

Masked Hypertension Guidelines Found Lacking

BY DAN HURLEY

EXPERT ANALYSIS FROM THE ANNUAL MEETING OF THE AMERICAN SOCIETY OF HYPERTENSION

NEW YORK — Guidelines for detecting masked hypertension in adults should be changed to account for pre-existing conditions such as diabetes and kidney disease, Dr. Robert A. Phillips said at the meeting.

“Masked hypertension isn’t adequate-

ly addressed by current guidelines,” said Dr. Phillips, director of the Heart and Vascular Center of Excellence and professor of medicine at the University of Massachusetts, Worcester. “We’re only beginning to understand how prevalent it is, and how dangerous.”

He reviewed a host of studies indicating that recent recommendations for when to use home and ambulatory blood pressure monitoring (ABPM) would miss

the majority of those affected (J. Am. Soc. Hypertens. 2008;2:119-24). Rather than selecting those with borderline hypertension for ambulatory monitoring, he urged hypertension specialists to focus on other risk factors supported by a growing body of evidence: smoking, diabetes, chronic kidney disease, left ventricular hypertrophy, microalbuminuria, and obstructive sleep apnea.

Support for the view that borderline

blood pressure is a red herring—not a red flag—in the case of masked hypertension was found in a study presented at ASH. Fourteen percent of children aged 5-15 whose BP readings were normal when measured at a hypertension referral clinic nevertheless met diagnostic criteria for masked hypertension when assessed by ABPM, a Brazilian researcher reported.

The study involved 99 children who had been referred to have their BP eval-

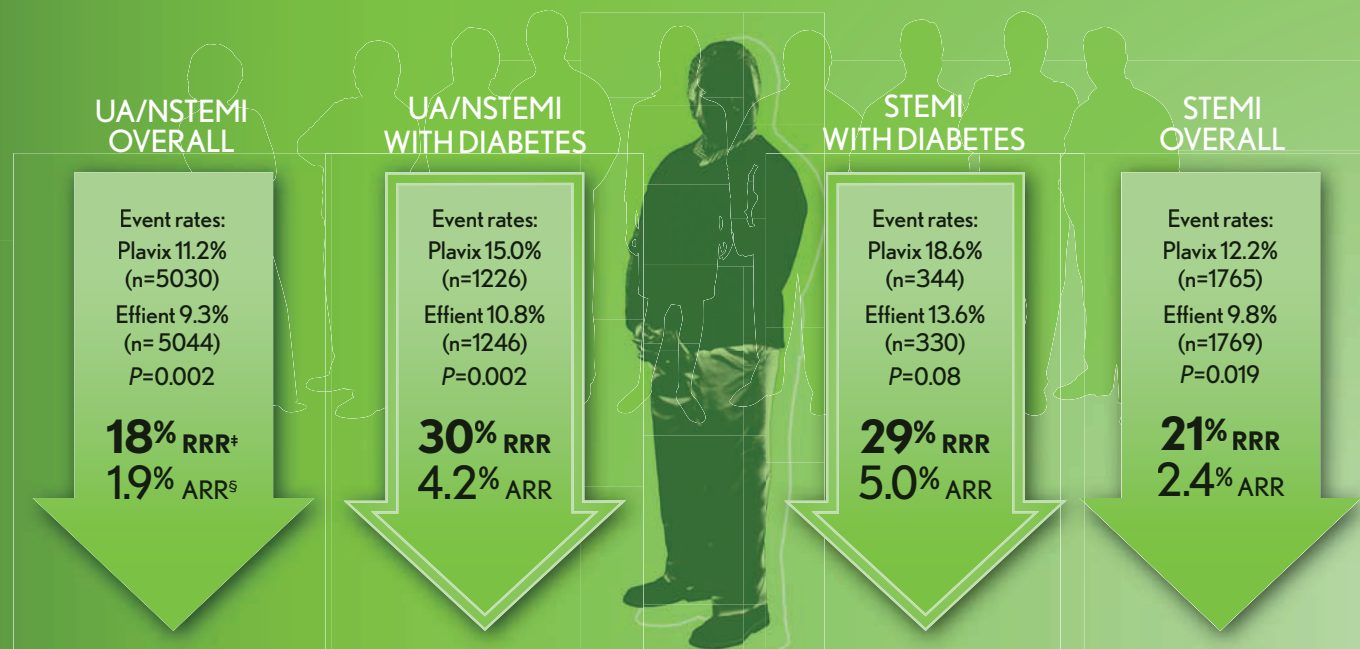
INDICATIONS AND USAGE

Effient is indicated to reduce the rate of thrombotic CV events (including stent thrombosis) in UA/NSTEMI patients who are to be managed with PCI and in STEMI patients when managed with primary or delayed PCI



REDUCTIONS IN THROMBOTIC CV EVENTS: TRITON-TIMI 38 DIABETES SUBGROUPS**†,‡

The greater reduction in the primary composite endpoint in patients with diabetes treated with Effient plus ASA compared with Plavix plus ASA was consistent with those observed in the overall UA/NSTEMI and STEMI populations



*As measured by reduction in the primary composite endpoint of CV death, nonfatal MI, or nonfatal stroke. †The loading dose of Effient was 60 mg followed by a 10-mg daily dose (plus ASA) and the loading dose of Plavix was 300 mg followed by a 75-mg daily dose (plus ASA). ‡Relative risk reduction. §Absolute risk reduction.

- In the overall study, the benefit in each population was primarily driven by a significant reduction in nonfatal MIs, with no significant differences in CV death or nonfatal stroke¹
 - Approximately 40% of MIs occurred periprocedurally and were detected solely by changes in CK-MB
- In TRITON-TIMI 38, the loading dose of Plavix was delayed relative to the placebo-controlled trials that supported its approval for ACS
- TRITON-TIMI 38 was not prospectively designed or powered to determine if Effient would have greater efficacy over Plavix in the UA/NSTEMI or STEMI diabetes subgroups alone

SELECTED SAFETY, INCLUDING SIGNIFICANT BLEEDING RISK

Effient can cause significant, sometimes fatal, bleeding. With the dosing regimens used in TRITON-TIMI 38, major and minor bleeding events were more common with Effient plus ASA compared with Plavix plus ASA.

uated at a pediatric hypertension clinic at the Federal University of Goiás in Brazil. Of these, 17 were diagnosed in the clinic as having an office BP higher than the 95th percentile. The remaining 82 subjects were all assessed by ABPM.

None of the 12 children who had previously been found to have borderline high BP in the office (greater than 90th but less than 95th percentile) showed evidence of masked hypertension according to the ABPM. But 10 of the 70 children who had normal BP during the office visit had masked hypertension.

The critical factors associated with in-

creased risk of masked hypertension were in the children's parents—not in the children themselves. Children of hypertensive parents had a 4.3-fold increased risk of masked hypertension compared with children whose parents had normal BP. Children whose parents had a waist-to-hip ratio of at least 0.9 had a ninefold increased risk of masked hypertension, compared with those whose parents did not have abdominal obesity.

“When children are referred to you for possible hypertension, and their parents have these characteristics, you should consider assessing them for masked hy-

pertension,” said the study's lead author, Dr. Claudia Maria Salgado of Federal University of Goiás's department of pediatrics and hypertension league.

The 2008 recommendations suggest the use of self-measurement home BP or ABPM when patients' office BP is greater than 125/75 but less than 135/85 mm Hg. But Dr. Phillips said that following those recommendations will fail to identify many of the patients at risk for the condition. Patients with type 2 diabetes who have normal BP during office visits are 1.6 times more likely to have masked hyper-

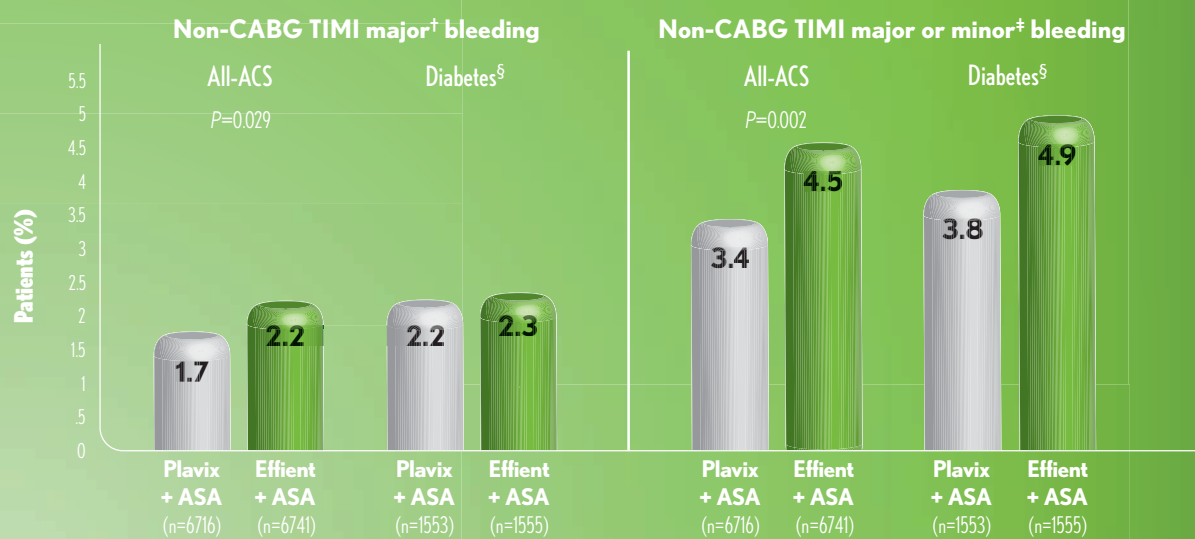
tension than are patients without diabetes

(Arch. Intern. Med. 2007;167:2139-42). He proposed new guidelines: Patients with one of the risk factors for masked hypertension should conduct self-measurements of BP at home. Those with self-monitored BP of at least 135/85 mm Hg should have their drug treatment intensified; those with a BP of less than 125/75 mm Hg should be considered normal; and those between the two poles should be assessed by ABPM.

In those diagnosed as having masked hypertension, Dr. Phillips urged physicians to treat them by lowering nocturnal BP. ■



NON-CABG-RELATED BLEEDING: TRITON-TIMI 38 ALL-ACS POPULATION, INCLUDING DIABETES SUBGROUP*1,4



*Observed event rates. [†]Intracranial hemorrhage or clinically overt bleeding associated with a fall in hemoglobin ≥ 5 g/dL. [‡]Clinically overt bleeding associated with a fall in hemoglobin of ≥ 3 g/dL but < 5 g/dL. [§]P value not provided because the trial was not designed to prospectively evaluate bleeding differences in subgroups.

- In TRITON-TIMI 38, overall rates of non-CABG TIMI major and non-CABG TIMI major or minor bleeding were significantly higher on Effient than on Plavix¹
- In patients who underwent CABG (n=437), the rates of CABG-related TIMI major or minor bleeding were 14.1% with Effient plus ASA and 4.5% with Plavix plus ASA. Do not start Effient in patients likely to undergo urgent CABG¹
- Patients at highest risk of bleeding were those ≥ 75 years of age and/or those < 60 kg (132 lb)¹
- Effient is contraindicated in patients with active pathological bleeding, such as from a peptic ulcer or ICH, or a history of TIA or stroke¹
 - Patients who experience a TIA or stroke while on Effient generally should have therapy discontinued

Please see Important Safety Information, including Boxed Warning regarding bleeding risk, on previous page. See also Brief Summary of Prescribing Information on adjacent pages.