Subtypes of Resistant Hypertension Based on Out-of-Office Blood Pressure Measurement

To the Editor:

We read with considerable interest the article by de la Sierra et al.1 clarifying the prevalence and clinical features of resistant hypertension based on office and ambulatory blood pressure (BP) monitoring in a large cohort of treated hypertensive patients in Spain. The prevalence of white-coat resistant hypertension (24-hour ambulatory BP <130/80 mm Hg for systolic/diastolic) and true resistant hypertension (24-hour ambulatory BP ≥130 and/or 80 mm Hg) was 37.5% and 62.5% among patients with uncontrolled office BP (≥140 and/or 90 mm Hg) and taking ≥3 antihypertensive drugs. They also demonstrated a difference in characteristics between white-coat and true resistant hypertension. These findings indicate that physicians should have patients with factors that are associated with true resistant hypertension monitor their ambulatory BP to differentiate between true and white-coat resistant hypertension.

We also evaluated the prevalence of the following subtypes of resistant hypertension in a large-scale nationwide study in Japan: controlled, isolated home (masked) resistant, isolated office (white-coat) resistant, and sustained (true) resistant hypertension based on 140/90 and 135/85 mm Hg cutoff values for office and home BP, respectively.2 The prevalences of white-coat and true resistant hypertension were 27.4% and 72.6% of the 310 patients with uncontrolled office BP and taking ≥3 antihypertensive drugs. On the other hand, the prevalences of controlled and masked resistant hypertension were 43.1% and 56.9%, respectively, among the 218 patients with controlled office BP and taking ≥3 antihypertensive drugs. They also demonstrated a difference in characteristics between white-coat and true resistant hypertension. These findings indicate that physicians should have patients with factors that are associated with true resistant hypertension monitor their ambulatory BP to differentiate between true and white-coat resistant hypertension.

Therefore, we are interested in knowing the prevalence of masked resistant hypertension in a large cohort of treated hypertensive patients in Spain. Furthermore, demonstrating the clinical features of masked resistant hypertension in this population could be very helpful for improving risk stratification in the clinical setting.

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Disclosures

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