1980 Recommendations of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure

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In 1975-76 a committee of representatives from several medical organizations published a report outlining criteria for detecting, evaluating, and treating hypertension. Following the wide dissemination of this paper, several clinical trials were carried out, including the "Hypertension Detection and Follow-up Program," as a result, it was suggested that the 1975-76 recommendations be revised. A new Joint National Committee has now published an updated version which restates some previous recommendations and incorporates more current information concerning the benefits of treating hypertension.

The decade of the 1970s was marked by great interest in the field of hypertension, and a shift in focus from pathophysiologic mechanisms to issues of long-term management and control. The 1975-76 Joint National Committee made an important contribution toward the control of hypertension by recommending community programs, systematized management, and simplified evaluation procedures. Information from several parts of the country leads us to believe that these recommendations have greatly increased the number of successfully treated hypertensive patients. The 1980 Joint National Committee guidelines should help to extend these gains.

The key recommendations of the 1980 Joint National Committee are anchored in new data that suggest that effective lowering of blood pressure reduces mortality and morbidity in individuals classified as mild or less severe hypertensives (i.e., those having diastolic blood pressures of 90-104 mm Hg). The Veterans Administration Cooperative Study had already demonstrated the effectiveness of antihypertensive therapy and given impetus to programs for control of severe and moderate hypertension in the United States. The conclusions of the Hypertension Detection and Follow-up Program extend these conclusions to the hitherto neglected category of mild hypertension.

In focusing on mild hypertensives, who comprise over 65% of all hypertensive patients, the new Committee has sought to establish a common ground for their management. The central message is that benign neglect of hypertension at any level, from the lowest to the highest, is unwarranted at any age, and that even in the elderly, lowering of blood pressure reduces mortality and morbidity. There is a new focus on refractory hypertension and on patient education for therapy maintenance, an important problem in the long-term management of all hypertensive patients. Recently approved drugs for the treatment of hypertension are incorporated in the stepped-care regimen, as are dietary and other nonpharmacological methods of management.

A difficult task of the Joint National Committee has been to identify clinically acceptable blood pressure levels for intervention, and to define elevated blood pressure. The Committee suggests that two diastolic readings of 90 mm Hg or more on successive examinations should confirm the diagnosis of hypertension. Such a definition is at variance with the commonly accepted World Health Organization criteria of 160/95 mm Hg or higher. The Committee re-emphasized that the diagnostic evaluation of the majority of hypertensive patients need not include routine renin determinations, intravenous urograms, or catecholamine studies.

Dietary therapy (reduction of weight and decrease in sodium intake), if vigorously pursued, is suggested as a prudent initial approach for young individuals with mild, uncomplicated hypertension. High-risk mild hypertensives are identified for drug treatment. The treatment of diastolic hypertension in elderly individuals, which is often neglected, is recommended. The Committee suggests that isolated systolic blood
pressures in the elderly should also be lowered to 140 to 160 mm Hg if this can be accomplished without significant side effects.

The Committee has again suggested a stepped-care program as a successful, empirical approach for the drug management of hypertension. New drugs, including diuretics, adrenergic-inhibiting drugs, and vasodilators, have now expanded the therapeutic options and offer the physician a wide range of choices. Diuretics are recommended as the first-step drug of choice in the majority of cases. In a few younger patients with a rapid pulse, wide pulse pressure, or significant postural blood pressure changes, beta blockers may be considered. However, the Committee does not concur with many European observers who suggest beta blocker therapy as the first-step treatment of choice.

The 1980 Recommendations of the Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure should provoke renewed interest in hypertension. They call for continuing integrated community activity and intense clinical focus on the problem of high blood pressure. The demonstrated effectiveness of systematic management of hypertension to diastolic blood pressure goals of 90 mm Hg or below argues against nihilism. Mere observation of elevated blood pressures is no longer acceptable. At the most general level, the new report reinforces the conclusions of community-based clinical trials and urges clinicians and public health workers alike to focus afresh on this ubiquitous disorder.

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