Response

We thank Dr Tsai for his thoughtful comments and questions. Our paper "Diagnosing hypertension. Evidence supporting the 2015 recommendations of the Canadian Hypertension Education Program"[1] is a review article and speaks mainly of the value of improving the diagnosis of hypertension through improved blood pressure (BP) measurement in the office and in out-of-office settings. The full evidence-based discussions are published elsewhere.[2,3]

Dr Tsai's initial comment on the cost to patients of out-of-office BP measurement is valid—very few jurisdictions in Canada cover ambulatory BP measurement (ABPM) through provincial health care plans, and no private insurance companies cover ABPM or home BP measurement. We agree this is a serious problem in Canada and is very short-sighted. The mandate of the Canadian Hypertension Education Program (CHEP) is to review the clinical evidence and create recommendations for practice. It is hoped that once the evidence is published, funders will see the merit of providing the necessary technologies and fee codes to improve accuracy of BP measurement. Efforts are currently under way in several provinces to bring the benefit of ABPM testing to the publicly funded system. As we wrote, other jurisdictions (United Kingdom and United States) have made similar recommendations and face the same economic issue for their patients.

The published CHEP recommendations provide a description for instructing patients in performing home BP measurement. Dr Tsai's description is close but not quite accurate: "duplicate measures [should be taken], morning and evening, for an initial 7-day period. First-day home BP values should not be considered."[3]

Although we welcome comments and questions on our recommendations, the evidence does not support Dr Tsai's call for pharmacologic management of patients with white-coat hypertension (WCH). We addressed this concern previously[4,5] and calculated the absolute risk reduction that would be obtained by treating all WCH patients with medications, representing a number needed to treat of 1000 per year. Published evidence shows that treating patients with WCH might lower their office BP readings but not their ABPM[6] or cardiovascular risk.[7,8]

Finally, CHEP agrees fully with Dr Tsai's final comment that as WCH might not be benign, a healthy lifestyle should be encouraged and supported at all times. We do not disagree with his addition of the term *emphasized*.

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Competing interests
Dr Gelfer has received consulting fees from BpTRU, Microlife, and PharmaSmart in the past. **Dr Dawes** has received research funds from AstraZeneca, Pfizer, Janssen, Merck, Roche, and GlaxoSmithKline.

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Correction

In the article "Improving primary care. Continuity is about relationships,"[1] which appeared in the February issue of *Canadian Family Physician,* the authors were listed in the incorrect order. The correct order is as follows:

Cheryl Andres RN Shannon Spenceley RN PhD
Lisa L. Cook PhD Rob Wedel MD FCFP Tobias Gelber MD FCFP

Canadian Family Physician apologizes for this error and any confusion it might have caused.

Reference

1. Andres C, Cook LL, Spenceley S, Wedel R, Gelber T. Improving primary care. Continuity is about relationships. *Can Fam Physician* 2016;62:116-9 (Eng), e57-60 (Fr).

Correction

Dans l'article intitulé « Améliorer les soins primaires. La continuité est une question de relations[1] » et publié dans le numéro de février du *Médecin de famille canadien*, la liste des auteurs aurait dû apparaître dans l'ordre suivant :

Cheryl Andres RN Shannon Spenceley RN PhD
Lisa L. Cook PhD Rob Wedel MD FCFP Tobias Gelber MD FCFP

Le *Médecin de famille canadien* s'excuse de cette erreur et de toute confusion qu'elle aurait pu causer.

Référence

1. Andres C, Cook LL, Spenceley S, Wedel R, Gelber T. Améliorer les soins primaires. La continuité est une question de relations. *Can Fam Physician* 2016;62:116-9 (ang), e57-60 (fr).