

adverse effects of treatment on mortality, which was previously a concern, and indeed showed a beneficial effect. We can cautiously infer that the treatment of high blood pressure is unlikely to do harm in a general population.

The data supplied by Messerli et al. may not provide an appropriate comparison with our results, since the vast majority of their patients appear to be under the age of 80 years. Those who reach 80 years are, by definition, survivors.

As noted by Cheah and Wilson, side-effect profiles and safety are important considerations in regard to potentially long-term pharmacologic interventions, particularly in the elderly, who have adverse drug reactions more commonly than younger patients. In our study, there were fewer serious adverse events in the group that received indapamide than in the placebo group. Data on other adverse events were not routinely collected. Preliminary analyses revealed nonsignificant differences in serum sodium levels between the two groups in the 2-year cohort and no increase in orthostatic hypotension, although the majority of patients were receiving treatment with a combination of indapamide and perindopril at 2 years.

The performance of subgroup analyses and the extrapolation of data from such studies always arouse concern.¹ There were too few patients who were recruited from Western Europe and the follow-up of Chinese patients was too short to al-

low for comparisons on the basis of country. However, the combination of being 80 years of age or older and having hypertension already puts a person at high risk for a future cardiovascular event, and HYVET showed positive benefits with regard to cardiovascular events. A history of treatment for hypertension was not a criterion for assignment to a prespecified subgroup and was not analyzed as such.

Sutton asks whether it was ethical to include patients who had already had a stroke or myocardial infarction in our study. Evidence of a benefit in patients who are 80 years of age or more is very scanty and has accrued since the trial was started. In the Perindopril Protection against Recurrent Stroke Study (PROGRESS),² patients were much younger than those in our study. A history of cardiovascular disease was a criterion for assignment to a prespecified subgroup and will be addressed in future analyses of HYVET data.

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1. Lagakos SW. The challenge of subgroup analyses — reporting without distorting. *N Engl J Med* 2006;354:1667-9. [Erratum, *N Engl J Med* 2006;355:533.]
2. PROGRESS Collaborative Group. Randomised trial of a perindopril-based blood-pressure-lowering regimen among 6,105 individuals with previous stroke or transient ischaemic attack. *Lancet* 2001;358:1033-41. [Errata, *Lancet* 2001;358:1556, 2002; 359:2120.]

Keratoderma Blennorrhagicum–like Rash

TO THE EDITOR: Tonna and Laing (May 15 issue)¹ describe a patient with secondary syphilis. I question the authors' use of the term "keratoderma blennorrhagica," which are the psoriasiform and vesicular pustular lesions of the palms and soles seen in Reiter's syndrome, along with symptoms involving the joints, eyes, and urinary tract. Although similar, the lesions depicted in this Image in Clinical Medicine appear to be the typical symmetric papules and plaques with collarette scales (i.e., Bielt collarettes) seen on the palms and soles in secondary syphilis. The lesions shown appear to be classic and pathognomonic for secondary syphilis.

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1. Tonna I, Laing RBS. Keratoderma blennorrhagica. *N Engl J Med* 2008;358:2160.

THE AUTHORS REPLY: We agree with Lombardo that the term "keratoderma blennorrhagicum" is often used in conjunction with Reiter's syndrome. However, syphilis can mimic a number of conditions, and as Lombardo suggests, the lesions look similar to keratoderma. We wanted to make the point that when someone presents with such a rash on the soles, the differential diagnosis should include secondary syphilis.

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