Editorial Commentary

Acute Stroke

Lower Blood Pressure Looks Better and Better

Fernando Elijovich, Cheryl L. Laffer

Not much progress has occurred in guidelines to treat blood pressure (BP) during acute stroke since Sir George Pickering wrote in 1968 about cerebral hemorrhage: “Probably diastolic pressures over 110 are worth reducing to 90 mm Hg. This is a guess, and theoretical arguments could be urged against, or for, different figures,” and about ischemic stroke: “There is no evidence that reducing arterial pressure in the acute phase will help.”1

Perhaps the different purposes of treating BP for the prevention of stroke versus managing BP during its acute phase explain this. In the former, BP reduction (and blockade of vasoactive systems) aims at reducing arteriolar remodeling and arterial atherosclerosis, the culprits for both intracerebral hemorrhage (ICH) and ischemic strokes. Its effectiveness has been unequivocally proven; stroke prevention is quantitatively the most beneficial effect of antihypertensive therapy. In contrast, the purpose of managing BP during an acute stroke is to improve outcomes by diminishing the magnitude of the bleed, or the development of edema in the ischemic region, or the extension of tissue necrosis into the penumbra. The physiology of the hypertensive cerebral circulation, before and during a stroke, is complex and contributes to the fact that achieving one of the goals above may conflict with achieving another one.

Normal autoregulation of cerebral blood flow (CBF) maintains it constant over a wide range of mean arterial pressures (MAPs; ≈50 through ≈150 mm Hg; Figure A). BPs above these limits will produce cerebral edema. In contrast, below the lower limit (located at ≈75% of usual MAP), hypoperfusion does not cause immediate ischemia, because the brain is capable of increasing O2 extraction (thick portion of the curve in the Figure). Cerebral hypoxemia ensues if additional hypotension overwhelms this compensation.

In chronic hypertension, autoregulation is shifted to the right (Figure B). Hence, patients are somewhat protected from developing cerebral edema (ie, hypertensive encephalopathy is more likely with abrupt BP elevation in a previously normotensive individual, eg, acute glomerulonephritis in children or eclampsia, than in severe chronic hyperten-

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with antihypertensive therapy. Authors suggested that BP targets currently used for tissue plasminogen activator administration (<185/110 mm Hg) could be beneficially extended to all patients within the first 24 hours, if sharp BP reduction is avoided and age is taken into consideration.6

Clinical trials favoring intervention at lower BP levels are consistent with a meta-analysis of the effect of 5 families of antihypertensive drugs on CBF. When given to 291 patients in 11 trials, 0.5 to 7.0 days after event onset, MAP reductions of −6.0 to −15.7 mm Hg did not reduce CBF. Most measurements (single photon emission computed tomography, Xenon-computed tomography, and positron emission tomography-computed tomography) were of hemispheric CBF, but reports on penumbra CBF produced similar results. Furthermore, unwarranted withholding of treatment may neglect BP-independent beneficial effects of certain drugs. In the Acute Candesartan Cilexetil Therapy in Stroke Survivors Trial (n=339), candesartan administration within 24 to 36 hours of event onset reduced 12-month mortality and cardiovascular events by more than half, without BP reduction beyond that by placebo over 7 days.8 Benefit was in cardiovascular morbidity/mortality, not in recurrent strokes, leading to the speculation that early protection of cerebral autonomic function may be important for future protection of cardiovascular disease.

In a metaregression analysis of 37 trials, including 9008 patients with ischemic stroke or ICH, the relationship among on-treatment BP (active versus control groups), early (<1 month) and late (90 day) mortalities, and 90-day death/dependency was U-shaped.9 Treatment, given within 1 week, involved 13 classes of drugs. Lowest odds ratios for untoward outcomes were obtained with ΔSBPs of −8.1 to −14.6 mm Hg. The Controlling Hypertension and Hypotension Immediately Post-Stroke pilot study (n=179) directly tested the effect of lisinopril or labetalol therapy on ischemic stroke and ICH within 36 hours of onset. Target SBP was 145 to 155 mm Hg, to be achieved within 8 hours, with discontinuation if <140 mm Hg. There were no differences between treatments and placebo in combined death/dependency at 2 weeks.10 However, active therapy halved mortality at 3 months (9.7% versus 20.3%). Despite greater SBP reduction with active therapy (−21 mm Hg versus placebo −11 mm Hg), sustained over 2 weeks, neither deterioration of neurological status over the initial 72 hours nor any increase in serious adverse events was observed.

In this issue of Hypertension,11 investigators of the Intensive Blood Pressure Reduction in Acute Cerebral Hemorrhage Trial present further analyses of their data, the first attempt at exploring target BP for patients with acute ICH. They previously published a 24-hour 22.6% smaller proportional growth of hematoma size (CT scan) by aggressive therapy with goal SBP <140 mm Hg (achieved in 1 hour in 42% and in 6 hours in 66% of 203 patients), compared with usual care (1999 American Heart Association guidelines, SBP <180 mm Hg, n=201).12 Patients with compelling indications or contraindications for hypertension treatment, structural cerebral abnormalities, deep coma, and requiring tissue plasminogen activator or neurosurgical intervention were excluded. Participants were randomized ≈3.5 hours and started therapy ≈4.2 hours after event onset. They were mostly Chinese (95%) and hypertensive (74%), with average BP 181/103 mm Hg (74% required therapy in the usual care versus 98% in the intensive group). SBP throughout the initial 24 hours was 10.8 mm Hg lower in the intensive group. The risk of substantial hematoma growth (defined as >33% or >12.5 mL) was 36% less in the intensive group (26% versus 40%), independent of age (> or <65), SBP (> or <181), or functional status (National Institutes of Health Stroke Scale > or <9). The effect was larger in subjects randomized within 4 hours of onset (n=210, Δ−52%, intensive: 15% versus usual care: 30%). Early (72-hour) neurological deterioration, 90-day death/dependency, and serious adverse events were not different between groups. In the current publication, the most important observation is that achieved SBP throughout 24 hours (not baseline BP) is the major determinant of hematoma growth at 24 hours, in single and multivariate regression analyses and in covariate adjusted analysis of trends for tertiles of achieved SBP. Based on observed maximum benefit in the lowest tertile (median: 135 mm Hg), the authors cautiously suggest that achieving SBP 130 to 140 mm Hg over the initial 24 hours may be the target of treatment in ICH. Actually, their Figure 3 shows ≈20 patients with SBP <130 mm Hg (although this was the limit to stop therapy), without any evidence for a J-curve,
making their suggestion a conservative one. The study cannot
be generalized; for example, Chinese subjects have different
prevalence and anatomic characteristics of ICH, and severe
disease was excluded. Furthermore, despite the recognized
prognostic implications of hematoma growth, clinical benefit
was not demonstrated, probably because the study was
underpowered or its follow-up not long enough. Nonetheless,
it provides a strong signal favoring early and aggressive BP
reduction in ICH, particularly because the aggressively
treated group did not have worse clinical outcomes or adverse
events, dispelling concerns about hypoperfusion of the sur-
rounding edematous penumbra.

Ongoing trials in ischemic stroke and ICH, such as Continue
or Stop post-Stroke Antihypertensives Collaborative Group
(continuation versus interruption of preceding antihypertensive
therapy), Scandinavian Candesartan Acute Stroke Trial (cande-
sartan on 6-month outcomes), and The Efficacy of Nitric Oxide
in Stroke (transdermal nitroglycerin on death/disability at 90
days) and further research in ICH (Intensive Blood Pressure
Reduction in Acute Cerebral Hemorrhage Trial 2, death/
dependency at 90 days with the aggressive approach above)
will provide additional data. The recently published guide-
lines from the American Heart Association and American
Stroke Association acknowledge that, in ICH, intensive BP
lowering is clinically feasible and potentially safe, although
target BP and duration of therapy remain unclear.13 However,
the flurry of research results over the last 2 years already
suggests that our current guidelines are too permissive,
perhaps even harmful, and will have to be revised soon,
recommending judicious BP reduction to lower targets in
ischemic stroke and a more aggressive antihypertensive
approach to acute ICH.

Disclosures

F.E. is a member of the Novartis Speakers Bureau.

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