Evidence for Upgrading the Ratings for Transcendental Meditation: Response to AHA Scientific Statement on Alternative Methods and BP

To the Editor:

The AHA Statement on alternative approaches to lowering blood pressure (BP) is a groundbreaking effort to inform physicians and public of their options.1 As principal investigator on several randomized controlled trials (RCTs) on the Transcendental Meditation (TM) technique and other alternative interventions for BP and cardiovascular disease, I suggest 5 points for consideration.

First, an alert reader notices a discrepancy between the level of evidence (LOE) of B for research on TM and the published evidence. The Statement defines LOE B as “Data derived from a single randomized controlled trial or nonrandomized studies.” However, the Statement surveys 11 RCTs with >1200 subjects and 2 well-conducted meta-analyses on TM and BP.2–5 Moreover, there are multiple hard event outcome trials on TM that are not available for other nonpharmacologic approaches.5,6

Most of the RCTs published in the past 20 years have been competitively reviewed and externally funded, rigorously conducted in collaboration with leading academic medical centers, blinded, independently monitored, published in peer-reviewed journals, and replicated.4 The 2012 cardiovascular disease event trial was analyzed independently.3 BP effects of TM have been confirmed by numerous investigators, in multiple populations and with ambulatory monitoring.2,3,6

Second, on page 18, it was suggested that TM is less practical, and on page 19, TM was omitted from the conclusion although it received a IIb recommendation (classification of recommendation [COR]), the same or higher than other methods in the list. Practicality has not been an issue in RCTs on TM conducted at 10 clinical sites with diverse sex, race/ethnicity, socioeconomic status, age, and geographic populations.2,5,6 Subjects generally report the practice is easy, relaxing, enjoyable, and convenient. Certified TM instructors are available widely. In the trials, the standard TM course of 1.5 hours/d over 5 or 6 days was implemented.2–6

My impression is that both the LOE B and the COR IIb ratings were based only partially on objective evidence and that additional, nonprespecified judgments were applied. Ideally, the Statement would be transparent about subjective input and systematically apply prespecified criteria. Third, page 6 reads: “As a result of the paucity of data, we are unable to recommend a specific method of practice when TM is used for the treatment of high BP.” This implies there is >1 method of TM, but there is only 1. As with other behavioral therapies, there is consideration of individual patient characteristics. However, instruction is protocolized and standardized.2–6

Fourth, the summary states that TM “modestly lowers BP” however, the effect is the same order of magnitude as aerobic exercise and other nonpharmacologic methods recommended by the Statement.1

Fifth, Table I indicates that COR is based on size of treatment effect, whereas the text suggests that LOE and clinical practicality are also considered. Given that the magnitude of treatment effect is similar to other recommended methods, that LOE meets criteria for level A, and the TM techniques demonstrated practicality and generalizability, it seems that COR of IIa should be considered as a more appropriate clinical rating.

Overall, the AHA Statement is to be commended. We think that these clarifications will further enhance its veracity and clinical use.

Disclosures

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