Unmasking True Resistant Hypertension: Is the Real-World Resistance Just Revealed?

To the Editor:

We read with interest the well-written article by de la Sierra et al aiming to estimate the prevalence of resistant hypertension (RH) in a large cohort of treated hypertensive patients, most of them in the primary care setting, from the Spanish Ambulatory Blood Pressure Monitoring Registry. The authors have elegantly shown that RH was present in 12% of patients, but among these patients, only two thirds had true RH. The remaining one third of the patients demonstrated normal ambulatory blood pressure, which suggests a white-coat RH phenotype.

Although both the study protocol and the retrospective analysis of the data are of high quality and provide novel insights to our knowledge for RH, there are some obscured points seeking clear answers. First, the authors declare that antihypertensive treatment was evaluated in a 3-category scheme (ie, breakfast, lunch, and dinner). However, the analysis for the medication delivery is solely limited to the dichotomous separation for evening and not evening. Because some of the patients clearly received part of the antihypertensive regimen during lunch, the present reporting of data does not allow the comparative evaluation between morning and evening antihypertensive therapy efficacy. Therefore, the authors’ statement that ambulatory blood pressure control might not be improved with switching a part of the medication from morning to evening constitutes a foggy suggestion, which needs to be further clarified and analyzed.

Second, it is known that sleep apnea syndrome resembles the leading unrevealed cause of RH, and along these lines, we are wondering whether patients with true RH were screened for sleep apnea. We also question whether sleep apnea patients were treated with the appropriate etiologic therapy (ie, continuous positive airway pressure therapy) above and under the underlying drug therapy. In light of the authors’ finding that the younger age is significantly associated with true RH, it is unknown whether the unreported masked RH phenotype would have an impact on the investigational outcome, because both masked hypertension and isolated nocturnal hypertension are frequent in those with sleep apnea syndrome, especially in younger ages.

Finally, beyond sleep apnea syndrome, the authors might provide data on the overall prevalence of masked RH in their cohort. Do the authors believe that accounting for patients with masked RH would have counterbalanced the “decrease in prevalence” of RH attributed to the white-coat phenomenon?

Beyond all of these concerns, the study by de la Sierra et al is pivotal for our views on the clinically misplaced topic of RH. In view of the emerging therapies of RH, including interventional therapies (ie, renal denervation and baroreflex activation), a better definition of patients with true RH is imperative to avoid the implementation of “last-resort therapies” in false RH candidates.

Disclosures

None.

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