authors concluded that venous ulcers healed more rapidly and with lower overall cost with compression therapy than without. In the largest trial (N=233) the compression group healed in 20 weeks versus 43 weeks without compression (P=.03).

Five trials included in the above Cochrane review specifically compared the effectiveness of a 4-layer bandage system (more commonly used in the United Kingdom) with the “Unna boot” (a less expensive system favored in the United States).1 Pooled data from 2 of these trials (N=71) revealed no significance difference between the 2 systems in complete healing at 1 year (RR 1.3; 95% CI, 0.78–2.3). Data from the 2 largest and most recent trials (N=201) could not be pooled but neither demonstrated any significant differences in complete healing between the 2 systems at 6 months and 1 year.

A meta-analysis of 8 RCTs (6 included in Cochrane review above) including 692 patients compared the effectiveness of calf-length medical compression stockings (MCS) with various compression bandages in healing VLU.2 MCS were more effective than other bandages in healing VLU (OR of failure 0.44; 95% CI, 0.32–0.61). Time to healing (in weeks) was less with MCS (standard mean difference [SMD] –0.33; 95% CI, –0.50 to –0.16) and averaged 3 weeks shorter when compared with compression bandages.

A Cochrane review of 42 RCTs (N=3,001) evaluated the effectiveness of various wound dressings (hydrocolloids, foams, alginates, hydrogel dressings, and gauze) used under compression dressings or hosiery in the treatment of VLU.3 A meta-analysis of 8 trials (N=311) comparing the effectiveness of hydrocolloid dressings with gauze observed no significant difference in effectiveness (RR 1.1; 95% CI, 0.89–1.3). Data were insufficient to reach strong conclusions for other dressing types, but there was no evidence indicating any one dressing as superior to another.

Another Cochrane review found that pentoxifylline with compression was more effective for healing VULs than placebo with compression (7 trials; N=659; RR 1.6; 95% CI, 1.1–2.1).4 Pentoxifylline without compression was more effective in healing ulcers than placebo or no treatment (4 trials; N=182; RR 2.3; 95% CI, 1.5–3.4). A small prospective RCT (N=51) evaluated the effect of aspirin 300 mg/d versus no drug treatment on the healing rate of VLU.5 All patients received standard compression therapy. Patients with diabetes, ankle-brachial index <0.9, and prior treatment with nonsteroidal anti-inflammatory drugs or anticoagulants were excluded. Healing time was significantly shorter in the aspirin group compared with the control group (12 vs 24 weeks; P=.04).
received the other treatment for 2 months (period 2). IOP was measured in all groups at the 1- and 2-month time marks.

For the PEA-treated groups in both study periods, at 1 and 2 months, respectively, the mean IOP reduction was 3.2 mmHg (14.7%) and 3.5 mmHg (15.9%; ANOVA \( P < .001 \)). This agent has been evaluated only in Italy and is not available in the United States.²

The American Glaucoma Society recommends against smoking marijuana for glaucoma, citing its short duration of action, psychoactive potential, and the harmful effects of marijuana smoke on the lungs.³

**How effective is salt restriction in treating hypertension?**

**Evidence-Based Answer**

In hypertensive patients, salt restriction decreases systolic blood pressure by 1 to 4 mmHg and diastolic pressure by 0.5 to 4 mmHg when the diet is maintained >6 months. Shorter periods of salt restriction yield slightly greater reductions (5 mmHg for systolic and 2.5 mmHg for diastolic blood pressures) (SOR: C, systematic reviews of disease-oriented outcomes).

Cardiovascular disease (CVD) is associated with significant morbidity and mortality as well as substantial health care costs. In 2007, the World Health Organization released its guidelines for the primary prevention of CVD and recommended limiting daily salt intake to <5 g/d to reduce the incidence of hypertension.¹

A 2011 Cochrane review of 7 RCTs with 6,489 participants focused on the cardiovascular benefits of reduced salt intake in adults over periods of longer than 6 months.² The intervention groups received initial and follow-up education on salt reduction and diets targeting between 70 and 100 mmol/d or <80 mmol of daily sodium intake.

A meta-analysis of the hypertensive subgroups (2 trials; N=758 patients) followed for 24 or 30 months yielded a decrease in systolic blood pressure of 4.1 mmHg (95% CI, 5.8–2.4) and diastolic pressure of 3.7 mmHg (95% CI, 8.4–0.93) compared with control groups who received no dietary education. Neither all-cause mortality nor cardiovascular morbidity was altered in salt-restricted individuals. The authors noted that the analysis was underpowered to be conclusive regarding the positive or negative effects of salt restriction.²

A 2008 Cochrane meta-analysis of 20 RCTs with 802 individuals focused on the effects of reduced salt intake on blood pressure over periods as short as 4 weeks.³ The intervention groups had a daily salt intake of 3.4 to 7.4 g, which correlated with a net reduction of 3.1 to 6.9 g/d of dietary salt intake (vs the usual salt intake of 9.5 g/d).

Of the 19 RCTs (number of patients not defined) in this review that followed systolic blood pressures in hypertensive patients compared with a control group, a 5.1-mmHg reduction was noted (95% CI, 4.3–5.8). In the 21 studies (number of patients not defined) in this review that followed diastolic blood pressures in hypertensive patients compared with a control group, a 2.7-mmHg reduction was noted (95% CI, 2.2–3.2). The trials ranged from 4 weeks to 1 year (median 5 weeks).³
