Abstract—The purpose of this study was to calculate statistically the minimum (base) blood pressure (BP) of nighttime (sleep-time) BP values obtained by ambulatory BP monitoring (ABPM) and to investigate its clinical significance. Twenty-four-hour recording of ECG with ABPM was performed directly (n = 89) or indirectly (n = 117) in 206 patients with essential hypertension. A telemeter was used for the direct method and a multi-biomedical recorder (TM2425) was used for indirect measurement. First, minimum heart rate (HR$_0$=60/RR$_0$) was determined from sleep-time ECG. The mean product of sleep-time diastolic BP (DBP) and pulse interval (RR) was divided by RR$_0$ to obtain DBP$_0$ [DBP$_0$=(DBP×RR)/RR$_0$]. The correlation between systolic BP (SBP) and DBP was used to determine SBP$_0$ corresponding to DBP$_0$. Statistical base mean BP (MBP$_0$) was calculated from these values, and its reproducibility and relation to hypertension severity were investigated. MBP$_0$ values were similar to true base values of sleep-time MBP obtained by the direct method (mean±SD difference, 2.0±4.2 mm Hg). Direct MBP$_0$ criteria predicted hypertension severity (mild, moderate, or severe target organ damage) more accurately (predictive accuracy, 89%) than daytime MBP criteria (53%, P<0.01). Almost the same results were obtained using indirect MBP$_0$ criteria. Day-to-day indirect MBP$_0$ variation (mean absolute difference) was smaller (2.4±1.8 mm Hg) than day-to-day daytime and nighttime MBP variation (6.3±5.3 and 5.4±3.4 mm Hg, respectively; n = 61, P<0.01), and the correlation coefficient between day-to-day variations of daytime MBP and physical activity (measured by an acceleration sensor) was 0.38 (P<0.05). In conclusion, statistical base BP was almost equal to true base (minimum) BP of sleep-time BP distribution. It was closely related to the severity of hypertensive organ damage, was highly reproducible, and is considered likely to serve stochastically and physiologically as a representative BP value in an individual subject. (Hypertension. 1998;32:430-436.)

Key Words: blood pressure monitoring, ambulatory □ sleep □ hypertension, essential
valvular defect, myocardial infarction, or secondary cause of hypertension. They were subdivided into 3 groups (Table 1). Group 1 (mild group with World Health Organization [WHO] stage I) consisted of subjects with no objective signs of hypertensive organic change. Their chest x-rays showed a cardiothoracic ratio (CTR) of <50%. The sum of SV1 and RV5, on their ECG was <4.0 mV, the echocardiographic left ventricular mass (LVM) index was <134 g/m² for male subjects or 110 g/m² for female subjects, and their Keith-Wagner-Barker (KW) ophthalmic category was grade 1. They demonstrated no cerebral or renal hypertensive complications (plasma creatinine level was <91.5 µmol/L). Group 3 (severe group) consisted of patients with accelerated hypertension whose KW ophthalmic category was grade 3 or whose plasma creatinine level was >152 µmol/L. Group 2 (WHO stage II) was intermediate between these 2 moderate groups with LV hypertrophy and without retinopathy, plasma creatinine <152 µmol/L. Table 1 shows numbers of subjects and gender, age, mean office BP, and main clinical characteristics for each group.

Methods consisted of direct and indirect ABPM measurements. Direct measurements were made in 89 patients (47 men and 42 women; 37 from group 1, 38 from group 2, and 14 from group 3) after hospitalization. Indirect BP measurements were made in 117 patients (60 men and 57 women; 52 from group 1, 52 from group 2, and 13 from group 3) at the outpatient clinic. All subjects gave informed consent to participation in the study, and the study protocol was approved by the ethics committee of the Yokohama City University Department of Internal Medicine.

**Direct BP Measurement**

Although it has been reported previously, we here briefly outline the procedure whereby direct BP measurements were made. Using a system developed in our laboratory, we used the telemetric method to perform continuous 24-hour monitoring of intra-arterial pressure and ECG under almost unrestricted conditions. With patients under general anesthesia, a stiff-walled Teflon catheter was inserted into the femoral artery and connected to a strain-gauge transducer (Statham P50, Gould Statham Instruments Inc) attached to the chest wall at the level of the heart. BP calibrations were performed with a sphygmomanometer at 0, 100, and 200 mm Hg both before and after measurement. To prevent coagulation, a portable microinfusion pump (NEC Sanei Instruments Ltd) continuously flushed the catheter with heparinized saline solution. A V1 lead was used to record ECG waves, which, together with BP waveform, were telemetrically transmitted by means of a portable transmitter (model 1429, NEC Sanei Instruments Ltd). Both paper and tape recordings were collected (CR-31 portable tape recorder, TEAC Co). An analog-to-digital converter was used to input BP and ECG waves into a computer at a sampling rate of 1 kHz for subsequent computer processing to determine beat-to-beat heart rate (HR), SBP, and DBP.

In accordance with the hospital schedule, sleep-time (nighttime) was defined as the hours between 9 P.M. and 6 A.M. The remainder of the 24-hour period was regarded as waking time (daytime). The 24-hour trendgrams and sleep-time frequency histograms of BP and HR were made by computer (Figure 1A and 1B).

**Measurement of True Base BP Values From Direct Recordings**

The minimum values (values corresponding to the 0.5% lower probability integral during 1 hour) of intra-arterial SBP and DBP were almost the same as baseline values during sleep-time (Figure 1A). Sleep-time frequency distributions for intra-arterial SBP, DBP, and HR were compiled; values corresponding to the 0.5% lower probability integral were taken as true base SBP and DBP.

**Measurement of Estimated Base BP Values From Direct Recordings**

Because true base BP values can be calculated only on the basis of large numbers of directly obtained samples (about 30,000 samples), we devised a new method for determining statistical (estimated) base BP values from a small number of either directly or indirectly obtained samples. HR can be measured noninvasively by ECG, which makes it possible to derive the minimum value (lowest 1% value; HR0) from the HR frequency histogram obtained during sleep-time. This determines the corresponding pulse interval (RR) or RR0, which makes it possible to derive the minimum value from the RR histogram during sleep-time (Figure 2). The minimum value (SBP0) of DBP and RR was almost equal to mean sleep-time DBP × RR and mean waking-time DBP × RR. Using this value, we calculated the mean of DBP × RR during sleep-time: DBP × RR. Then, dividing this by RR0, we obtained the statistical base DBP (DBP0):

\[
DBP_0 = \frac{DBP \times RR}{RR_0}
\]

Because of the high positive coefficient of correlation (r) between direct SBP and DBP (r = 0.70 to 0.98), we used the linear-regression formula

\[
SBP_0 = a \times DBP_0 + b
\]

Tochikubo et al. September 1998

### TABLE 1. Main Clinical Characteristics of 3 Groups

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Group 1 (WHO Stage I)</th>
<th>Group 2 (WHO Stage II)</th>
<th>Group 3 (Accelerated Hypertension)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No. (M/F)</td>
<td>89 (44/45)</td>
<td>90 (46/44)</td>
<td>27 (17/10)</td>
</tr>
<tr>
<td>Age, y</td>
<td>42±13</td>
<td>48±11</td>
<td>43±8</td>
</tr>
<tr>
<td>KW classification, grade</td>
<td>0–1</td>
<td>1–2</td>
<td>3</td>
</tr>
<tr>
<td>CTR on chest x-ray, %</td>
<td>44±3</td>
<td>53±3</td>
<td>55±4</td>
</tr>
<tr>
<td>SV1+RV5 (ECG), mV</td>
<td>3.6±0.4</td>
<td>4.3±1.2</td>
<td>5.7±1.0</td>
</tr>
<tr>
<td>LVM index, g/m²</td>
<td>104±16</td>
<td>151±22</td>
<td>205±37</td>
</tr>
<tr>
<td>Plasma creatinine, µmol/L</td>
<td>77.7±9.1</td>
<td>85.4±11.4</td>
<td>173±10.6</td>
</tr>
<tr>
<td>Office BP</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>SBP, mm Hg</td>
<td>162±9.5</td>
<td>179±16.0</td>
<td>217±23.6</td>
</tr>
<tr>
<td>DBP, mm Hg</td>
<td>99±4.9</td>
<td>105±4.8</td>
<td>128±4.8</td>
</tr>
</tbody>
</table>

Values are mean±SD. KW indicates Keith-Wagner grade: 0–1 = normal or slightly narrowed retinal arteries, 2 = generalized narrowing of retinal arteries, or nipping of veins, 3 = retinopathy with hemorrhages and cotton-wool spots without papillema; CTR, cardiothoracic ratio; and SV1+RV5, sum of S in V1 lead and R in V5 lead on electrocardiogram.
both directly and indirectly (Figure 2A and 2B). In this study, its accuracy was evaluated first using directly obtained BP values and then with indirect BP measurements.

**Indirect BP Measurement**

The portable multi-biomedical recorder (TM2425, A&D Co Ltd) can simultaneously record 24-hour indirect BP and ECG and measure body position, motion (acceleration), and temperature. The BP accuracy of TM2425 was validated according to and satisfied the criteria of the Association for the Advancement of Medical Instrumentation.\(^{12,13}\) Body motion (activity) was measured by an acceleration pickup sensor, and cumulative values for 1 minute were recorded at 18-millisecond intervals at frequencies ranging from 1 to 10 Hz in the vertical direction, with a sensitivity of \(4.1 \times 10^{-3} \text{ m/s}^2\).\(^{12}\) SBP and DBP were recorded at 30-minute intervals, and HRs were recorded beat-to-beat on ECG by TM2425. The process of obtaining indirect statistical base BP by computer is as follows (Figure 2B).

First, a sleep-time HR distribution was compiled from the ECG obtained with TM2425. Arrhythmic beats were automatically excluded.\(^{12}\) HR frequency distribution, mean, SD, skewness (sk), and minimum (lowest 1%) value were calculated by computer, and HR\(_0\) and RR\(_0\) (60/HR\(_0\)) were derived. After indirect DBP\(_0\) was obtained by means of Equation 1, Equation 2 was used to arrive at indirect SBP\(_0\) (Figure 2B). The coefficient of correlation \((r)\) between sleep-time SBP and DBP was often smaller than the corresponding value obtained with the direct method, but Equation 2 was applied only when \(r \geq 0.6\) (n=82). In instances in which \(r < 0.6\) (n=35), the following equations (arrived at stochastically from least-squares linear regression analysis performed on 82 patients in whom correlation between SBP and DBP was \(r = 0.6\) were used for estimating SBP\(_0\):

\[
\text{SBP}_0 = \text{DBP}_0 \times \left[ \frac{\text{SBP}_0}{\text{DBP}_0} \right]^{0.05}
\]

and

\[
\text{SBP}_0 = \frac{60}{\text{HR}_0} \times \left[ \frac{\text{SBP}_0}{\text{DBP}_0} \right]^{0.05}
\]

The difference between SBP\(_0\) derived from these equations and SBP\(_0\) derived from Equation 2 was \(1.5 \pm 4.9 \text{ mm Hg}\) in the 82 patients. The indirect measurements were performed during the subjects’ daily routines, and sleep-times were determined from their diaries.
With the aim of investigating the reproducibility of statistical base BP, 24-hour measurements were performed twice (Figure 3) using TM2425 for 61 patients (31 men and 30 women). The second measurement was made more than 1 week after the first (median interval of 3 weeks; range, 1 week to 2 months).

**Echocardiographic Measurements**

Because LV hypertrophy is related to hypertension severity, echocardiography was used to examine LVM. All subjects underwent standard M-mode and 2-dimensional echocardiography performed by a cardiologist using an echocardiograph equipped with a 2.5-MHz sensor; ACTW, mean ACT per minute during daytime; G, acceleration of gravity (m/s²); and φ, MBPW/MBP₀.

Almost the same results were obtained from indirect measurements (Figure 6, Table 2). There was a high correlation between indirect MBP₀ and echocardiographic LVM index (r=0.75, P<0.01; Figure 6). The correlation coefficient (r) between indirect MBP₀ and indirect MBP₉ was 0.72, and r between indirect MBP₀ and LVM index was 0.61.

Mean physical activity (acceleration) during waking hours (ACTₜ₉) in group 3 patients was less than in groups 2 and

2.6±4.8 mm Hg. A high coefficient of correlation (r=0.93) was also found between the true base SBP and statistical base SBP (direct SBP₀). The difference between them was 1.0±6.0 mm Hg. MBP calculated from direct DBP₀ and SBP₀ was taken as direct MBP₀. The difference between true base MBP and direct MBP₀ assessed by paired t test and Bland-Altman plotting was not significant, although MBP₀ tended to be higher than true base MBP (mean difference, 2.0±4.2 mm Hg) (Figure 4).

**Statistical Base BP and Hypertensive Target Organ Damage**

Waking-time mean MBP was obtained and designated MBP₉. Investigation was then performed to determine whether statistical base MBP or MBP₉ is more closely related to hypertension (organ damage) severity (Figure 5, Table 2). MBP criteria (MBP₀=110 to 129 mm Hg; MBP₉=89 to 109 mm Hg) were established to discriminate well between the groups by discriminant analysis (Table 2).

Sensitivity and specificity for direct MBP₀ criteria were almost equal to or higher than those for direct MBP₉ criteria (Figure 5, Table 2). The predictive accuracy (sum of accurately classified number/total number×100) of direct MBP₀ criteria (79/89×100=89%) was significantly higher than that of direct MBP₉ criteria (47/89×100=53%). These results suggest that direct MBP₀ criteria predict hypertension (target organ) severity more precisely than direct MBP₉ criteria.

In this case, MBP₉ is expressed as a function of φ×MBP₀ (φ=MBPW/MBP₀), and it becomes essential to know whether φ is independently related to hypertension severity. The absence of a significant difference in φ values among the 3 groups (Figure 5) indicates that φ contains no information related to hypertension severity. A negative coefficient of correlation (r=-0.43, P<0.01) was observed between direct MBP₀ and φ (Figure 5, bottom).

Almost the same results were obtained from indirect measurements (Figure 6, Table 2). There was a high correlation between indirect MBP₀ and echocardiographic LVM index (r=0.75, P<0.01; Figure 6). The correlation coefficient (r) between indirect MBP₀ and indirect MBP₉ was 0.72, and r between indirect MBP₀ and LVM index was 0.61.
Day-to-Day Variation of Statistical Base BP

To investigate the reproducibility, we used a multi-biomedical recorder (TM2425) to observe daily (day-to-day) variation (mean absolute difference between values obtained in 2 measurements) in indirect MBP₀ and MBPₐ (Figure 7). Day-to-day indirect MBP₀ variation was significantly less (2.4 ± 1.8 mm Hg) than daily indirect MBPₐ variation (6.3 ± 5.3 mm Hg, \( P < 0.001 \)). Furthermore, day-to-day indirect MBP₀ variation was significantly less than daily night-time indirect MBP variation (5.4 ± 3.4 mm Hg, \( P < 0.01 \)).

There was a significant correlation \( r = 0.38, P < 0.05 \) between day-to-day MBPₐ variation (first-day MBP₀–second-day MBP₀) and physical activity variation (first-day ACTₚ–second-day ACTₚ, where ACTₚ is mean acceleration during waking hours).

![Figure 5](image5.png)

**Figure 5.** Scatterplots show relation between statistical base MBP (direct MBP₀) and direct MBPₐ and relation between direct MBP₀ and MBPₐ/MBP₀. Direct MBPₐ indicates mean of direct MBP during waking time; ○, group 1; ▲, group 2; □, group 3. Mean \( \delta \) (MBP₀/MBPₐ) of groups 1, 2, and 3 was 1.35 ± 0.13, 1.33 ± 0.22, and 1.26 ± 0.21, respectively.

![Figure 6](image6.png)

**Figure 6.** Scatterplots show relation between statistical base MBP (indirect MBP₀) and echocardiographic LVM index and relation between indirect MBPₐ/MBP₀ and indirect MBP₀. ○ indicates group 1, ▲, group 2; and □, group 3.

### TABLE 2. Relationship Between MBP Criteria and Classified Groups According to Degree of Hypertensive Organ Damage

<table>
<thead>
<tr>
<th>MBP Criteria, mm Hg</th>
<th>No. of Patients, Direct Method (Indirect Method)</th>
<th>%, Direct Method (Indirect Method)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Group 1</td>
<td>Group 2</td>
</tr>
<tr>
<td>MBPW*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>80–109</td>
<td>19 (30)</td>
<td>1 (9)</td>
</tr>
<tr>
<td>110–129</td>
<td>16 (20)</td>
<td>15 (31)</td>
</tr>
<tr>
<td>130–185</td>
<td>2 (2)</td>
<td>12 (22)</td>
</tr>
<tr>
<td>Total</td>
<td>37 (52)</td>
<td>38 (52)</td>
</tr>
<tr>
<td>MBP₀†</td>
<td></td>
<td></td>
</tr>
<tr>
<td>60–89</td>
<td>33 (48)</td>
<td>3 (4)</td>
</tr>
<tr>
<td>90–109</td>
<td>4 (4)</td>
<td>33 (46)</td>
</tr>
<tr>
<td>110–140</td>
<td>0 (0)</td>
<td>2 (2)</td>
</tr>
<tr>
<td>Total</td>
<td>37 (52)</td>
<td>38 (52)</td>
</tr>
</tbody>
</table>

*MBPW* discriminant functions \( Z_{12} = -0.076 \) MBPW + 8.4, when \( Z_{12} = 0, \) MBPW = 110 mm Hg; \( Z_{23} = -0.082 \) MBPW + 10.9 mm Hg, when \( Z_{23} = 0, \) MBPW = 129 mm Hg; †MBP₀ discriminant functions \( Z_{12} = -0.15 \) MBP₀ + 13.4, when \( Z_{12} = 0, \) MBP₀ = 89 mm Hg; \( Z_{23} = -0.26 \) MBP₀ + 28.4, when \( Z_{23} = 0, \) MBP₀ = 109 mm Hg.

‡\( P < 0.05; \) §\( P < 0.01 \) vs MBPW criteria.
related to them. Applying this concept to ABPM measured but supplemental BP (casual BP minus basal BP) was not measuring basal metabolism, basal BP was more closely individual representative BP value satisfying the conditions index representative of nocturnal sleep-time BP. This study sate for this fault, we propose statistical base BP as a new

manifesting itself at this time takes the most efficient pulse

values obtained during nighttime and daytime are distributed

asymmetrically with a levopositional mode (mode

distribution. The L parameters took approximately the

gamma distributions. True base BP corresponds to an actual

BP reaches a minimum value during the electroencephalo-

graphic slow-wave phase. The base BP waveform man-

interval (RR) for producing a maximum per-minute wave-

form area, which indicates a maximum per-minute blood flow in relation to BP value. Moreover, at this time, base BP demonstrates a higher correlation with total peripheral vascular resistance and arterial elastic modulus than MBP. DBP, and SBP, which are statistical base BP values, are the estimated values for the true base BP values of each of their frequency distributions and are thought to satisfy the stochas-
tical and logical conditions set forth in the introduction.

Every BP, , during daytime and nighttime may be expressed by the formula \( BP_f = \phi \times \text{base BP} \) \( (\phi = \text{incremental ratio}) \). The \( \phi \) value, which can be analyzed by means of the formula \( \phi = FI + BI \) \( (FI \text{ indicates cardiovascular function index; } BI \text{ baroreflex function index}) \).\( \text{may vary because of the changes of cardiovascular and baroreflex responses to physical and mental activity. Because } \phi \text{ (MBP/base BP) is unrelated to hypertension (target organ) severity and } \phi \text{ correlates with physical activity (group 3 patients had lower } \phi \text{ and lower physical activity), using MBP is consid-
ered more logical than using MBP for evaluation of hypertension severity. Figure 3 shows typical variations of } \phi \text{ value and indirect MBP caused by changes in physical activity (acceleration) monitored in 1 patient with TM2425. Although the means of waking-time BP and night-time BP are also statistical parameters, because they are greatly influenced by daily activities, their } \phi \text{ values may be changed by alterations in such factors as external tempera-
ture, insufficient sleep, duration of sleep, physical activity (acceleration), emotional stress, and autonomic nervous activity.} \text{\(12,18,19\)

Indirect MBP values demonstrated less day-to-day variation than the indirect MBP 0 (\( \phi \times \text{MBP} \)) and nighttime mean MBP values (Figure 7). This means that daily activities and sleep duration may exert no influence on statistical base BP. It is therefore more logical to use it instead of mean nighttime BP as a value representative of sleep-time BP.

The circadian change in BP in human subjects is well recognized, with BP levels being lower at night, and this observation has led to the perception of hypertensive subjects as dippers (with a nocturnal BP fall or dip) and nondippers. There are many reports that nighttime BP is closely related to end-organ damage, which is more severe in nondippers than dippers. However, the reproducibility of BP dipping (nighttime BP/daytime BP) is poor. We suggest that the statistical base BP, instead of mean nighttime BP, may be useful for evaluating the extent of the dipping phenomenon (dipping corresponds to \( \phi \) value).

It is true that we should compare indirectly measured statistical base BP with true base BP obtained by means of the direct method, but such an investigation would be very difficult because of the great burden imposed on subjects by the need for simultaneous 24-hour measurement of both direct and indirect BP. In addition, there are ethical reasons for rejecting such a practice. Our inability to perform this kind of study prevents our being able to conclude yet whether statistical indirectly measured base BP is consistent with true base BP value obtained with the direct method.

Nonetheless, statistical base BP is considered significant as a BP value that can serve as a normalized BP value free of the

Discussion

Because of the great influence of daily activity and duration of sleep, the mean of nighttime BP values and the day-night differences demonstrate low reproducibility. To compensate for this fault, we propose statistical base BP as a new index representative of nocturnal sleep-time BP. This study investigates the extent to which this new index serves as an individual representative BP value satisfying the conditions set forth in the introduction.

Sir F.H. Smirk first stated that for purposes such as measuring basal metabolism, basal BP was more closely related to hypertensive severity and mortality than casual BP, but supplemental BP (casual BP minus basal BP) was not related to them. Applying this concept to ABPM measured values, we have specified minimum sleep-time BP as a value representative of sleep-time BP.

Nonetheless, statistical base BP is considered significant as a BP value that can serve as a normalized BP value free of the
effects of environmental conditions. It reflects true basal BP, and because it approximately fulfills the first 4 of the 5 conditions set forth above (logical, clinical, noninvasive, and highly reproducible conditions), statistical base BP is believed to be suitable as an individual representative BP value. Determination of its relation to the second and fifth conditions (indicating severity and prognosis of hypertension) requires further study involving noninvasive BP measurement in a much larger number of subjects. The present study is only the first step toward achieving this ultimate goal.

**Acknowledgments**

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**References**

Statistical Base Value of 24-Hour Blood Pressure Distribution in Patients With Essential Hypertension
Osamu Tochikubo, Satoshi Hishiki, Eiji Miyajima and Masao Ishii

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