SHOULD TREATMENT BE INITIATED FOR MILD CHRONIC HYPERTENSION IN PREGNANCY TO IMPROVE OUTCOMES?

JAIMEY M. PAULI, MD (JUNE 2022)

Consider this, when it comes to treating chronic hypertension

I welcome the article by Dr. Jaimey Pauli, which focuses on initiating treatment for mild chronic hypertension in pregnancy to reach a goal blood pressure (BP) of <140/90 mm Hg to prevent adverse maternal and fetal outcomes.[1] I would like to offer 3 additional thoughts for your consideration. First, it is known that there is a physiological decrease in BP during the second trimester, which results in a normotensive presentation. Thus, it would be beneficial to see if pregnant women with high-normal BP levels before the third trimester be administered a lower dose of antihypertensives. However, there is also a concern that decreased maternal BP may compromise uteroplacental perfusion and fetal circulation, which also could be evaluated.[2]

Second, I would like to see how comorbidities affect the initiation of antihypertensives for mild chronic hypertension in pregnancy. Research incorporating pregnant women with borderline hypertension and comorbidities such as obesity, hyperlipidemia, and diabetes mellitus type 2 (DM) is likely to yield informative results. This is especially beneficial since, for example, chronic hypertension and DM are independent risk factors for adverse maternal and fetal outcomes; therefore, a mother with both these conditions may have additive effects on obstetric outcomes.[3]

Lastly, I would suggest you include a brief conversation about prepregnancy ways to manage women with chronic hypertension. Because many women who enter pregnancy with chronic hypertension have hypertension of unknown origin, it would be beneficial to optimize antihypertensive regimens before conception.[4] Also, it should be further evaluated whether initiation of lifestyle modifications, such as weight reduction and the DASH diet before pregnancy, for women with chronic hypertension improves pregnancy outcomes.

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2022 UPDATE ON FEMALE SEXUAL HEALTH

BARBARA LEVY, MD (AUGUST 2022)

Are these new and rare syndromes' pathophysiological mechanisms related?

I read with great interest Dr. Barbara Levy's UPDATE in the August 2022 issue on testosterone therapy for women with hypoactive sexual desire disorder (HSDD), as well as her comments on persistent genital arousal disorder/genito-pelvic dysesthesia (PGAD/GPD) that was recently so coined by the International Society for the Study of Women's Sexual Health (ISSWSH) as a 2-component syndrome.[1] The new syndrome, explains Dr. Levy, presents with "the perception of genital arousal that is involuntary, unrelated to sexual desire, without any identified cause, not relieved with orgasm, and distressing to the patient (the PGAD component)," combined with "itching, burning, tingling, or pain" (the GPD component).

Although agreeing with ISSWSH that diagnosis and management require a multidisciplinary biopsychosocial approach, in her practical advice, Dr. Levy mentioned: "neuropathic signaling" with "aberrant sensory processing" as the syndrome's possible main pathophysiology. Interestingly, there are 2 other rare, chronic, and "poorly recognized source(s) of major distress to a small but significant group of patients." Persistent idiopathic orofacial pain (PIFP) disorder[2] after dental interventions and burning mouth syndrome (BMS),[3] defined by the absence of any local or systemic contributing etiology, also present with continuous local burning and pain (as in GPD). Consequently, PGAD/

GPD may indeed have the same pathophysiological explanation—as Dr. Levy suggested—of being a (genital) peripheral chronic neuropathic pain condition.

A potentially promising new therapeutic approach for PGAD/GPD would then be to use the same, or similar, antineuropathic medications (Clonazepam, Nortriptyline, Pregabalin, etc.) in the form of topical vaginal swishing solutions similar to the presently recommended antiepileptic and/or antidepressant oral swishing treatment for PIFP and BMS. As the topical approach works well for oral neuropathic pain, vaginal swishing could potentially be the answer for PGAD/GPD peripheral neuropathic pain. Moreover, such a novel topical approach would significantly increase patient motivation for treatment by avoiding the adverse effects of ingested antiepileptic or antidepressant drugs.

This is the first time that anticonvulsant and/or antidepressant vaginal swishing is proposed as topical therapy for GPD peripheral neuropathic pain, still pending scientific/clinical validation. ●

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