We should do better. I think by and large chlorthalidone or indapamide have a renaissance. The other issue to be considered is that we were so convinced that ACEIs and ARBs are the way to go that we almost forgot that calcium channel blockers (CCBs) are as efficacious—if not more efficacious—than ACEIs and ARBs, and we know now that amlodipine and to some extent nifedipine are very well-documented drugs that have excellent outcome data and have been shown to reduce morbidity, mortality, heart attack, stroke, and death, in some cases even better than the ACEIs and ARBs.

In a nutshell, what we do know is that chlorthalidone or indapamide as diuretics, amlodipine and nifedipine as CCBs, and the ARBs and ACEIs are all suitable for first-time therapy. Clearly we have learned that β-blockers are no longer in that position.

A loaded question but an incredibly informative answer. The notion that hydrochlorothiazide data are almost nonexistent but those for chlorthalidone and indapamide are available is revolutionary for most of the primary practitioners, including myself. The dose of chlorthalidone would be similar to that of hydrochlorothiazide?

Actually no, it is about half. We just recently published a paper in the *Journal of the American College of Cardiology* showing that 6.25 mg is a decent antihypertensive dose of chlorthalidone. So you can use a minimal dose. In the US, we actually have the problem that the lowest dose available is 25 mg, so if you break the tablet it usually crumbles, but I tell my patients, “Just take a crumb.”

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REFERENCES