We may approach the topic of Session 3 by asking two different questions. What should (and can) the practicing physician do? What can the patient contribute and how can the physician obtain the patient’s cooperation?

Aspects of these questions have already been discussed in the course of this symposium. Obviously, the large majority of hypertensive patients, independent of the degree or severity of the disease, are treated by practicing physicians. This means that, with the improved control of hypertension, the availability of active drugs, and the better understanding of the importance of general measures, patients seen in hospitals increasingly presented a special selection rather than those with ordinary uncomplicated hypertension. This has to be kept in mind in studying new drugs in hospitals without outpatient departments.

General measures should always be considered at the beginning of treatment, especially in mild hypertension, and their long-term application is possible only in practice. In contrast to drugs, general measures have no demonstrable harmful effects. They may be cumbersome or difficult to maintain, but they do not cause adverse reactions; however, most of them have not been proved effective. The exception is reduction of overweight, which has been shown to reduce high blood pressure in some studies, though the decrease in weight by diet, changing eating habits, and increasing physical activity may be achieved for limited periods only.

The value of moderate salt restriction and increased potassium intake is widely discussed, and the results of various studies have given equivocal results. The same is the case with an increase in physical exercises. Psychotherapy, yoga, biofeedback, and transcranial meditation are at best effective in only a small percentage of patients. Cessation of cigarette smoking has less effect on hypertension than on coronary heart disease, but reduction of excessive alcohol intake will reduce high blood pressure. Nevertheless, the success

![Figure 1. Chart showing the possibilities of combination therapy.](http://hyper.ahajournals.org/Downloaded from)
of all these general measures depends largely upon the patient's cooperation and compliance with the doctor's recommendations.

Session 2 discussed the various contributions of new drugs, in particular, slow calcium channel blockers, alpha-adrenoceptor blocking drugs, and clonidine. But we heard little of captopril, which was the star of the therapeutic session last year. We also had one paper on triple therapy: the administration of a diuretic, a beta-blocker, and a vasodilator. We should, however, be aware that various possibilities of drug combinations — either in the form of a fixed ratio or as individual drugs — can be realized with the many active drugs available. We have also heard of the efficacy of placebo treatment, especially in mild hypertension.

In general we should start with monotherapy, but there is no reason not to begin with combination treatment, at least in some patients, administering two or three drugs initially and reducing the number subsequently. We need to always keep in mind which drug could or should be combined with which (fig. 1).

Finally, with respect to mild hypertension, I should like to issue a word of caution about starting drug treatment too early, and to warn against taking the blood pressure value as the only indicator for starting drug treatment. I should like to quote the opinion of the members of the recent Symposium on Mild Hypertension (1973):

"Blood pressure between 90 and 95 mm Hg should be observed during a period of over four months, and then general measures should be applied, but no drug treatment. It is, however, important that blood pressure is measured every three to six months."
Practical problems in hypertension management. Introductory remarks.

F Gross

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