Response to Evaluating the True Prevalence of Resistant Hypertension

We thank Anyfanti et al\(^1\) for their interest in our article.\(^2\) The main point addressed in their letter is a possible underestimation of the prevalence of resistant hypertension (RH) found in our study, based on several aspects affecting the population selected, the criteria for definition, and the specific analyses performed. First, regarding the population examined, we agree that the fact that the Spanish hypertensives included were mainly white and were probably adherent to a Mediterranean diet might have underestimated the prevalence of RH when translating the figure to other populations, with higher rates of individuals belonging to other ethnic groups or with higher levels of salt intake. This was something that we could not address in our study, and in our original article we never tried to translate our results to other countries, world regions, or populations.

Second, they argue that some hypertensive patients were not included in the analyses, such as the untreated, those receiving \(\leq 2\) antihypertensive drugs, or those controlled with \(\geq 4\) drugs. Regarding untreated hypertensives or those not controlled with \(<3\) drugs, it is obvious that they could have increased the prevalence of RH if all were uptitrated to \(\geq 3\) drugs, but for unknown reasons, this was not done by their doctors. As we said in our main article, the analyses were carried out on a registry reflecting daily practice. Even in clinical trials, not all patients not reaching BP goals with 2 drugs are automatically uptitrated to a third drug, and this situation is even more common in usual clinical practice. Thus, if doctors decided not to go further with the number of antihypertensive drugs, the proportion of them who possibly will fulfill criteria for RH was unknown, and we are not allowed to speculate on this subject. With respect to those controlled on \(\geq 4\) drugs, we clearly stated in our main article the criteria for definition, and the specific analyses performed.

Third, it is also obvious that considering lower BP targets for specific populations would also have increased the prevalence of RH. However, specific groups requiring these lower BP targets are not uniformly depicted in different guidelines, because some include only diabetics and chronic kidney disease patients, whereas others also include those with documented cardiovascular disease. Moreover, they have been questioned recently.\(^3\) For these reasons and also for favoring the comparison with data published previously, we decided to use 140/90 mm Hg as the cutoff value for the entire population.

Finally, masked RH is an important factor that can significantly increase the prevalence of RH. We have already mentioned this aspect in a response to another letter related to our article, estimating that both masked and white-coat hypertension have similar prevalences in subjects treated with 3 drugs.\(^4\) On the contrary, previous data from our registry revealed that, in the general cohort of treated patients, irrespective of the number of drugs used, white-coat hypertension was more prevalent than masked hypertension.\(^5\)

Disclosures
None.

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