nomic medications were encouraged over brand name medications, but medications representing all therapeutic classes for hypertension treatment were available. Clinicians were encouraged to follow evidence-based practice; however, there was no mandate to use a specific agent in the initial treatment of hypertension.

While the patterns of care observed may not be generalizable to other settings, these 3 health care systems care for over 4 million patients in geographically distinct areas and the patient cohort included a clinically and demographically diverse population, approximately 50% female and 17% African American/Hispanic patients. Our findings of a slow but persistent increase in thiazide use suggest that clinical practice guidelines may have an impact on practice within these health care systems.

P. Michael Ho, MD, PhD
Chan Zeng, PhD
Heather M. Tavel, MS
Joe V. Selby, MD, MPH
Patrick J. O’Connor, MD, MPH
Karen L. Margolis, MD, MPH
David J. Magid, MD, MPH

Author Affiliations: Institute for Health Research, Denver, Colorado (Drs Ho, Zeng, and Magid, and Ms Tavel); Denver Department of Veterans Affairs Medical Center, Denver, Colorado (Dr Ho); Departments of Medicine (Dr Ho) and Emergency Medicine (Dr Magid), University of Colorado, Denver; Division of Research, Kaiser Permanente of Northern California, Oakland (Dr Selby); and HealthPartners Research Foundation, Minneapolis, Minnesota (Drs O’Connor and Margolis).

Correspondence: Dr Ho, Denver VA Medical Center, 1055 Clermont St (111B), Denver, CO 80220 (michael.ho@va.gov)

Author Contributions: Drs Ho and Magid had full access to all of the data in the study and take responsibility for the integrity of the data and the accuracy of the data analysis. Study concept and design: Ho, Selby, O’Connor, and Magid. Acquisition of data: Tavel, Selby, O’Connor, Margolis, and Magid. Analysis and interpretation of data: Ho, Zeng, Selby, O’Connor, Margolis, and Magid. Drafting of the manuscript: Ho. Critical revision of the manuscript for important intellectual content: Ho, Zeng, Tavel, Selby, O’Connor, Margolis, and Magid. Obtained funding: Selby and Magid. Administrative, technical, and material support: Tavel, Selby, O’Connor, and Magid. Study supervision: Magid.

Financial Disclosure: Dr Ho serves as a consultant for WellPoint Inc. Dr Margolis receives research support from Bristol-Myers Squibb in the form of an institutional research grant.

Funding/Support: This study was funded by grant U19HL091179 from the National, Heart, Lung, and Blood Institute as part of the Cardiovascular Research Network. Dr Ho is supported by a VA Research & Development Career Development Award (05-026-2).


Clinical and Molecular Evidence for Transmission of Novel Influenza A(H1N1/2009) on a Commercial Airplane

Influenza A(H1N1/2009) has spread rapidly throughout the world by international air travel. However, in-flight transmission of the virus has not been well documented. We report 6 cases of influenza A(H1N1/2009) associated with a single flight from the United States to Asia via Europe (“Flight A”) linked by molecular epidemiological data.

See also pages 861 and 868

Report of Cases. Five passengers and 1 crew member who had traveled on Flight A presented with acute onset of fever, malaise, cough, sore throat, or rhinorrhea, with the first case presenting symptoms while he was in New York, New York, and the rest within 3 days of the flight’s arrival in Singapore. All were discharged well, without se-
A total of 596 passengers and crew members were on Flight A's route at that time (as demonstrated by the 98 bootstrap value in the Figure). The phylogenetic tree built from these sequences shows that the crew member was infected by a virus strain virtually identical to other New York strains circulating at the time, while passengers (including the business class passenger [case 2]) were infected by viruses that could be derivatives of this strain. Overall, the molecular and epidemiological data support the evidence of in-flight transmission of influenza A(H1N1)2009, although the precise mode of transmission is difficult to ascertain with certainty.

**Comment.** Modern commercial aircraft with high-efficiency particulate filters and frequent recirculation of cabin air have reduced the risk of transmission of airborne respiratory infections. Spread of respiratory viral infections, however, is thought to be related to infectivity of the source patient(s), proximity, and duration of contacts. Only 2 of the infected passengers on Flight A would have been detected using the WHO criteria for contact tracing. This was also the case with severe acute respiratory syndrome, another emerging viral infection, transmitted predominantly by large particle droplets and direct contact with respiratory secretions or fomites. Perhaps contact tracing all passengers and crew in the same cabin or served by the same crew might be more appropriate in future airline outbreak investigations.

Human activities including onboard interactions may be important in in-flight influenza transmission. Our study showed that the infected passengers slept less on the plane (P = .06; Table). This was also reported in an outbreak of influenza on a delayed Alaskan Airlines flight in 1977. Unfortunately, too few of the passengers we studied used hand sanitizers or masks to assess their impact in reducing transmission of respiratory infections in air travel.

The most important limitation of our study is that we were unable to interview the majority of passengers and crew on Flight A or to do airflow, environmental, or seroepidemiological studies. We also depended on reporting from other international agencies to ascertain all infections. We could thus have underestimated the attack rates.

Our clinical, epidemiological, and molecular evidence are, however, highly suggestive that influenza A(H1N1/2009) transmission occurred on board Flight A, possibly through human interaction in a crowded cabin. Efforts to contain future emerging respiratory viral in-
One Can’t Judge a Stent by Its Cover

The “law of unintended consequences” states that any purposeful action will produce some unintended consequences.1 The recent acquisition of the Guidant Corporation by Boston Scientific (BS Corporation) has led to policies that promote wasteful spending, delay the acquisition of necessary clinical information, and expose the interventional cardiology community to potential appearance of conflict of interest at a time when physician-industry relationships are being carefully scrutinized.2-4

In 2006, BS Corporation purchased Guidant Corporation for $2.7 billion. In an attempt to avoid competitive market imbalance, the Federal Trade Commission (FTC) also approved the acquisition of Guidant’s vascular business by Abbott Laboratories, Abbott Park, Illinois. The 3-way deal was quite complex, and as a result of this deal, BS Corporation was given the right to co-market the Xience V (Abbott Laboratories) drug-eluting stent system under a different name (PROMUS; BS Corporation). Marketing approval was then granted by the Food and Drug Administration (FDA) allowing 2 new (yet identical) options to enter the US market.3 Clearly, the profits, sales revenue, and market share are dependent on which company supplies the device, but in reality, this should have no impact for the end user.

The FDA has mandated that new drug-eluting stents be labeled as “2” stents in the marketplace, with separate studies demonstrating the safety and efficacy of these 2 types. While we applaud this requirement, there are unintended consequences because these 2 stents are the same. By allowing the identical device to be marketed under 2 different names (Xience V and PROMUS), the FDA and the FTC have created the perception that these 2 stents are different devices. Each company is running their own postmarketing surveillance, which makes no sense for identical devices. Instead of combining resources for 1 large registry of Xience V and PROMUS implantations that could rapidly enroll, separate studies delay enrollment, waste money, and most importantly divert attention and resources away from optimal patient care.

It would appear that excess profit concerns have led to a situation that has shifted the focus away from the patient. Companies bring products to market that are similar if not identical (in this case) to other products. Physicians choose between these products based on factors beyond what is best for the patient.

Dealing with these “2” stents in the marketplace varies across the country. Hospitals and buying groups have the choice of purchasing identical products in different colored boxes, with different names, from 2 different vendors. Some hospitals have chosen one over the other, while others have honored historic relationships and have products from both companies. With the assumption of price neutrality, which is often difficult for physicians to ascertain (owing to lack of awareness, lack of knowledge,