White-Coat and Masked Hypertension: Selective Elevation of Blood Pressure or an Arbitrarily Partitioned Continuum?

To the Editor:

Data from the Pressioni Arteriosc Monitorate e Loro Associazioni (PAMELA) study, presented by Mancia et al.,1 are invaluable for understanding the true nature of white-coat and masked hypertension. Thus, in terms of long-term risk, the authors’ conclusions that these are not innocent entities and that physicians treating patients with any blood pressure should be aware of their consequences should be definitely adopted. However, the title of the article and some of the interpretations of the data ignore the authors’ acknowledged finding that subjects with white-coat and masked hypertension have in-office and out-of-office blood pressure values between normal and hypertensive levels. Thus, when defined by home blood pressure monitoring, subjects with white-coat hypertension have greater (rather than selective) elevation of office blood pressure. Likewise, subjects judged by ambulatory blood pressure monitoring to have masked hypertension do not have selective elevation of 24-hour blood pressure but rather a categorically more notable elevation compared with office values. A striking finding revealed in the article by the PAMELA authors is that, when categorized according to office and 24-hour blood pressure (Table 1, top),1 patients with white-coat and masked hypertension have similar home blood pressure values in between those of normotensive and hypertensive subjects. The same is true regarding 24-hour blood pressure values when home blood pressure is the basis of classification (Table 1, bottom).1 According to the age- and gender-adjusted mortality analyses, statistically significant findings were reported only for the combined subgroup, namely, the true hypertensive subjects. Therefore, the authors have not proven that being categorized as masked or white-coat hypertensive, and not the actual office or out-of-office blood pressure values, carries increased risk. The significant trend findings are conceivably strongly influenced by the mortality of the subgroups with combined elevations in blood pressure. Would adjustment for office blood pressure (in the case of masked hypertension), or out-of-office blood pressure (in the case of white-coat hypertension), not generate more pointed results?

Disclosures

None.

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