



Fighting Hypertension: Let's Try Harder

Hypertension is extremely prevalent in the United States—and will become more so as the population ages and the epidemic of obesity expands. Although the condition is usually asymptomatic, the damage it wreaks on the vascular system is truly devastating in scope.

Hypertension is the single most important risk factor for stroke, which has been identified consistently as one of the maladies most dreaded by patients. It is also a key risk factor for coronary artery disease, peripheral arterial disease, and congestive heart failure. Indeed, data from the landmark Framingham epidemiologic survey, which has been ongoing since the late 1990s, continue to demonstrate that poorly controlled hypertension remains the number one etiology for congestive heart failure.¹ Additionally, hypertension is second only to diabetes as an etiology in the current epidemic of end-stage renal failure, a true scourge that afflicts black patients disproportionately. Hypertension also has been implicated in progressive visual loss and in the progressive dementia for which most of our older patients are at high risk.

It seems incontrovertible that hypertension is a condition with devastating outcomes for many if it is not brought under control. But, if that is the case, why are we in the United States doing such a dismal job of helping patients achieve their blood pressure (BP) goals? Several recent surveys, such as the CDC's National Health and Nutrition Examination Survey epidemiologic data sets, have demonstrated that, at best, only about a third of hypertensive patients reach their BP goals.² Recent performance measures for federal practitioners suggest that we may be doing better than the general community in

this respect,³ but there is much room for improvement all around.

What are the current recommended BP goals? The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC-7), issued in May 2003, identifies a systolic BP of less than 140 mm Hg and a diastolic BP of less than 90 mm Hg as the goal for the majority of people with hypertension.² For patients with diabetes or renal insufficiency, the goal is a bit more aggressive: a systolic BP of less than 130 mm Hg and a diastolic BP of less than 80 mm Hg.

Why is it proving so difficult for patients to achieve their BP goals? Admittedly, part of the problem can be attributed to patient apathy—though even there, we practitioners are not entirely off the hook, for it's our job to stress the importance of hypertension control with vigor. The reality is that patients are often sluggish in their

lem that was addressed specifically by the JNC-7 panel was "clinical inertia," a term meant to convey the unfortunate complacency that many practitioners demonstrate when they fail to titrate or combine medications or to reinforce lifestyle modifications for patients who continue to miss their BP goals.² Likewise, some providers do little but switch patients, fruitlessly, from one antihypertensive medication to another.

Only a distinct minority of patients have their BP controlled by a single class of antihypertensive medication. And while there are minor differences in the response to medications between certain racial and age groups, a general rule worth remembering is that all classes of antihypertensive medication work reasonably well in all patients. The imprecision with which BP typically is measured in the office setting may obscure the beneficial effects of a particular medication, but it is a bad

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efforts to decrease salt intake, increase activity levels, reduce alcohol consumption, and bring their weight down to healthy levels. Even worse, they are sometimes cavalier in their adherence to medication regimens, finding it difficult to stick with ongoing treatment for a condition that causes them no symptoms.

Ultimately, though, it is the practitioner who must bear the bulk of the responsibility when patients fail to achieve the desired BP levels. One prob-

idea to discontinue a given medication simply because it does not appear to be working for a particular patient. Medications should be discontinued only if there are disabling adverse effects; otherwise, the operative principle should be to add small to moderate doses of medications from different antihypertensive classes until the BP goal is achieved.

The recent emphasis on the findings of the landmark Antihypertensive and Lipid-Lowering Treatment to

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Prevent Heart Attack Trial (ALLHAT), which was sponsored by the National Institutes of Health and completed in March 2002,⁴ may have contributed inadvertently to underutilization of combination therapy. The focus in the dissemination of the ALLHAT results has been on the relative utility and advantages of diuretics as compared with two newer agents: calcium channel blockers and angiotensin converting enzyme inhibitors.⁵ Unfortunately, these arguments comparing one class with another appear to have reinforced the false impression that a single class of medication can get the job done all by itself—obscuring the larger truth that most patients require two, three, or even more classes of antihypertensive medications to achieve their goal. Aggressive and early use of combination regimens clearly is needed if the

bulk of our patients are to achieve BP goals in a timely fashion.

Our nation has a great number of older, vulnerable patients who currently are poised at the knife's edge of the potentially devastating consequences of poorly controlled hypertension. It's time to take action and harvest the low hanging fruit of vascular risk reduction that is represented by aggressive blood pressure lowering. ●

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adverse effects—before administering pharmacologic therapy to patients.

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