the importance of unhealthy lifestyles in promoting population-wide rises in blood pressure, leading to an increase in the prevalence of hypertension in the United States and most other parts of the world.

Shil raises issues regarding the management of systolic hypertension in elderly patients. Although the control of hypertension in the geriatric population is admittedly an important and complex problem, it was not the focus of the lecture, and space considerations precluded a full discussion of the topic. However, my views on the subject have been summarized in another publication.[2]

Spital disagrees with the designation of "prehypertension" for persons with blood pressures in the 120–139/80–89 mm Hg range and instead would replace the term with "stage 1 hypertension." The prehypertension terminology has been the subject of considerable discussion and debate since its introduction in 2003.[1] It identifies persons who are at greater risk of cardiovascular disease than those who have lower blood pressures.[1] Other than for patients with chronic renal diseases, diabetes, or certain cardiac conditions, no data are yet available for this group regarding the benefits or risks of therapy with antihypertensive drugs. Until such evidence becomes available, it is appropriate to classify such persons as prehypertensive and restrict therapy to appropriate healthy lifestyles that reduce blood pressure and minimize age-related increases.

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COX-2 Inhibitors in Patients with Sensitivity to Nonselective NSAIDs

TO THE EDITOR: Controlled oral challenge is the only definitive way to detect sensitivity to nonsteroidal antiinflammatory drugs (NSAIDs) in patients with adverse reactions to these agents.[1] Patients who have adverse reactions to nonselective NSAIDs have very limited analgesic and antiinflammatory therapeutic options, but several studies have shown that highly selective cyclooxygenase-2 (COX-2) inhibitors can be safely used.[2-4] However, in a small percentage of cases, adverse reactions (respiratory or cutaneous) have been observed during challenge with a COX-2 inhibitor.[5] When these occur, the next step to be taken is not clear. Can we use another highly selective COX-2 inhibitor as a safe alternative? We present two patients with skin reactions to highly selective COX-2 inhibitors (confirmed by oral challenge) who had no adverse reactions to another COX-2 inhibitor.

The first patient was a 69-year-old man with no history of asthma or atopic disorders who had several episodes of exanthema during treatment with nonselective NSAIDs (ibuprofen, aspirin, diclofenac, and dipyrone). A single-blind, placebo-controlled oral challenge with the highly selective COX-2 inhibitor etoricoxib was carried out in a supervised hospital setting. A nonpruritic exanthem limited to the patient's arms and internal thighs developed 145 minutes after he reached the 60-mg dose. Diphenhydramine and deflazacort were administered orally, with rapid clinical resolution. One week later, a similar oral challenge was performed with 200 mg of celecoxib; no adverse reaction occurred.

The second patient was a 32-year-old woman without asthma in whom a generalized cutaneous rash had previously developed when ibuprofen and dipyrone were administered. She underwent a single-blind, placebo-controlled oral challenge with celecoxib, and a non-itching exanthem on her upper limbs developed 60 minutes after she reached the 200-mg dose. A similar oral challenge confirmed that there were no adverse reactions to 60 mg of etoricoxib. Neither patient had an adverse reaction to acetaminophen.

These cases show that choosing another highly selective COX-2 inhibitor may be a safe alternative in patients who have adverse reactions to nonselective NSAIDs and who have previously had an adverse reaction to a first COX-2 inhibitor. They

also show that not all persons with adverse reactions to nonselective NSAIDs will necessarily be free of adverse reactions to COX-2 inhibitors.

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The program will be held in Rotterdam, the Netherlands, Jan. 18–Feb. 5.

Contact S. de Groot, Erasmus MC, P.O. Box 2040, 3000 CA, Rotterdam, the Netherlands; or call (31) 10 7043669; or see http://www.erasmuswinterprogramme.nl; or e-mail s.degroot@erasmusmc.nl.

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Contact Valesca Hulsman, IQ Healthcare, Internal postal code 114, P.O. Box 9101, 6500 HB Nijmegen, the Netherlands; or call (31) 24 3615320; or e-mail v.hulsman@iq.umcn.nl.

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