

patients redeveloped pain following readministration of the drug therapy. After discontinuation of the drug treatment, some patients experienced immediate improvement while the majority had more gradual improvement.

The FDA received 6 US SAE reports of severe bone, joint, or muscle pain for risedronate sodium (Actonel; Procter & Gamble Pharmaceuticals, Cincinnati, Ohio), a less widely used bisphosphonate, between initial marketing in September 1998 and June 2003. The data suggest a possible class effect.

The clinical trials leading to FDA approval of alendronate and risedronate were reviewed and did not show meaningful differences between drug and placebo for SAE reports of severe bone, joint, and/or muscle pain. However, differences in reported adverse events are sometimes seen for marketplace experience compared with pre-approved clinical trials.

Underreporting of pain is probably considerable because of its subjective nature and because physicians may attribute pain to osteoporosis. Serious or severe bone, joint, and/or muscle pain that begins shortly after bisphosphonate use should be reported to physicians for consideration of discontinuing drug therapy.

Diane K. Wysowski, PhD
Jennie T. Chang, PharmD

Correspondence: Dr Wysowski, Division of Drug Risk Evaluation, HFD-430, Food and Drug Administration, Parklawn Building, Room 15B-08, Rockville, MD 20857 (diane.wysowski@fda.hhs.gov).

Resistance to Use of Perioperative β -Blockers: A No-Man's Land

Siddiqui et al¹ reported underutilization of perioperative β -blockers. We wish to confirm and extend their observation by demonstrating resistance to change.

We prospectively monitored the perioperative use of β -blockers, before and after an intervention among the medical staff, as a project of safety and quality at Hadassah University Hospital (a leading academic center in Jerusalem, Israel), following a recent recommendation² by the Agency of Healthcare Research and Quality.

At baseline, over a period of 6 weeks, 602 patients underwent a noncardiac operation in general surgery, neurosurgery, urology, orthopedics, or gynecology. Of 75 patients who met criteria for β -blocker use, none received this treatment (18 had known coronary artery disease [CAD] and 57 had at least 2 CAD risk factors). In 43 patients receiving β -blockers before surgery, the treatment was maintained.

An intervention included presentations of current evidence and local use at several departmental meetings of surgery and anesthesiology. An institutional protocol for perioperative β -blocker use was developed in agreement with senior cardiologists, anesthesiologists, and surgeons and approved by department heads. In 2 departments, we attempted academic detailing by a visiting nurse who reminded physicians about the protocol and sug-

gested use of β -blocker for patients meeting the criteria. After the intervention, there was no change at all. Over a period of 6 weeks, 475 patients underwent noncardiac operations, 72 patients met criteria for β -blocker use, and none received treatment (18 had known CAD and 54 had at least 2 CAD risk factors).

During the same period and using a similar intervention, we observed a significant increase in the use of low-molecular-weight heparin for postoperative thromboprophylaxis. We were surprised by the resistance to change with regard to the use of perioperative β -blockers: although the medical staff knew and generally accepted the recommendations, they did not get implemented. Only a few physicians might have been aware of an emerging controversy regarding the use of perioperative β -blockers.³

In addition to the explanations suggested by Siddiqui et al,¹ we suggest another reason for this inertia: the surgeon thinks this is a problem for cardiologists or internists (who do not see most of the patients) or for anesthesiologists (who see the patients too late). For this no-man's land problem, we need perhaps a system solution, such as a computer-based reminder.

Avishay Grupper, MD
Mayer Brezis, MD, MPH

Correspondence: Dr Brezis, Center for Quality & Safety, Hadassah University Hospital, PO Box 12000, Jerusalem, Israel (brezis@vms.huji.ac.il).

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An Alternative View of Current Evidence in Support of Perioperative β -Blockers

We read with interest the studies by Siddiqui et al¹ and Lindenauer et al.² Each report has, as its *raison d'être*, the supposition that perioperative β -blockade is the standard of care for the prevention of postoperative cardiac complications. Furthermore, both studies presume that physicians who do not prescribe β -blockers are not practicing good perioperative medicine. We wish to express the contrarian view that the evidence supporting the recommendation for perioperative β -blockade is insufficient and that a vast amount of research is still required in the field of perioperative risk reduction.

Two meta-analyses have pooled the data from randomized controlled studies of perioperative β -blockade.^{3,4} Although both groups of reviewers found statistically significant reductions in myocardial infarction (MI), the pooled effect estimates were heavily weighted by 2 studies. One study was an *interim* analysis of an un-