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https://reachmd.com/programs/cme/clinical-practice-guidelines-for-resistant-hypertension-what-are-recommendations/14223/

Released: 08/15/2022
Valid until: 08/15/2023
Time needed to complete: 1h 02m

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Clinical Practice Guidelines for Resistant Hypertension – What Are Recommendations?

Announcer:
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Dr. Bakris:
Hello, I'm Dr. George Bakris, Professor of Medicine and Director of the American Heart Association Comprehensive Hypertension Center at the University of Chicago Medicine. Today, I'm going to speak with you about clinical practice guidelines for resistant hypertension. What are the recommendations? I want to start off by showing you a key table that is in the ACC/AHA guidelines and we also have it in the Resistant Hypertension Consensus Report published in Hypertension in 2018 and it's looking at lifestyle issues that specifically affect blood pressure. And this is critically important in people with resistant hypertension.

In terms of medications, the triangle here illustrates that you need a blocker of the renin-angiotensin system at maximal tolerated doses, a calcium antagonist and a thiazide-type diuretic. And those three drugs need to be given in good doses that have been shown to reduce blood pressure. And if all three are present and in good doses and blood pressures are still significantly above 130/80, then you've got true resistant hypertension, assuming the patient's taking it.

I want to show you data from clinical trials that look at the number of anti-hypertensive medications taken under different conditions. And you can see clearly here that the average number of medications being taken, even in people with garden variety hypertension, are 2.6 medications a day. So a lot of people are taking more than one medication. Very important.

I also want to stress the importance of starting with initial single pill combinations if you can. Why? If you look at this, this is a very classic study that looked at the question of, should we double the dose of an initial drug or should we keep the dose low and add a second drug to get blood pressure control? You can see here it did not matter what drug class you started with. Increasing the dose only gave you more side effects and did not give you the blood pressure control of adding a second complementary mechanistic drug. So for example, calcium blockers with an ACE or an ARB or diuretics with an ACE or an ARB will give you better blood pressure control.

The American Society of Hypertension came out now over a decade ago with recommendations of initial single pill combinations and the evidence base that goes with it. And you can see here exactly what I was talking about. Certain combinations like beta-blockers with ACEs and ARBs don't work, don't have any activity, should not be used. Clonidine in combination with beta-blockers should never be used. This paper really covers this in great detail.

The American Heart Association most recent guidelines ACC clearly demonstrates a need for this, gives it a 1C rating to start with initial single pill combination if the blood pressure is 20 over 10 above the goal. So what does that mean? If your blood pressure is 150/90 or higher, you need to start with an initial single pill combination.

The European guidelines took it a step further and recommended everybody starts with initial single pill combination because of adherence reasons and the chance to get better blood pressure control. And so there, everybody starts with a single pill combination.

The way I want to finish up is to basically show you the guidelines, the consensus report that we published in late 2018 and still holds today of how you should approach a patient with resistant hypertension. And it goes through many of the things that I've already mentioned. And it's very important that you start with that triple dose drug combination. If you need a fourth drug, the recommendation is to use spironolactone at doses of 25 to 50 milligrams and that's based on a trial that showed very good adherence and reflects better blood pressure control than adding a beta-blocker or adding an alpha-blocker. If they're on four drugs and you feel uncomfortable, you should refer them to a certified hypertension specialist. And I think it's important to keep in mind that just throwing drugs at them is not going to work. They may need further evaluation if you have not already done a secondary evaluation. And then the algorithm walks you through it to the very end. And if you want, you can persist in that manner.

The bottom line here is to treat resistant hypertension, you need to make sure you've excluded secondary causes of hypertension, especially primary hyperaldosteronism. You need to make sure they're adhering to lifestyle intervention. You need to make sure they're on three complementary different classes of antihypertensive medications at maximal tolerated doses. And then they're not taking medications that could impact on the blood pressure-lowering effect of those drugs, like NSAIDs, amphetamines, et cetera. So if they're controlled, if you've got them on spiro and you're still not there, please refer them to a certified hypertension specialist. Thank you very much for your time and for listening.

Announcer:
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