Physicians Neglecting Hypertension Guidelines

An IOM report suggests hypertension 'has dropped off the radar screen. It's time to bring it back on.'

BY CHRISTINE KILGORE

WASHINGTON — Poor physician adherence to hypertension treatment guidelines is a significant reason why hypertension is undiagnosed and uncontrolled at "alarming rates" in the United States, according to an Institute of Medicine report.

Multiple studies have shown that physicians are not providing treatment consistent with the current Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure guidelines. In particular, physicians are less aggressive about treating older patients, who are most likely to have the condition and who do benefit from therapy. They also are less aggressive in treating isolated systolic hypertension, according to the report.

"We really didn't find any information about why clinicians are not adhering to the most recent guidelines," commented Dr. Corinne Husten, a member of the Committee on Public Health Priorities to Reduce and Control Hypertension in the U.S. Population, which wrote the report.

"It was quite striking, actually, that physicians do a pretty good job at controlling diastolic blood pressure. … It's systolic blood pressure that they're not aggressively treating, and especially isolated systolic hypertension," she said at a briefing announcing their findings.

In the report, which was sponsored by the Centers for Disease Control and Prevention, the authors urge the CDC to give high priority to research on guideline adherence, and then to work with accreditation programs, providers, and health care quality organizations to improve providers' adherence to such recommendations.

The IOM committee urged the CDC to move away from a focus on individual and health care–based approaches in favor of taking population- and systems-based approaches that encourage people to lower their sodium intake, increase consumption of potassium, lose weight, and increase physical activity.

The CDC must ensure, they continued, that such population-based efforts—from those involving industry to various state and local projects—are properly targeting those at greatest risk. It also must work with health insurance plans and the Medicare and Medicaid programs to find ways to eliminate or reduce deductibles and co-pays for antihypertensive medications.

"This is where, in a time of limited resources, there's the greatest bang for the buck," said Dr. David W. Fleming, who chaired the committee.

About three-quarters of Americans already recognize the importance of having their blood pressure checked, leading Dr. Fleming to emphasize that "we're not simply calling for better health education of the public."

For example, the committee suggested that the CDC consider advocating for "greater use of potassium/sodium chloride combinations."

In a recent report from the CDC, only about 2% of adults met the current guidelines for dietary potassium intake. Furthermore, more than 8 in 10 Americans consume more salt than is recommended, said Dr. Fleming, director of the department of public health in Seattle and a former deputy director of the CDC.

One in three Americans have hypertension, according to the IOM report, which calls hypertension a "neglected disease." The disorder accounts for about one in six adult deaths annually, triggering more than one-third of heart attacks and almost half of heart failures.

Hypertension "has dropped off the radar screen," Dr. Fleming said at the briefing. "It's time to bring it back on."

Data show that 85% of individuals with uncontrolled hypertension have insurance and visit their physicians, the report noted.

Physicians may not adhere to current recommendations due to a lack of awareness about them or because they don't realize guidelines have been updated. Some physicians may still be waiting for patients to reach the previous 160 mm Hg/95 mm Hg thresholds before treating systolic and diastolic blood pressure, respectively. Current guidelines recommend starting treatment if systolic blood pressure is greater than 140 mm Hg or diastolic blood pressure is greater than 90 mm Hg. Physician may also doubt the benefit of treatment, or may have concerns about drug side effects.

Dr. Husten was executive vice president for program and policy at the Partnership for Prevention in Washington during her work with the committee and has recently been appointed senior medical adviser to the Center for Tobacco Products at the Food and Drug Administration. ■

Disclosures: *All committee members were screened and do not have any conflicts of interest, according to an IOM spokesperson.*

White-Coat Hypertension Associated With Hypertrophy

BY BRUCE JANCIN

ORLANDO — White-coat hypertension is often shrugged off in clinical practice as a benign condition, but an Italian study suggests it is anything but.

Indeed, 184 young adult Italians with white-coat hypertension at baseline experienced a greater increase in 24-hour ambulatory blood pressure during 8.5 years of follow-up in the Hypertension and Ambulatory Recording Venetia Study (HARVEST) than did 286 other participants with baseline sustained hypertension, Dr. Lucio Mos reported at the annual scientific sessions of the American Heart Association.

During follow-up, 8.2% of the group with white-coat hypertension and 6.3% with sustained hypertension developed echocardiographic left ventricular hypertrophy.

The white-coat hypertensives were as likely to develop left ventricular hypertrophy as were subjects with sustained hypertension. Plus, HARVEST participants with white-coat hypertension gained twice as much weight during follow-up.

This evidence of problematic trends in a variety of surrogate risk markers implies an increased risk of future cardiovascular events in patients with white-coat hypertension. Tighter control of their 24-hour blood pressure along with close target organ surveillance is warranted, according to Dr. Mos of Sant'Antonio Hospital in San Daniele del Friuli, Italy.

HARVEST is a multicenter prospective Italian study that began in the 1990s. The HARVEST participants in this analysis averaged 33 years of age at enrollment and had never been treated for hypertension.

During follow-up, 8.2% of the group with white-coat hypertension and 6.3% with sustained hypertension developed echocardiographic left ventricular hypertrophy.

Ambulatory blood pressure rose by an average of 7.9/5.6 mm Hg from a baseline of 120.9/76.3 mm Hg in the white-coat hypertension group, and by 1.2/1.9 mm Hg from a baseline of 135.5/83.4 mm Hg in the sustained hypertension group.

Subjects in the white-coat hypertension group gained an average of 3.5 kg, which was twice that seen in the group with sustained hypertension. ■

Disclosures: *Dr. Mos reported having no financial conflicts of interest in connection with the government-funded study.*

Delaying Ambrisentan Has Lasting Effect on Walk Test

BY BRUCE JANCIN

SAN DIEGO — In patients with pulmonary arterial hypertension, a short delay in starting endothelin receptor antagonist therapy with ambrisentan proved to have long-lasting deleterious consequences in the ARIES-E trial.

A total of 100 ARIES-E participants who received ambrisentan (Letairis) after completing 12 weeks of double-blind placebo responded with a less robust improvement in exercise capacity during 2 years of follow-up than did 197 patients on ambrisentan from the start. The group on placebo before ambrisentan never caught up in terms of 6-minute walk distance, Dr. Aaron B. Waxman reported at the annual meeting of the American College of Chest Physicians.

At the 12-week mark in the double-blind ARIES-1 (Ambrisentan in Pulmonary Arterial Hypertension, Randomized, Double-Blind, Placebo-Controlled, Multicenter, Efficacy Study) and ARIES-2 trials, patients on ambrisentan from the outset had a mean 42-m gain in 6-minute walk distance over their baseline of 345 m. Patients who received placebo before ambrisentan averaged a 1-m decline from baseline.

When assessed after 2 years of follow-up in ARIES-E (the extension study) patients who had been on ambrisentan from the start had a mean 30-m improvement in 6-minute walk distance, compared with baseline. Patients on placebo for 12 weeks before receiving ambrisentan had a mean 10-m improvement, according to Dr. Waxman of Massachusetts General Hospital, Boston.

The rate of clinical worsening at 1 year was 16% in the group on ambrisentan from the outset, compared with 24% in those who got placebo first.

By 2 years, however, the clinical worsening rate was similar in both groups, at about 30%.

Ambrisentan was well tolerated in ARIES-E, with mild to moderate peripheral edema the most common adverse event. Liver enzymes were elevated during 2 years of follow-up in seven patients on ambrisentan from the start and six patients on placebo followed by the endothelin receptor antagonist. ■

Disclosures: *The ARIES trials were funded by Gilead Sciences, which manufactures Letairis. Dr. Waxman disclosed serving on advisory boards for Gilead and United Therapeutics.*