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

We thank Dr Schneider1 for his positive comments and for raising important issues on our recent scientific statement. We highlight that when our conclusions differ it is a result of variances in perspective and not from any bias against transcendental meditation (TM). The writing group had spirited discussions on the level of evidence (LOE) and class of recommendation for each modality. Reaching consensus is often not as simple as following the exact wording of the writing-group guidance table.2 We did indeed review 11 randomized controlled trials and 3 meta-analyses, while acknowledging some limitations of the AHRQ (Agency for Healthcare Research & Quality) report,3 before conferring on TM an LOE of B. This was not intended to be a weak endorsement (nor a questioning of the research integrity) but rather a consensus of the full committee on the strength as well as limitations of the supporting literature. For example, the latter 2 meta-analyses4,5 that we cited are largely overlapping in studies, whereas the first reported that TM was not superior to health education.6 The recent outcome study also did not actually demonstrate a lowering of blood pressure (BP) from baseline.6 The sole presence of published meta-analyses and randomized controlled trials as such does not mean there is no discordance among results nor that an LOE of A is universally warranted. For example, meta-analyses of randomized controlled trials also exist for device-guided breathing and isometric handgrip; however, neither received an LOE of A because of other uncertainties.1 We do agree that TM is unique in the robustness and quality of evidence among meditation techniques for BP-lowering and that a reassessment of the LOE may be warranted should future studies, particularly using home or ambulatory BP monitoring as the primary outcome, more consistently corroborate its efficacy.

About practicality, there is a marked difference between providing a treatment in a randomized controlled trial and referring unselected patients with hypertension for TM training in clinical practice. TM is also more expensive than other approaches ($1500), and access to certified training may be more limited. For example, the Cleveland area has only 2 listed sites covering a population of ≈2 million people (http://www.tm.org/transcendental-meditation-cleveland).

About the specific method, this was simply meant to convey that the selected mantra is individualized and might (albeit unlikely) impact BP responses. Although the instruction for practice is universal, whether differences in each person’s actual implementation (eg, compliance) alters the efficacy is also not well known.

We objectively and fairly presented the published data about the lowering of BP from TM. Its efficacy was indeed shown to be on par with some other alternative approaches when cross-comparing summary meta-analyses results (although few direct comparisons are available). We clearly stated that most approaches have modest efficacy (not just TM), and that patients requiring >10 mm Hg reductions should be monitored closely.

TM was not invented to lower BP. We acknowledge that meditation techniques may offer numerous benefits to people. Nevertheless, we believe that existing limitations need to be addressed before revisiting a higher class of recommendation concerning TM for the sole purposes of managing high BP.

Disclosures

None.

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