and diuretic electrolyte disturbances have been recognized—a fairly easy exercise. The recommended use of combination drugs such as angiotensin-converting enzyme inhibitors and diuretics makes this more difficult, however, and offers little benefit.

I agree that home measurement of blood pressure (BP) is best, and I no longer make treatment decisions unless the patient brings me a 2-week home BP diary or a series of BP results taken in pharmacies. Blood pressure monitors can be purchased at discount stores for \$75, a good investment if the patient is spared years of costly and unnecessary drugs and adverse drug reactions. Two inventive manufacturers of angiotensin receptor blockers currently offer “free” monitors if we prescribe their products.

The article’s list of cardiovascular risk factors might also include the use of female hormones and anti-inflammatory drugs.

—David Rapoport MD CCFP FCFP
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Reference

1. 2010 Canadian Hypertension Education Program recommendations. An annual update. *Can Fam Physician* 2010;56:649-53.

CPS information lacking

We would like to comment on Ms Repchinsky’s response¹ to the Motherisk Update published in the March 2010 issue of *Canadian Family Physician*² regarding the *Compendium of Pharmaceuticals and Specialties* as a reference for safety information on drug use during pregnancy and breastfeeding.

Ms Repchinsky identified a number of useful resources for pregnancy and breastfeeding information that we neglected to mention in our article, as we were focusing on the product monograph, which is frequently used by physicians to elicit information regarding drugs in pregnancy and breastfeeding.

The “Clin-Info” section (a feature of the *Compendium of Pharmaceuticals and Specialties*), *Patient Self-Care*, and the upcoming edition of *Therapeutic Choices*—all published by the Canadian Pharmacists Association—can be a starting point for information on exposures to drugs during pregnancy and breastfeeding, and are more reliable resources than product monographs. However, it appears that many

health care providers might not be aware of these important resources, as consultations with the Motherisk Program most often involve concerns about use of a particular medication during pregnancy and lactation arising from information in the product monograph. Consulting with these Canadian Pharmacists Association publications rather than solely relying on the product monograph would be a better option; if questions remain unanswered or further information is required, the Motherisk Program is available to provide the most current evidence-based information on the safety of drug use in pregnancy and breastfeeding.

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2. Law R, Bozzo P, Koren G, Einarson A. FDA pregnancy risk categories and the CPS. Do they help or are they a hindrance? *Can Fam Physician* 2010;56:239-41.

Food-borne illnesses during pregnancy

We wish to thank Dr Khatter¹ and Ms Taylor and Dr Galanis² for their interest in our Motherisk Update “Food-borne illnesses during pregnancy” published in the April 2010 issue of *Canadian Family Physician*.³

We believe that some of their recommendations are not evidence-based. We concur that it is important for pregnant women to be very careful with regard to consuming certain foods. However, despite their impressions, we did not make contradictory statements, as will be clearly shown here.

Despite the increased relative risk for pregnant women contracting *Listeria*, the absolute risk is extremely low and avoiding deli meats altogether does appear to be

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1. **Clinical Review:** Incretin agents in type 2 diabetes (July 2010)
2. **Practice:** 2010 Canadian Hypertension Education Program recommendations. *An annual update* (July 2010)
3. **Emergency Files:** Mild traumatic brain injury. *Part 2: Concussion management* (July 2010)
4. **Motherisk Update:** Safety of triptans for migraine headaches during pregnancy and breastfeeding (June 2010)
5. **Clinical Review:** Femoroacetabular impingement syndrome. *Nonarthritic hip pain in young adults* (January 2008)

rather punitive. A risk assessment of *Listeria monocytogenes* in ready-to-eat foods conducted by the Food and Drug Administration Center for Food Safety and Applied Nutrition and the US Department of Agriculture Food Safety and Inspection Service estimated the risk of developing listeriosis to be 1.2×10^{-5} (95% confidence interval 3.2×10^{-6} to 1.4×10^{-5}) and 2.0×10^{-7} (95% confidence interval 4.8×10^{-11} to 5.3×10^{-6}) per serving of deli meat and soft cheese, respectively, in the perinatal population. Taking the reciprocal of these values, the model estimates 1 case of listeriosis in 83 000 servings of deli meat or 5 million servings of soft cheese consumed by pregnant women, which is a minimal risk.⁴

To put this in perspective, for a woman who is at less than 20 weeks' gestation, a conservative estimate of the risk of fetal loss following contact with an individual in the contagious stage of fifth disease (parvovirus B19 infection) is 1.8×10^{-3} . This calculation uses the lower estimates of the proportion of the population who are not immune (35%), the chance of maternal infection (20% in a day-care or school setting), the rate of vertical transmission (17%), and the estimated rate of spontaneous loss of fetuses affected by parvovirus B19 before 20 weeks' gestation (14.8%). For a woman who acquires the infection after 20 weeks' gestation, the estimated risk of fetal loss is lower (2.7×10^{-4}), but still 1 order of magnitude higher than the risk of developing listeriosis following consumption of a single serving of deli meat. However, most government agencies do not recommend that pregnant women be routinely excluded from a workplace where an outbreak of fifth disease is occurring.⁵⁻⁸

We strongly believe that each woman should be informed of the nature and magnitude of the risks associated with the consumption of deli meats and soft cheeses. The decision to consume or avoid these foods should be made by her, based on this information, allowing her to make an informed decision. Subsequently, if she chooses not to avoid them, she

should be advised on how she can minimize her exposure (and thus her risk). Factors that determine exposure include amount and frequency of consumption, duration of refrigeration before consumption, and temperature at which the food is stored. We acknowledge that *L. monocytogenes*—unlike most bacterial pathogens—are able to grow at refrigeration temperatures (ie, 4°C). However, growth at 4°C is slow, and limiting the duration of storage will limit bacterial growth.⁹

Therefore, pregnant women should be advised to do the following with respect to deli meats and soft cheeses: 1) limit the amount and frequency of consumption; 2) limit the duration of storage by choosing the freshest foods (ie, those dated as close to the manufacturing or packaging date as possible) and consuming them in a timely manner; and 3) ensure that these foods are kept at the correct temperature (ie, less than 4°C) at all times, including during transport from the retail outlet to the home.

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