International Perspectives

Selective Nontreatment of Hypertension

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Medicine, just as fashion, has its states of therapeutic enthusiasms and endeavours. One of the current areas of frenetic therapeutic activity is the treatment of high blood pressure with antihypertensive drugs. These are highly potent drugs that do what they are expected to do—lower the blood pressure—but they may do more besides. They have side effects, some merely unpleasant and some positively dangerous and even lethal. It behoves us as physicians to put our patient's interest and well-being before our scientific enthusiasm to diagnose and treat mere high sphygmomanometric readings without considering certain other factors and facets.

What is high blood pressure? The honest answer surely must be that in most cases we just don't know. Cases of secondary hypertension are rare. The bulk are "essential," a euphemistic term for unknown cause.

Who suffers from it? Most of course do not "suffer" from high blood pressure, that is, until it is diagnosed and treated. "High blood pressure" (BP over 160/100 mmHg) is prevalent in 10 to 15 percent of the population; one half of all patients with hypertension are over the age of 60 when first diagnosed, and more are women than men. This translates into 250 to 375 patients in a family practice of 2,500 persons, meaning that, if these persons are to be managed and treated, they will have to be seen three to four times a year, at 750 to 1,500 consultations a year, or three to six per day. Intensive treatment of all hypertensives in the United States would require full employment of 20,000 physicians and 100,000 nurses, at a cost of $4 billion a year!

What do we know of the risks of high blood pressure? First, it must be stated loud and clear that high blood pressure is a different disease in family practice than in hospital practice. In hospital practice the cases are selected and more severe.

From my own studies and observations on some 1,000 hypertensive patients over 30 years, I give you the following observations.[1-5]

1. High blood pressure has a good prognosis when first diagnosed over the age of 60 (half the cases). The risks of dying are no greater than in non-hypertensives. The risks increase with each younger decade. At 50 years of age the risks of dying are twice the expected rate, at 40 they are five times greater, and at 30 they are seven times greater.

2. High blood pressure is more frequent and more benign in women than in men.

3. The prognosis is generally worse with increasing levels of diastolic pressure.

4. The prognosis is also related to associated diseases and to a family history of sudden cardiovascular or cerebrovascular deaths.

5. High blood pressure increases in incidence with age, but in any individual patient it does not necessarily go on rising if untreated. In a long-term follow-up of untreated hypertensives, I found that the blood pressure rose somewhat in one half of the cases, it fell in time in one third, and remained unchanged in one fifth.

What implications do these observations have for sensible and sensitive care of our patients? My suggestions are as follows:

A. We should not endeavour to treat all cases of high blood pressure, particularly in elderly women. We would thereby treat many patients unnecessarily and could cause more trouble than good.

B. Certainly we should try to identify younger patients with hypertension. Probably it is better to do this by taking their blood pressures more frequently when they come to consult us as family physicians than by special screenings.

C. Once we have decided that treatment is necessary, it must be effective in bringing down the pressure and the patients must be persuaded to comply and cooperate.

References

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