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New CVD guidelines put focus in the right place

There is a lot for primary care physicians to digest in the new hypertension and lipid treatment guidelines.^{1,2} And there is one very important thing that we can be happy about: the guidelines focus on POEM (patient-oriented evidence that matters) outcomes—reducing the risk of stroke, heart attack, congestive heart failure, and renal failure—rather than treating the numbers.

In this month's audiocast on jfponline.com, Dr. Campos-Outcalt summarizes the new hypertension guideline. The Eighth Joint National Committee (JNC8), led by family physician Paul James, focuses on 3 important clinical questions: At what blood pressure should treatment begin? What is the treatment target? and What drugs should be used? The new guideline relies heavily on randomized trials and less on expert opinion

Overtreatment leading to hypotensive episodes—and falls—may be avoided with the new relaxed systolic target for patients over age 60.

than the prior JNC7 guideline. This new guideline simplifies management decisions to 2 treatment targets: <150/90 for patients 60 and older and <140/90 for everyone else. Lower targets for patients with diabetes and chronic kidney disease have been eliminated, based on a lack of evidence that tighter control leads to better outcomes.

Relaxing the systolic goal from 140 mm Hg to 150 mm Hg for patients 60 and older is a welcome and sensible change. I regret over-treating one of my elderly hypertensive patients who became hypotensive during a bout of diarrhea, fell, and fractured her hip. Permission to use 150/90 as a target

for patients over age 60 is likely to save other senior citizens from hip fractures.

The new lipid guideline, which Dr. Campos-Outcalt reviews on page 89, has received mixed reviews due to the use of a new, unproven risk calculator and a somewhat arbitrary decision to use a 10-year cardiovascular event risk of 7.5% as the treatment threshold. The big plus of this new guideline, however, is the elimination of treatment targets, a concept that never has had strong scientific evidence. Deciding who to treat is more difficult, but follow-up is simplified—no more lipid-level monitoring.

I believe the strength of these new approaches is that they are firmly grounded in high-quality evidence from clinical trials and they are patient centered. Patients and physicians are encouraged to discuss the risks and benefits and make personalized, informed decisions about treatment choices. This gives doctors permission to more aggressively treat those who are most likely to benefit and to back off on aggressive treatment for those least likely to benefit.

1. James PA, Oparil S, Carter BL, et al. 2014 Evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC8). *JAMA*. 18 Dec 2013. [Epub ahead of print].
2. Stone NJ, Robinson J, Lichtenstein AH, et al. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *J Am Coll Cardiol*. 7 Nov 2013. [Epub ahead of print].

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