surgery in hypertensive patients, but rather to assess whether introducing beta-blockade immediately prior to surgery and continuing it for 30 days reduced the risk of cardiac events in patients at risk of, or with, coronary artery disease, vascular disease, previous stroke, etc. In POISE, about 60% of patients had a history of hypertension, but there are no data on the quality of blood pressure control or the presence or absence of elevated blood pressure at the time of surgery. Hypertension did not figure among the predictors of adverse outcome, and no data suggest that beta-blockade did more harm than good specifically in hypertensive patients.

We are concerned that your editorial may lead some readers to conclude erroneously that patients on beta-blockers may be particularly at risk and that beta-blockers should be stopped. Beta-blockers are no longer first-line treatment for hypertension, yet, in those receiving them for indications such as coronary artery disease or tachyarrhythmias, cessation prior to surgery could be harmful. Indeed, maintaining beta-blocker treatment receives a Class I recommendation in the recent ACC/AHA/ASA and ESC/ESA guidelines.1,4

We think this needs to be clarified as misinterpretation of your editorial may result in the unnecessary and potentially harmful discontinuation of beta-blocker therapy.

Pierre Foex,
Emeritus Nuffield Professor of Anaesthetics, Nuffield Division of Anaesthetics, University of Oxford. E-mail: pierre.foex@nda.ox.ac.uk

John Sear,
Professor of Anaesthetics, Nuffield Division of Anaesthetics, University of Oxford.

REFERENCES

