Response

We thank Dr Peter Loveridge for his comment[1] on our call to action in controlling hypertension in older women in the October issue of *Canadian Family Physician*.[2] The article is not meant to be a criticism of Canadian primary care physicians. We recognize, congratulate, and participate directly, as clinicians as well as academics, in the stalwart work being done in primary care. We pointed out the declining control and awareness of hypertension in a specific high-risk segment of the population—namely, women older than age 60—as a symptom of a weakness in the health care system.

We are advocating for a rational, organized strategy that uses proven algorithms, team approaches, and registries to achieve blood pressure targets. These interventions (including algorithms with specified drugs and doses) are now a World Health Organization best practice.[3] We are certainly not advocating for aggressive blood pressure management in the frail or physically declining population where the goal is short-term quality of life and not prolonging life or preventing major cardiovascular complications that occur with aging. However, for a healthy, asymptomatic 80-year-old woman with a systolic blood pressure of 160 mm Hg or more, controlling her blood pressure is the intervention most likely to prolong life and prevent disability.

Controlling hypertension has some of the strongest evidence in all clinical medicine to prevent premature death and major disability at a population level. World Health Organization best-practice approaches[3] are being used in several high- and middle-income countries around the world, with success rates that are superseding the control rates in Canada for older women. This involves participation from all levels of government, all health care professionals, and the public. In fact, family physicians and other primary care disciplines are a core part of our guideline and the dissemination process at Hypertension Canada. We also note that the call to action is supported by the College of Family Physicians of Canada, the Canadian Nurses Association, and the Canadian Pharmacists Association, and is coauthored by primary care physicians in academic and clinical practices.

We understand the difficulties of clinical practice in our current environment, especially with the pandemic, as well as the difficulties in advocating for, adapting to, and incorporating the paradigm shifts in the health care system that are needed to optimize care for Canadians.

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Excellent summary of breast cancer recommendations

Your messaging in the January issue of *Canadian Family Physician* is great[1]; we should have a shared decision-making discussion with our patients about mammogram screening. Dr Ed Kucharski, I see that you are Regional Primary Care Cancer Screening Lead at Ontario Health–Cancer Care Ontario. It has concerned me that the messaging from Cancer Care Ontario regarding

breast cancer screening has been "get your mammogram" rather than "discuss with your primary care provider." Dr Elizabeth Del Giudice, I note you are from Sunnybrook Hospital in Toronto, Ont, and there was just a full-page advertisement in *The Globe and Mail* from the Louise Temerty Breast Cancer Centre in Sunnybrook Hospital entitled, "Are you walking around with undetected cancer?"

I know how challenging it is to change the narrative here, but I would really like to see Cancer Care Ontario's messaging changed at the very least. Any thoughts on this?

In addition, the "conditional recommendation" is not explained and we do not come across it that often in the Grading of Recommendations Assessment, Development and Evaluation system.

Finally, the recommendation to screen high-risk patients with colonoscopy is certainly what everyone is doing, but it is not what the Canadian Task Force on Preventive Health Care recommends[2]; they state, "We recommend not using colonoscopy as a screening test for colorectal cancer. (Weak recommendation; low-quality evidence)."

Thanks for this summary; it highlights the key issues!

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Competing interests
None declared

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Use of Roth score in virtual assessments

In response to the commentary in the January issue of *Canadian Family Physician*,[1] I note that virtual assessments have limitations but that the indiscriminate use of in-person examinations and imaging risks overusing resources that are already critically limited during the pandemic. We urgently need research to help identify mild cases of coronavirus disease 2019 (COVID-19) in community contexts and need to know how to manage low-risk patients presenting with dyspnea through virtual assessment.

The Roth score was suggested as a potential tool to assist in the virtual evaluation of patients with dyspnea.[2] There has been substantial controversy surrounding the Roth score. It was the topic of multiple expert reviews.[3-5] In essence, the Roth score is not validated and should not be used in isolation or at all.

While it is essential for clinicians not to be swayed by an unvalidated tool, we are disheartened that