The editorial written by Verma and Strauss in *British Medical Journal* of 27th November, 2004, (349:1248) puts the possibility that angiotensin II receptor blockers may be associated to the increase of acute myocardial infarction (AMI) rate. Clinical assays used to base such hypothesis were VALUE study1 and CHARM-alternative2. In both there was a statistically significant increase in the incidence of myocardial infarctions, with 19% (CI 95% from 2 to 38%) and 52% (CI 95% from 6 to 118%), respectively. However, the two greatest comparative studies with cardiovascular outcomes between ARB-II and angiotensin converter enzyme inhibitors (ACEI) were put aside, which means, OPTIMAAL3 and VALIANT4 studies.

In OPTIMAAL study, 5,477 post-AMI and left ventricular dysfunction patients were randomized for losartan (50 mg/day) or captopril (150 mg/day). After a 2.7-year follow-up, there was an excess of mortality in losartan group, but without reaching statistical significance (18% vs. 16%, p=0.07) and AMI incidence between groups was the same (14%).

In VALIANT study, 14,703 post-AMI individuals were randomized for valsartan, captopril or the combination of both. Results were shown neutral within limits of primary outcome (death) among the three groups. The number of AMI individuals was similar between valsartan (820) and captopril (840) groups, therefore, without statistically significant indication (16.7% vs. 17.1%) of excess between the groups.

Therefore, the hypothesis shown by the authors on mortality excess due to AMI associated to the use of ARB-II does wrong from tendentiousness and incomplete analysis. The ideal scenery to test such hypothesis would be the one of a clinical assay to detect clinically relevant differences, in the specific case, the incidence of fatal and non-fatal myocardial infarctions, in the comparison between ARB-IIs and ACEIs. Results from ONTARGET and TRANSCEND5 studies are expected to clarify that matter even more. By then, a decent alternative would be a meta-analysis6 with all available studies, in an impartial and non-oblique way.

ACEIs have a long positive history of positive results and great clinical relevance, including the reduction of acute myocardial infarction incidence among high cardiovascular risk patients. ARB-IIs, so far, have not shown superiority when compared to ACEIs in this and in other contexts, such as in heart failure. In the presence of such facts, ACEIs are still the best option when it comes to inhibit rennin-angiotensin system searching for relevant results for the patient. ARB-IIs are useful in cases of intolerance (especially cough and angioedema) to ACEIs. Those cases occur from 5 to 20% of the cases of first exposure to ACEIs, that is, at least 80% of the individuals are tolerant to ACEIs, and they can use them chronically. The affirmative that ARB-IIs are not alternative anymore, but “substitutes” for ACEIs, has no sound scientific basis. Besides, cost-effectiveness aspects must be considered in a country like Brazil, and also in this item, ACEIs remain superior to ARB-IIs and, therefore, the first choice.

References