Caution: Too low BP may also lead to heart attacks, experts conclude

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Heart specialists in the world had another great scientific smorgasbord last week in Munich, Germany, at the annual congress of the European Society of Cardiology. It's the most attended medical congress, with more than 35,000 specialists, scientists and medical practitioners from all over the world.

With more than a dozen simultaneous scientific sessions and numerous other activities, it's sometimes overwhelming to decide which to attend. You don't mind the huffing and puffing while rushing from one meeting room to another.

This year, I had the privilege to be invited again to be part of the faculty of two symposia and a video interview, and it's wonderful to share insights from our perspective in the country and in Asia.

This time, I shared the stage with world-renowned people like professors Bryan Williams, Franz Messerli, Stephan Laurent, Roland Schmieder and Thomas Unger.

I couldn't help getting starstruck as I listened to them. At the same time, I felt compelled to say something meaningful whenever I opened my mouth.

On the way home, at the airport, a group of delegates chanted "Filipinas, Filipinas!" They most likely didn't re- member my name, but so long as they remembered the country, that was enough.

New concepts

In the field of hypertension, they presented the latest European guidelines, which introduced several new concepts which will most likely change the way doctors manage high blood pres- sure (BP) worldwide.

Two drugs in a single pill are now the preferred initial treatment for most hypertensive pa- tients, once the doctor decides that treatment is needed. The old dogma was to start with one drug, gradually increasing its dose to maximum tolerated levels, before adding a second drug. This old dogma has caused undue delay in controlling high blood pressure, leading to severe, irreversible complications. The recommendation is to lower elevated blood pressure to target levels within three months in those who have moderate to high risk.

This can be achieved via a two-drug combination in a single pill right at the start.

Because management decisions depend on the cardiovascular risk assessment of a hyperten- sive patient, a simplified risk assessment chart has also been provided based on new guide-

lines.

Only a minority of hypertensive patients should be given a single drug as initial treatment for hypertension. These are the frail elderly patients, and those still considered at low risk for developing complications like heart attack and stroke.

Everyone else, which includes the bigger majority of hypertensive patients, should be prescribed at least a two-drug combination.

So, when your doctor immediately prescribes this, don't think he's being over-aggressive. It's for your own good in the long term.

Threshold for treatment

The threshold for treatment is still 140/90 mmHg, with 160/90 mmHg for the very elderly, 80 years or older.

For hypertensive individuals less than 65 years of age, the target is to bring it down to less than 130/80 mmHg, and if tolerated, up to 120/70 mmHg.

Everyone is cautioned, though, that bringing BP down to less than 120/70 mmHg may lead to a paradoxical increase in cardiovascular complications, especially heart attacks. This is based on fairly robust data suggesting a tilted Jcurve pattern in hypertension.

This pattern indicates that the complications decrease as you reduce elevated BP. But if you bring it down lower than a certain level, the complications paradoxically increase. This nadir point at which complications start to increase appears to be less than 120/70 mmHg.

'Sweet spot'

I described 130/75 mmHg as the "sweet spot" for BP control. But it can range from 120/70 mmHg to less than 140/80 mmHg.

Experts also now believe that physicians should be less conservative in setting treatment targets for older and very old patients. The old recommendation was to allow higher levels of BP for the elderly, especially for those aged 80 years and older.

However, data from well conducted clinical trials indicate that they are still more susceptible to strokes and heart attacks with previously recom- mended BP levels.

For so long as they can tolerate it, their BP should be brought down to less than 140/80 mmHg, up to a systolic BP level of 130 mmHg—meaning, no significant side effects like dizziness, weakness or blood electrolyte problems.

The guidelines emphasize considerations of biological rather than chronological age. Hence, the importance of frailty, independence and the tolerability of treatment.

Experts stress that treatment should never be denied or withdrawn simply on the basis of old age, provided that the patient can still tolerate the treatment well.

The new guidelines also recommend a wider use of out-of-office BP measurement, including home BP monitoring, as an option to confirm the diagnosis of hypertension, detect the so-called "white coat" hypertension (elevated BP in the clinic but normal at home), and "masked" hypertension (normal or high normal BP in the clinic but elevated at home).

Monitoring one's BP at home is also a good way of involving the patient actively in the treatment of hypertension and promoting better treatment adherence, which has been shown to be a major factor in sustaining BP control in the long term.