Target Blood Pressure Level Before Antihypertensive Class to Improve Outcomes More Quickly in Uncomplicated Hypertension

To the Editor:

The article by Ma et al,1 regarding changes in antihypertensive prescribing during US outpatient visits for uncomplicated hypertension, provides important information on the prescribing patterns and use of guideline recommendations for the treatment of hypertension in the United States. However, although the ongoing debate as to which class of antihypertensive to prescribe, especially in patients with uncomplicated hypertension, continues unabated, the importance of blood pressure reduction is too often forgotten.

Most patients with hypertension (>90%) will be evaluated in a primary care office (family medicine and internal medicine).2 In the primary care setting, the nuisances of antihypertensive class effect are generally considered from the 10 000-foot level (ie, prescribe an angiotensin-converting enzyme inhibitor in patients with diabetes and a β-blocker in those who have experienced a myocardial infarction). The subtlety of antihypertensive class choice for a patient with uncomplicated hypertension is often lost in the multifaceted world of primary care.

Forty percent of primary care physicians are not familiar with or have not heard of the Joint National Committee on Prevention, Detection, Evaluation, and Management of High Blood Pressure guidelines.3 Therefore, it should come as no surprise that current estimates suggest that only one third of patients with hypertension achieve a blood pressure of <140/90 mm Hg, only 60% of those with a known diagnosis of hypertension are being treated, and almost one third of the adults who have hypertension do not even know that they do.4

Although the discussion as to which antihypertensive to use in uncomplicated hypertension will continue to be deliberated, there is no disputing that patient outcomes are improved at lower levels of blood pressure.4,5 Before we are able to personalize the treatment of hypertension based on each patient’s complexities, we must first improve the overall control of hypertension itself. I do not dispute the overall importance of antihypertensive class selection needing to be based on the literature. However, given the current state of affairs, we would improve patient outcomes significantly, and more promptly, if we first focused on reducing blood pressure to appropriate levels and then targeted which class to use in patients with uncomplicated hypertension.

Disclosures

None.

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