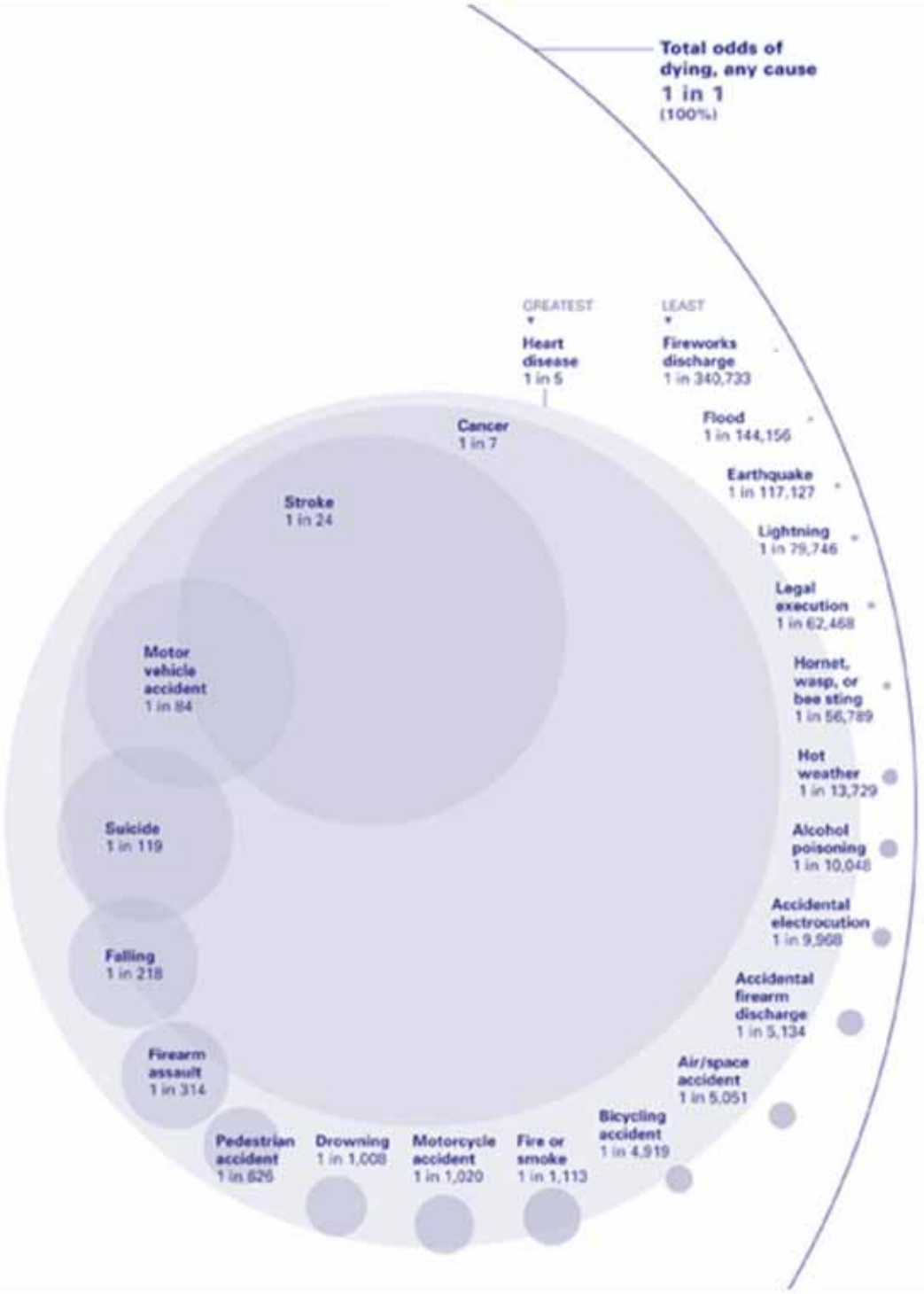
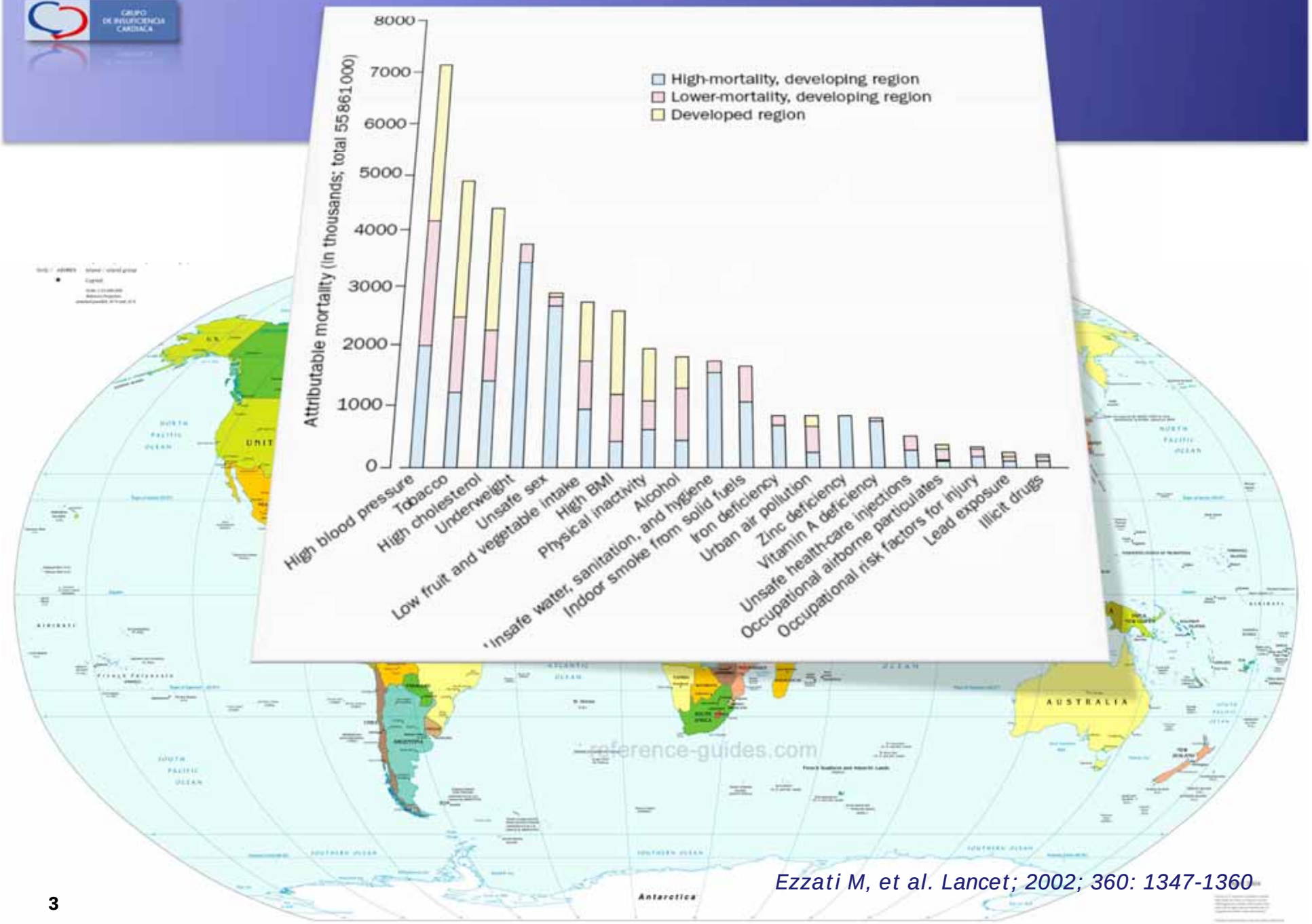
# PREVENCIÓN DE LA INSUFICIENCIA CARDIACA

# HIPERTENSIÓN ARTERIAL

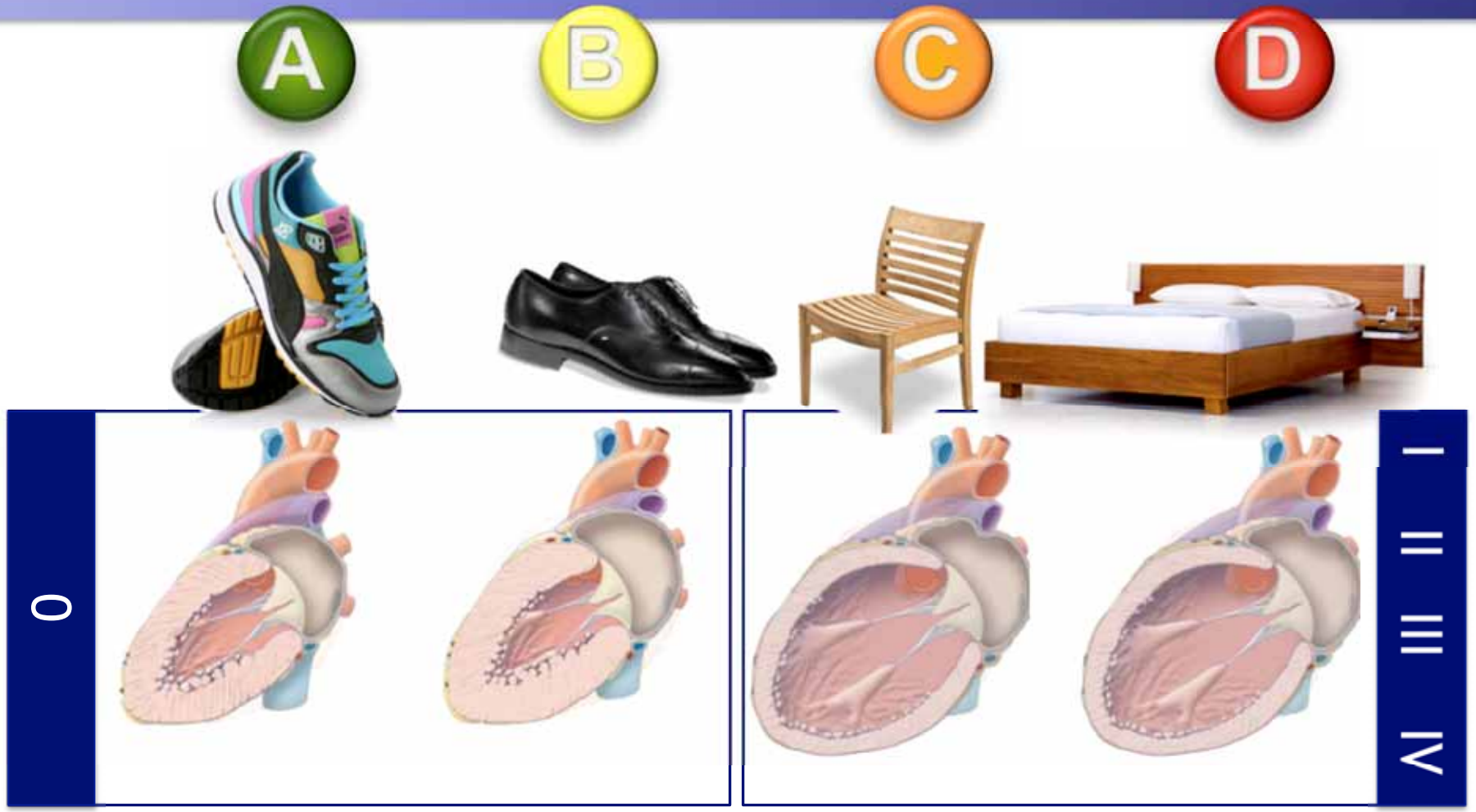
*Juan I Pérez Calvo*
*Servicio Medicina Interna*


Total odds of dying, any cause
1 in 1
(100%)
GREATEST
LEAST
Heart disease
1 in 5
Cancer
1 in 7
Stroke
1 in 24
Motor vehicle accident
1 in 84
Suicide
1 in 119
Falling
1 in 218
Firearm assault
1 in 314
Pedestrian accident
1 in 626
Drowning
1 in 1,008
Motorcycle accident
1 in 1,020
Fire or smoke
1 in 1,113
Bicycling accident
1 in 4,919
Air/space accident
1 in 5,051
Accidental firearm discharge
1 in 5,134
Accidental electrocution
1 in 9,968
Alcohol poisoning
1 in 10,048
Hot weather
1 in 13,729
Hornet, wasp, or bee sting
1 in 56,789
Legal execution
1 in 62,468
Lightning
1 in 79,746
Earthquake
1 in 117,127
Flood
1 in 144,156
Fireworks discharge
1 in 340,733



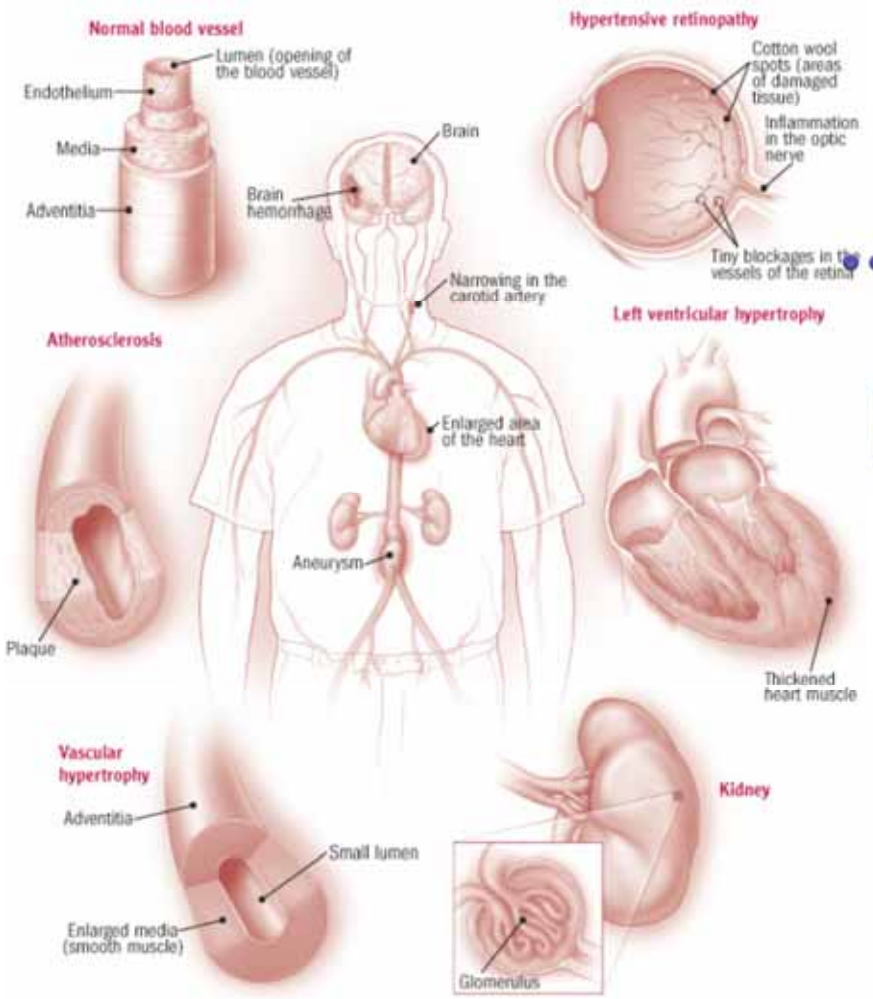

*Ezzati M, et al. Lancet; 2002; 360: 1347-1360*

# UNA VISIÓN PRONÓSTICA




*AHA/ACC GUIDELINES. J Am Coll Cardiol 2001;38:2101–2113*

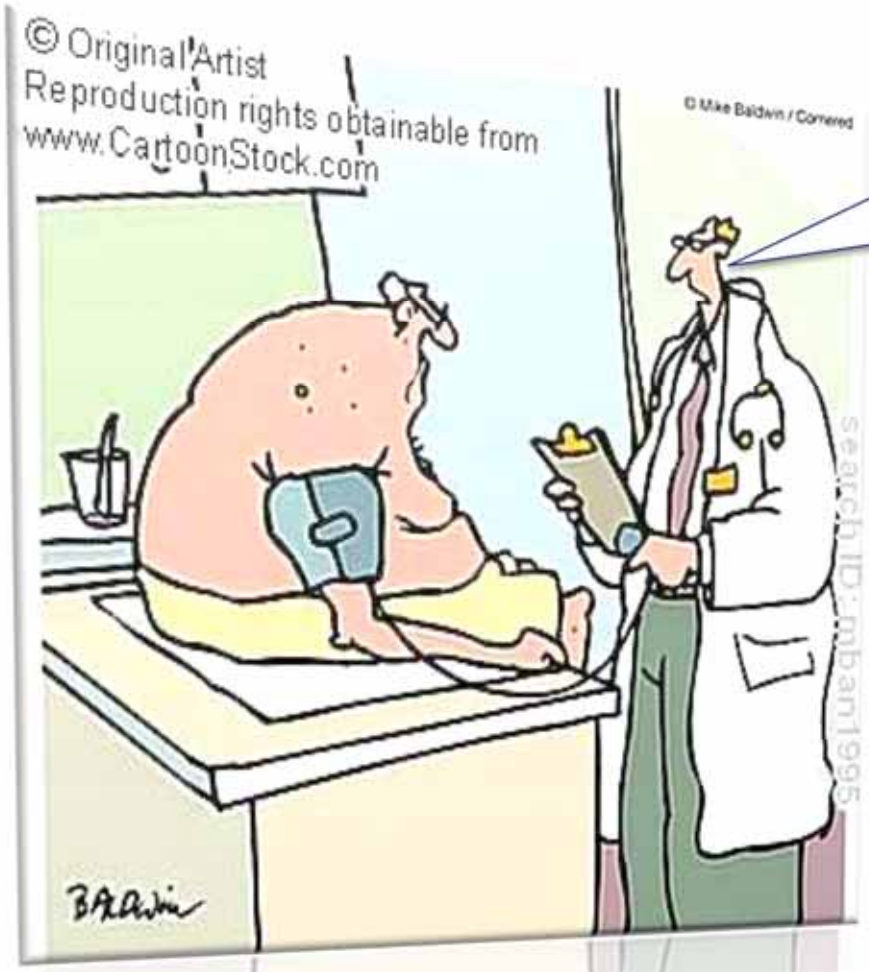
# HIPERTENSIÓN ARTERIAL …




… PREVENCIÓN DE LA INSUFICIENCIA CARDÍACA


IC
SOFTWARE UPDATE
SDK
ENTERPRISE
HTA

# ¿ QUÉ RELACIÓN TIENEN ?




***Tiene la TA de un muchacho ...***
***... que se alimenta de comida basura, sentado delante del ordenador y la tele***

## FACTOR DE RIESGO

1) ASOCIACIÓN ESTADÍSTICA
2) RELACIÓN "DOSIS-EFECTO"
3) PRELACIÓN EN EL TIEMPO
4) MEJORÍA CON LA ATENUACIÓN
5) MECANISMO PATOGÉNICO
6) POBLACIONES DISTINTAS

# NHANES I

**Table 4. Multivariate Relative Risk of Congestive Heart Failure in 13 643 Participants in the NHANES I Epidemiologic Follow-up Study by Socioeconomic and Health Characteristics***

| | Men (n = 5545) | | Women (n = 8098) | | Total (N = 13 643) | |
|---|---|---|---|---|---|---|
| | RR (95% CI)† | *P* | RR (95% CI)† | *P* | RR (95% CI)† | *P* |
| Male sex | . . . | . . . | . . . | . . . | 1.24 (1.10-1.39) | <.001 |
| Black race | 0.95 (0.72-1.26) | .73 | 1.20 (0.90-1.62) | .21 | 1.11 (0.89-1.38) | .37 |
| <High school education | 1.20 (0.99-1.45) | .06 | 1.25 (0.99-1.57) | .06 | 1.22 (1.04-1.42) | .01 |
| Low physical activity | 1.14 (0.94-1.38) | .19 | 1.31 (1.11-1.54) | .002 | 1.23 (1.09-1.38) | <.001 |
| Current cigarette smoking | 1.45 (1.24-1.70) | <.001 | 1.88 (1.53-2.30) | <.001 | 1.59 (1.39-1.83) | <.001 |
| Regular alcohol consumption | . . . | . . . | 0.70 (0.51-0.97) | .03 | 0.88 (0.75-1.03) | .12 |
| Overweight | 1.23 (1.00-1.52) | .05 | 1.34 (1.10-1.64) | .005 | 1.30 (1.12-1.52) | .001 |
| Hypertension | 1.33 (1.14-1.57) | <.001 | 1.51 (1.29-1.77) | <.001 | 1.40 (1.24-1.59) | <.001 |
| Diabetes | 1.83 (1.27-2.63) | .002 | 1.83 (1.38-2.41) | <.001 | 1.85 (1.51-2.28) | <.001 |
| Valvular heart disease | 1.74 (1.31-2.31) | <.001 | 1.36 (1.00-1.84) | .05 | 1.46 (1.17-1.82) | .001 |
| Coronary heart disease‡ | 8.12 (6.68-9.88) | <.001 | 8.16 (6.79-9.80) | <.001 | 8.11 (6.95-9.46) | <.001 |

*J He, et al. Arch Intern Med 2001; 161: 996-1002*

# NHANES I

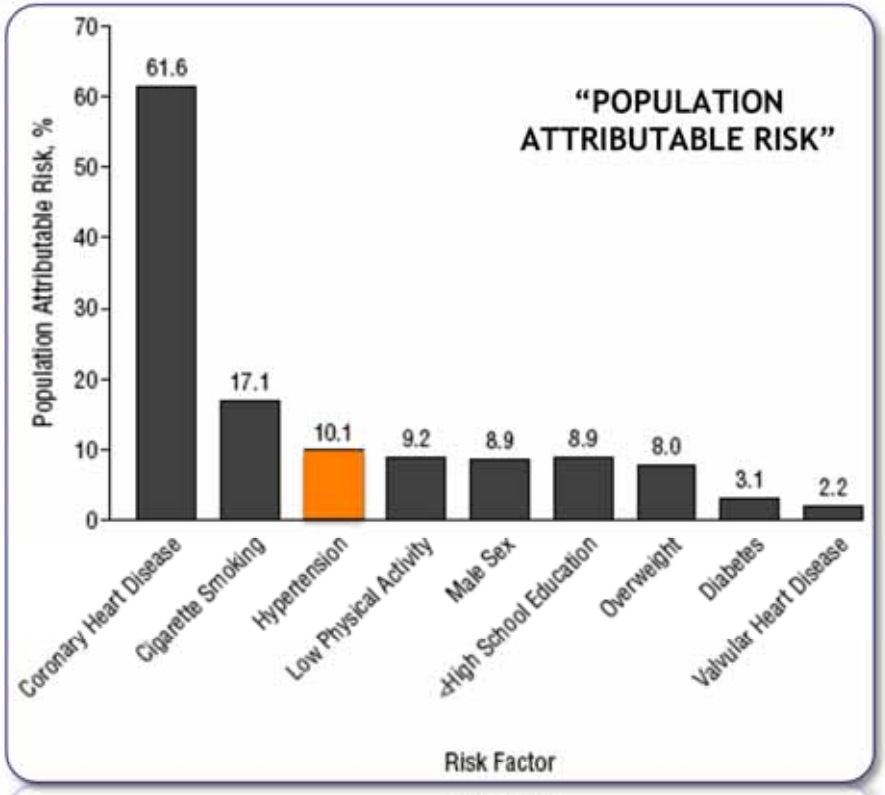
*IC EN CIFRAS*

4,6 millones afectados

400.000 nuevos casos/año

43.000 muertes/año

1.000.000 ingresos/año




nchs National Center for Health Statistics ...Monitoring the Nation's Health

*J He, et al. Arch Intern Med 2001; 161: 996-1002*

| | Lifetime Risk for CHF | | | | | |
|---|---|---|---|---|---|---|
| | Men | | | Women | | |
| Index Age, y | SBP <140 and DBP <90 mm Hg | SBP 140–159 or DBP 90–99 mm Hg | SBP ≥160 or DBP ≥100 mm Hg | SBP <140 and DBP <90 mm Hg | SBP 140–159 or DBP 90–99 mm Hg | SBP ≥160 or DBP ≥100 mm Hg |
| Treated subjects included in highest blood pressure stratum | | | | | | |
| 40* | 14.8 | 22.9 | 27.9 | 12.0 | 20.2 | 28.9 |
| 50† | 17.3 | 25.4 | 27.0 | 12.4 | 25.2 | 26.6 |
| 60 | 17.4 | 19.6 | 29.0 | 14.4 | 21.3 | 27.4 |
| 70 | 15.1 | 20.3 | 27.8 | 14.3 | 17.1 | 24.5 |
| 80 | 10.1 | 19.4 | 27.9 | 10.7 | 10.0 | 23.9 |
| Treatment status ignored | | | | | | |
| 40* | 15.6 | 23.2 | 27.4 | 12.0 | 20.4 | 29.5 |
| 50† | 16.8 | 27.1 | 27.4 | 12.4 | 26.5 | 24.4 |
| 60 | 18.1 | 20.7 | 30.0 | 15.9 | 21.8 | 27.1 |
| 70 | 18.2 | 22.0 | 27.3 | 15.4 | 22.6 | 24.3 |
| 80 | 16.6 | 23.3 | 27.0 | 17.1 | 17.0 | 24.4 |

*Lloyd-Jones DM, et al. Circulation 2002; 106: 3068-3072*


Touareg
Touareg

# ¿ PUEDE MODIFICARSE ?

# TRATAMIENTO FARMACOLÓGICO EN POBLACIÓN CON RIESGO VASCULAR

**Table 3 Prevention of heart failure in various populations**

| Trial | *n* | Population | Heart failure | Drug |
|---|---|---|---|---|
| HOPE (2000) | 9297 | High-risk | ↓ 23% | ramipril vs. p |
| EUROPA (2003) | 12218 | CAD | ↓ 39% hospitalization | perindopril vs. p |
| PROGRESS (2003) | 6105 | CVA/TIA | ↓ 26% | perindopril vs. p |
| ONTARGET (2008) | 8576 | High-risk | NS | telmisartan vs. ramipril vs. both |
| TRANSCEND (2008) | 5926 | High-risk | NS | telmisartan vs. p |
| 4S (1994) | 4444 | Angina/MI | ↓ 20% | simvastatin vs. p |
| CURE (2001) | 12562 | ACS | ↓ 18% | clopidogrel vs. p |
| SHEP (1991) | 4376 | Systolic HTN | ↓ 54% | chlorthalidone vs. p |
| HYET (2008) | 3845 | HTN | ↓ 64% | indapamide vs. p |
| UKDPS (1998) | 1148 | DM, HTN | ↓ 56%[a] | captopril/atenolol vs. p |
| RENAAL (2001) | [illegible]3 | DM + CKD | ↓ 32% hospitalization | losartan vs. p |
| ID[illegible] | [illegible] | HTN + DM + CKD | ↓ 23% hospitalization | irbesartan vs. amlodipine |


*CS Dupree. Curr Opin Cardiol 2009; 24: 142-147*

# TRATAMIENTO FARMACOLÓGICO EN HIPERTENSIÓN ARTERIAL

**SYSTOLIC HYPERTENSION IN ELDERLY PROGRAM**

*Multicéntrico*
*Doble ciego*
*Randomizado*
*Placebo*

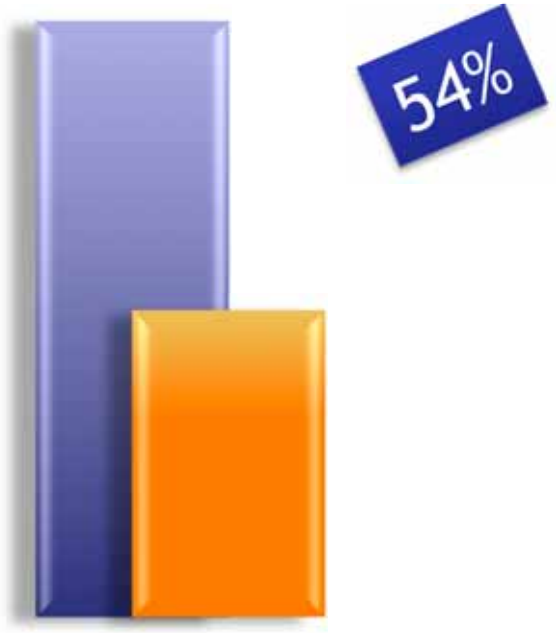
***HT Sistólica aislada***

2365 HCTZ ± Atenolol

vs

2371 Placebo

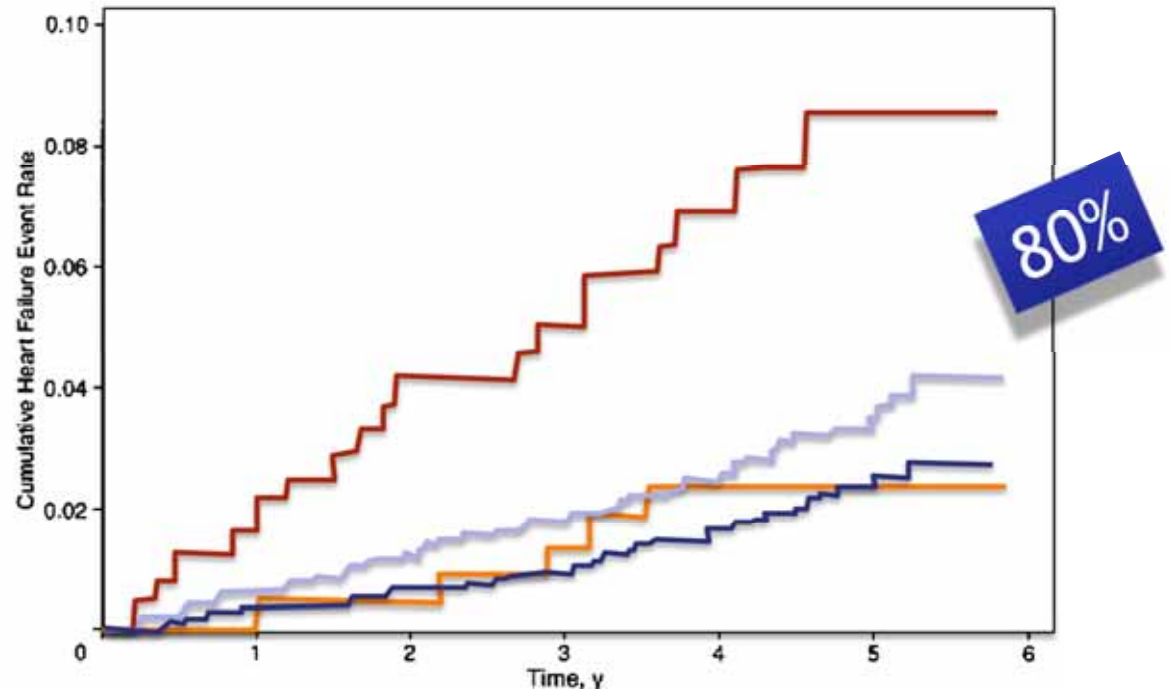
## SHEP




*SHEP Cooperative Research Group. JAMA. 1991; 265: 3255-3264*

## SYSTOLIC HYPERTENSION IN ELDERLY PROGRAM (cohortes)

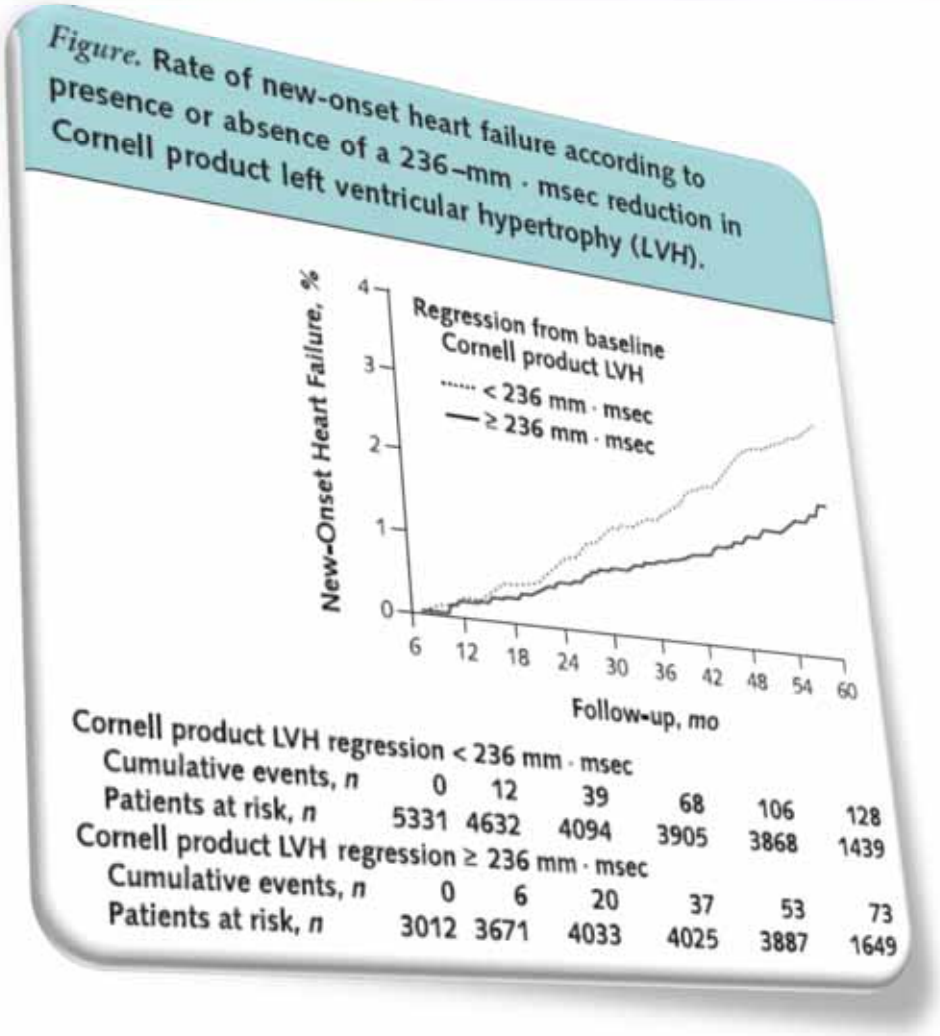
# SHEP




- ***PLACEBO IAM***
- ***ACTIVO IAM***
- ***PLACEBO NO IAM***
- ***ACTIVO NO IAM***

*JB Kostis. JAMA. 1997; 278: 2560-2572*

# HVI Y RIESGO DE IC




## Estudio LIFE

**8749 HTA sin IC**
**Tx con Losartan o Atenolol**
**Randomizado y ciego**
**Seguimiento 4,7 años**

**Cambios en el producto de Cornell**
**IC incidente**

*IECA-ARB > CCB > BB > Diur*

**No Minoxidil, Hidralacina**

*PM Okin, et al. Ann Intern Med 2007; 147: 311-319*
*SM Artham, et al. Prog Cardiovasc Dis 2009; 153-167*

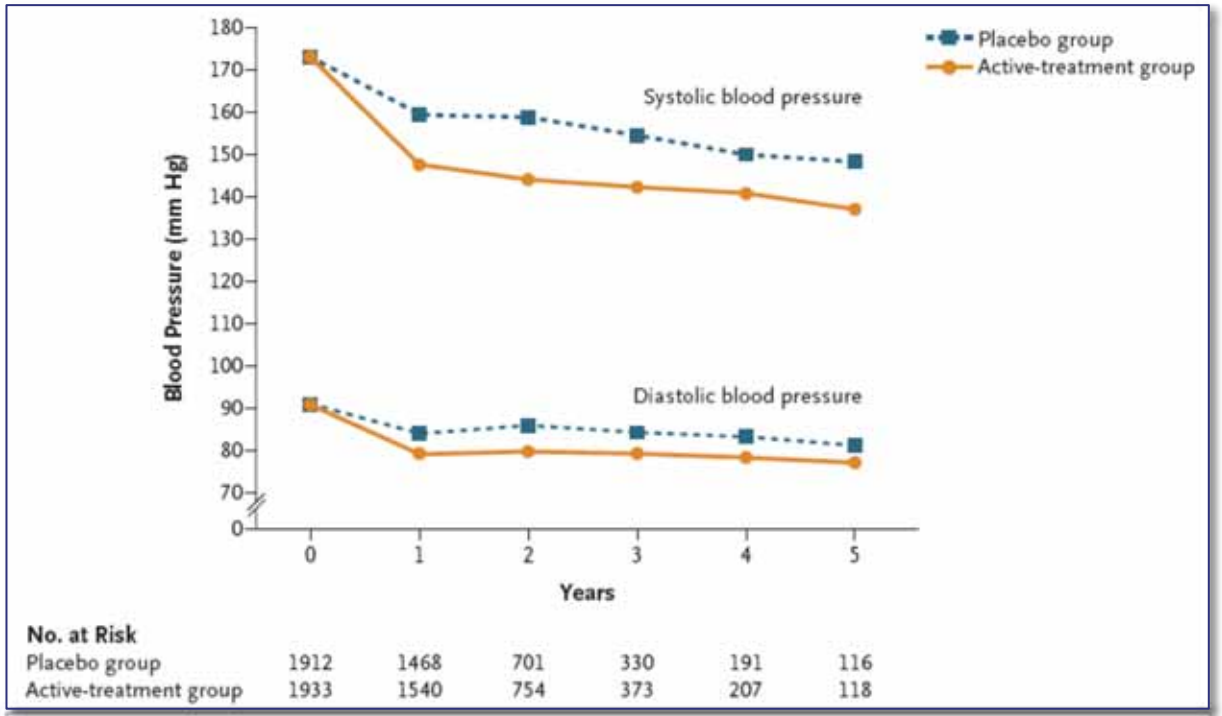
The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 MAY 1, 2008 VOL. 358 NO. 18

# Treatment of Hypertension in Patients 80 Years of Age or Older

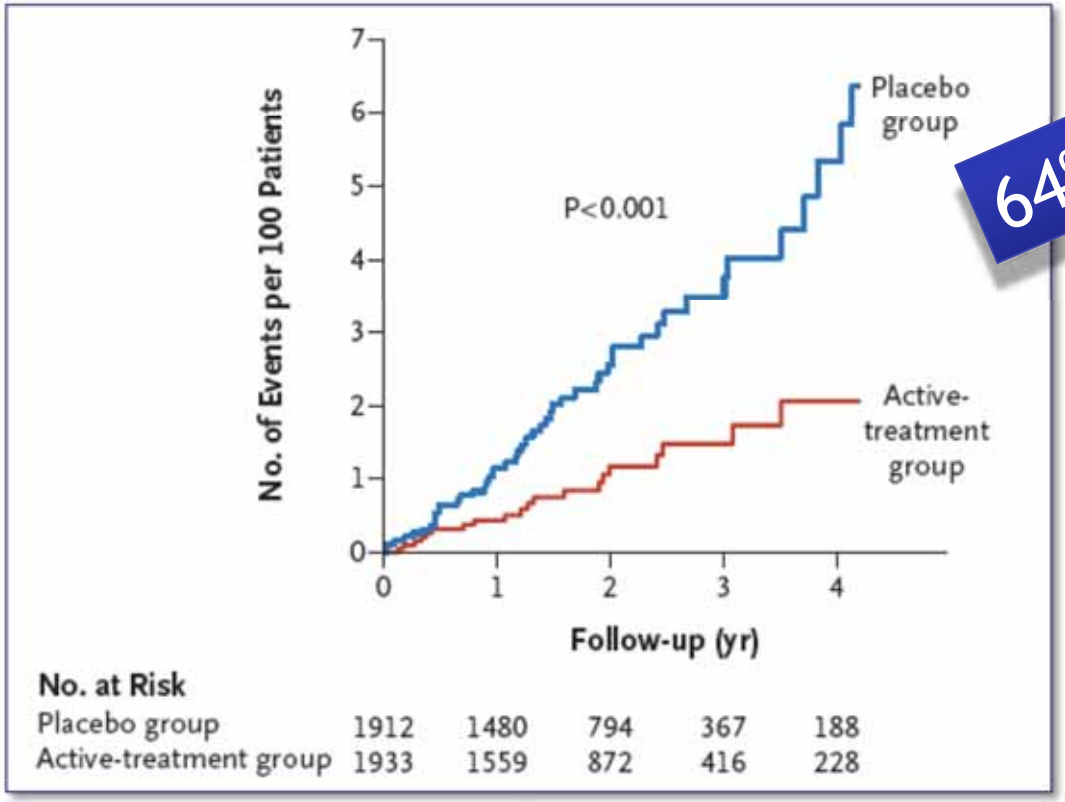
Nigel S. Beckett, M.B., Ch.B., Ruth Peters, Ph.D., Astrid E. Fletcher, Ph.D., Jan A. Staessen, M.D., Ph.D., Lisheng Liu, M.D., Dan Dumitrascu, M.D., Vassil Stoyanovsky, M.D., Riitta L. Antikainen, M.D., Ph.D., Yuri Nikitin, M.D., Craig Anderson, M.D., Ph.D., Alli Belhani, M.D., Françoise Forette, M.D., Chakravarthi Rajkumar, M.D., Ph.D., Lutgarde Thijs, M.Sc., Winston Banya, M.Sc., and Christopher J. Bulpitt, M.D., for the HYVET Study Group*

*NS Beckett et al. NEJM. 2008; 358: 1887-1898*




*NS Beckett et al.. NEJM. 2008; 358: 1887-1898*

## Insuficiencia cardiaca




*NS Beckett et al.. NEJM. 2008; 358: 1887-1898*

# ¿ CÓMO MODIFICARLA ?

# Primary prevention of heart failure: what is the evidence?

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No disclosures.

**Current Opinion in Cardiology** 2009, 24:142–147

There are no trials targeting primary prevention of heart failure

**Purpose of review**

Heart failure is a worldwide epidemic. Aggressive treatment of patients at risk for heart

vascular disease, hypertension, and diabetes can prevent heart failure.

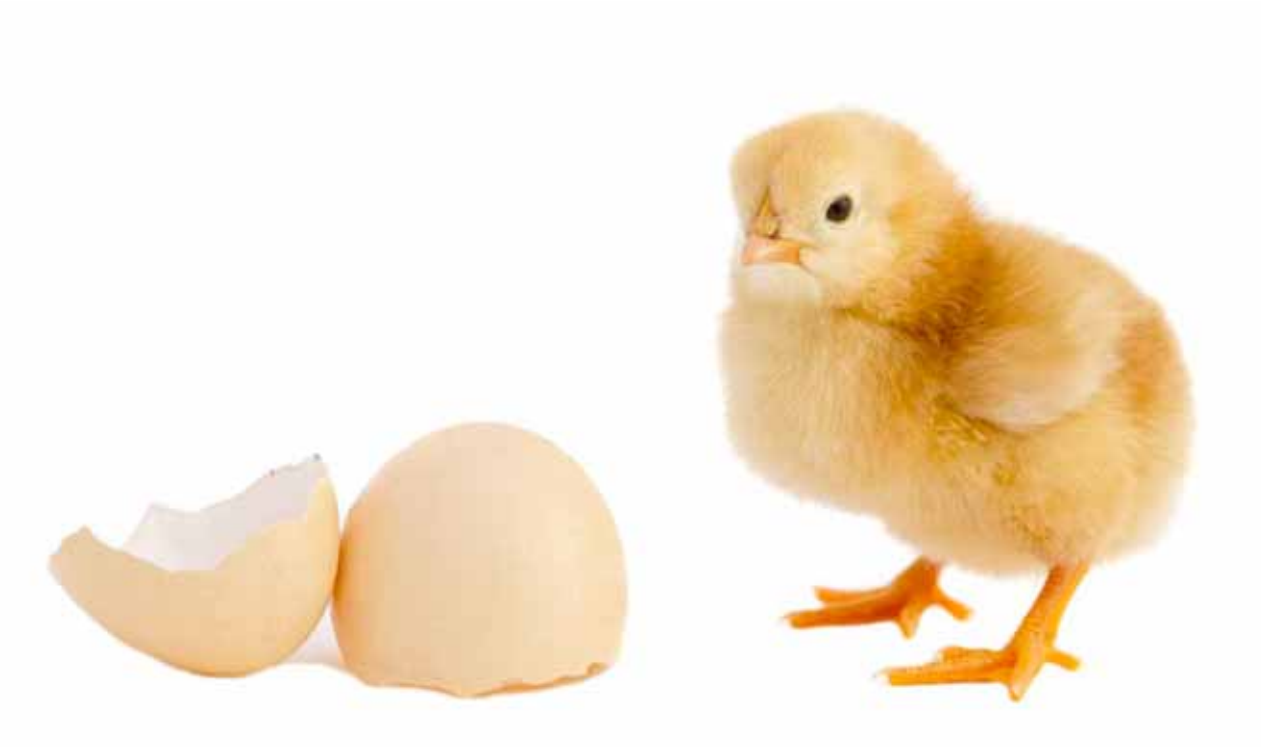
**Recent findings**

Several recent trials further expand our knowledge of how to best treat high-risk patients. Treatment of hypertensive patients over age 80 with indapamide and an ACE-inhibitor if needed can significantly reduce heart failure and mortality. There is no additional benefit from the combination of an ACE-inhibitor and angiotensin receptor blocker therapy in patients with vascular disease or high-risk diabetic patients. Continued blood pressure control is necessary to maintain beneficial cardiovascular outcomes.

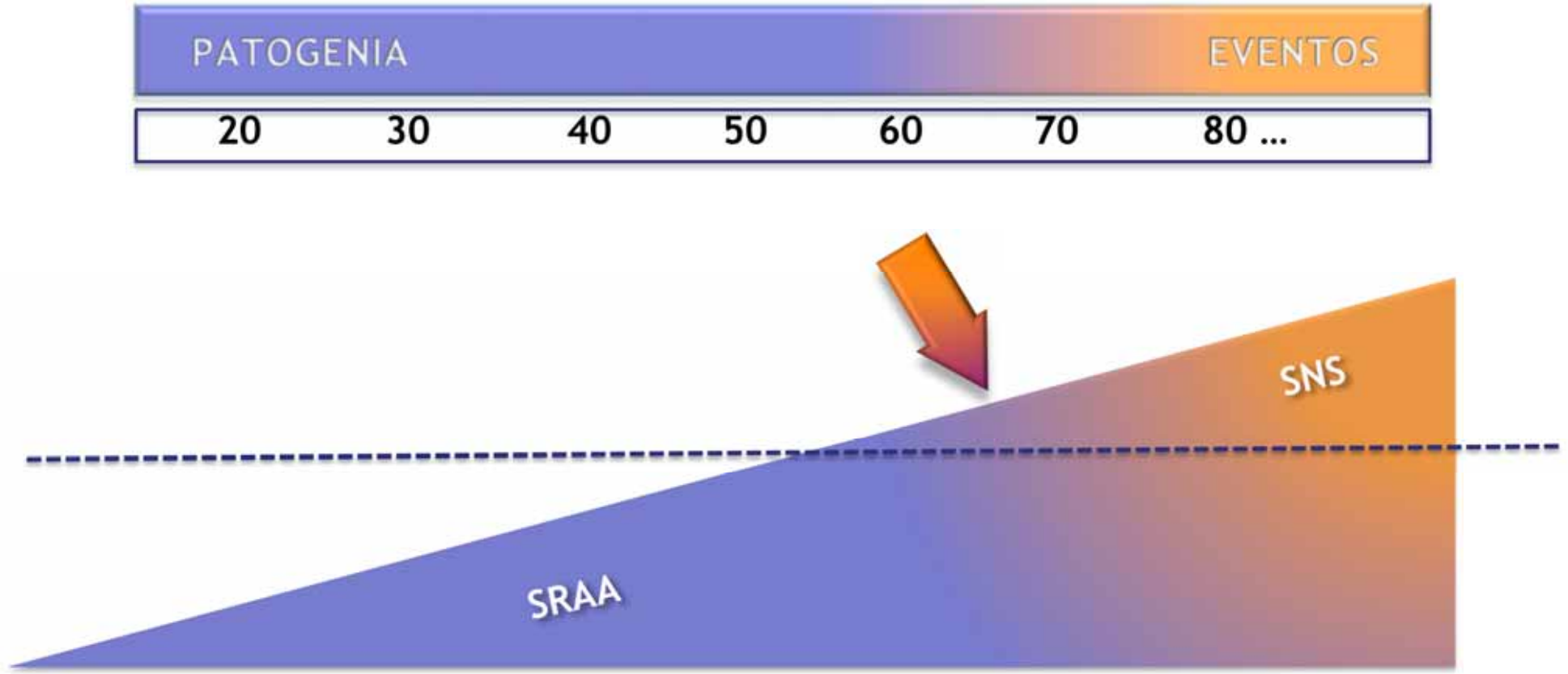
**Summary**

Identification and treatment of patients at high risk can prevent the development of heart failure and reduce heart failure hospitalization. Thiazide diuretics, ACE-inhibitors or angiotensin receptor blockers if ACE-inhibitor-intolerant are preferred first-line agents.

*CS Dupree. Curr Opin Cardiol 2009; 24: 142-147*



# ¿PREVENIR LA ENFERMEDAD O LOS EVENTOS?



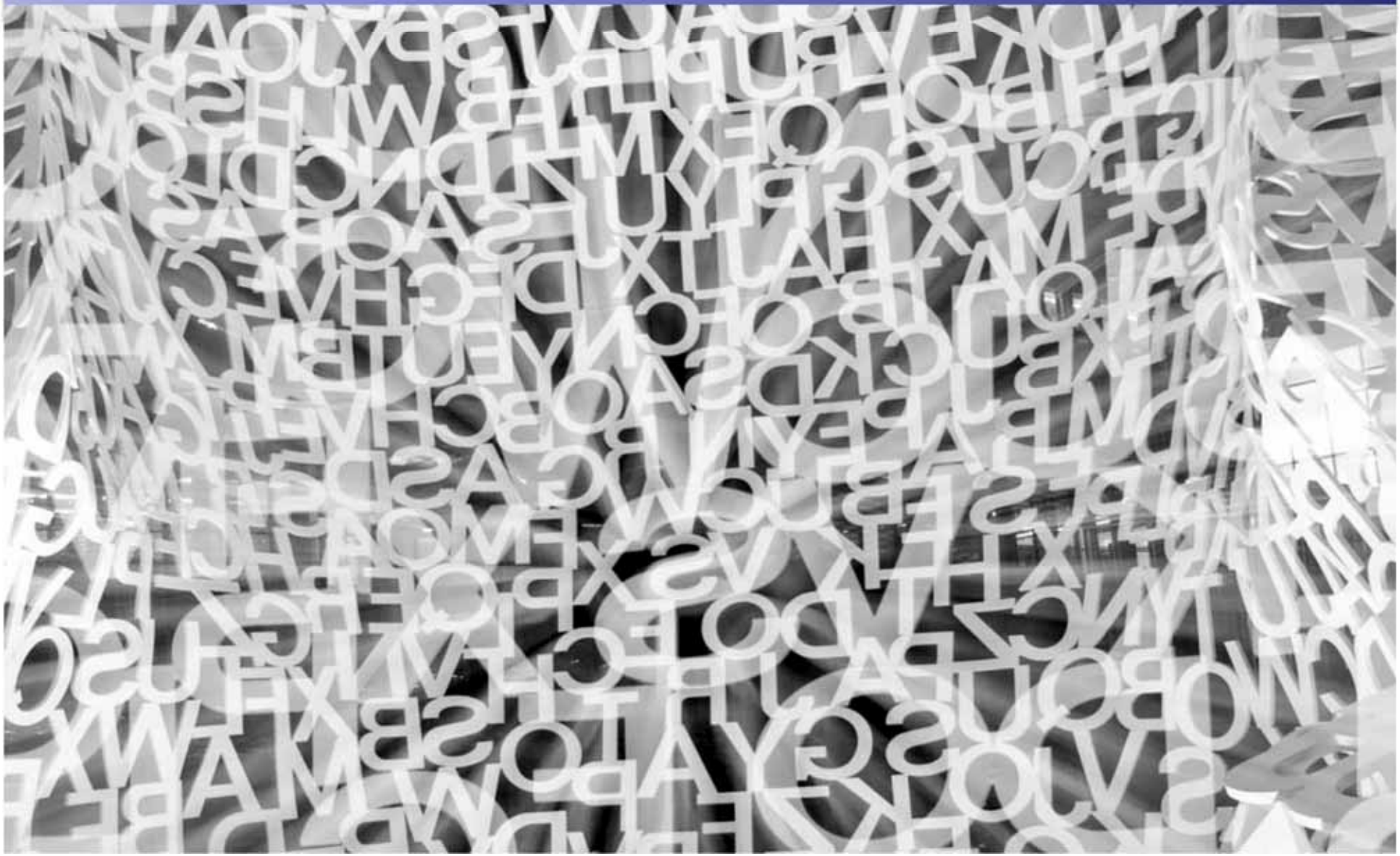

*B Williams JACC 2005; 45: 813-827*

# CONTROVERSIAS

- **¿ Todo depende de la reducción de PA?**
- **¿Hay diferencias en los resultados según los grupos farmacológicos?**
- **¿Son adecuados los marcadores surrogados?**
- **¿Son adecuados los límites de PA establecidos?**
- **¿Es más adecuada una estrategia activa sobre el riesgo vascular independiente de las cifras de PA?**

*B Williams JACC 2005; 45: 813-827*

# ENSAYOS CLÍNICOS



JAMA®

## Major Outcomes in High-Risk Hypertensive Patients Randomized to Angiotensin-Converting Enzyme Inhibitor or Calcium Channel Blocker vs Diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT)

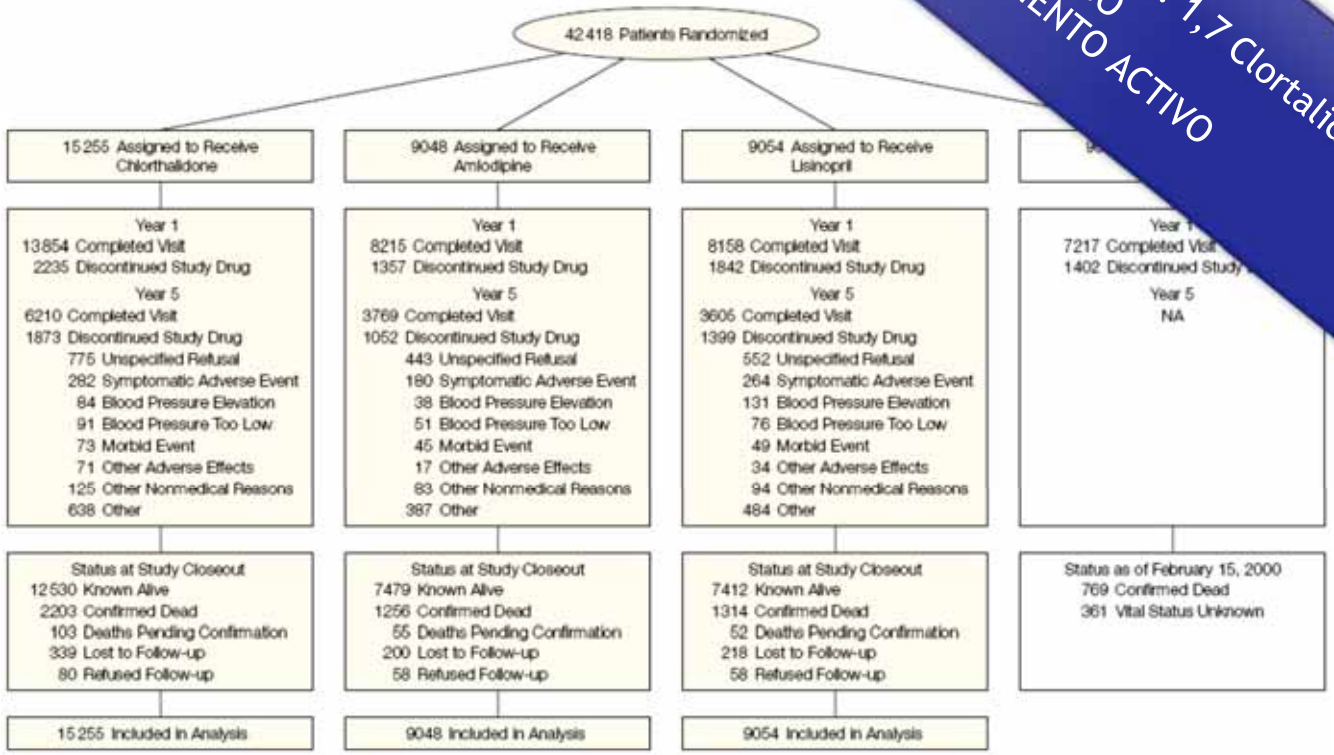
The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group

*JAMA*. 2002;288(23):2981-2997 (doi:10.1001/jama.288.23.2981)

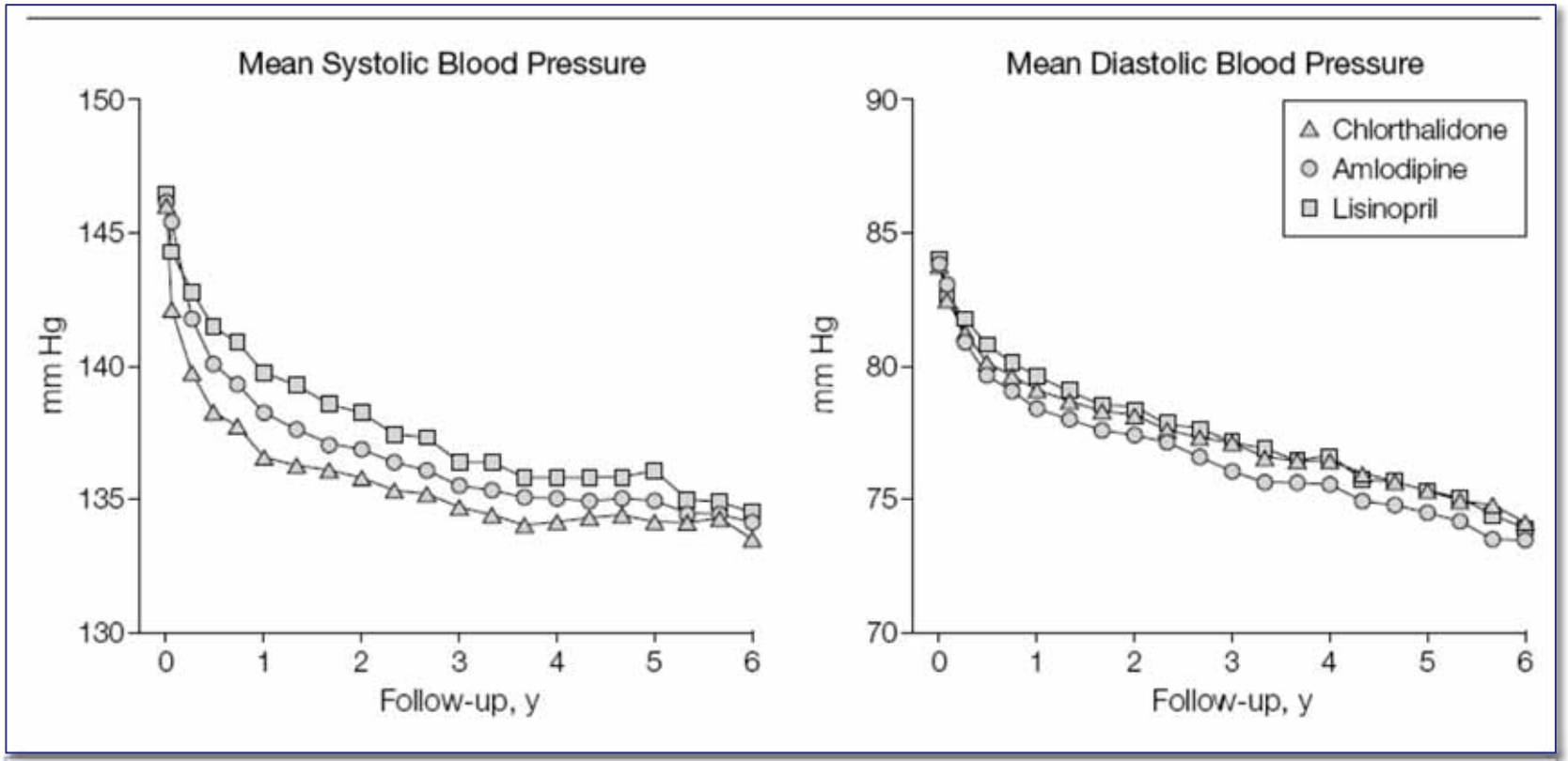
http://jama.ama-assn.org/cgi/content/full/288/23/2981

***ALLHAT JAMA 2002; 288: 2981-2997***

RANDOMIZADO: 1,7 Clortalidona vs 1 Resto
DOBLE CIEGO
TRATAMIENTO ACTIVO

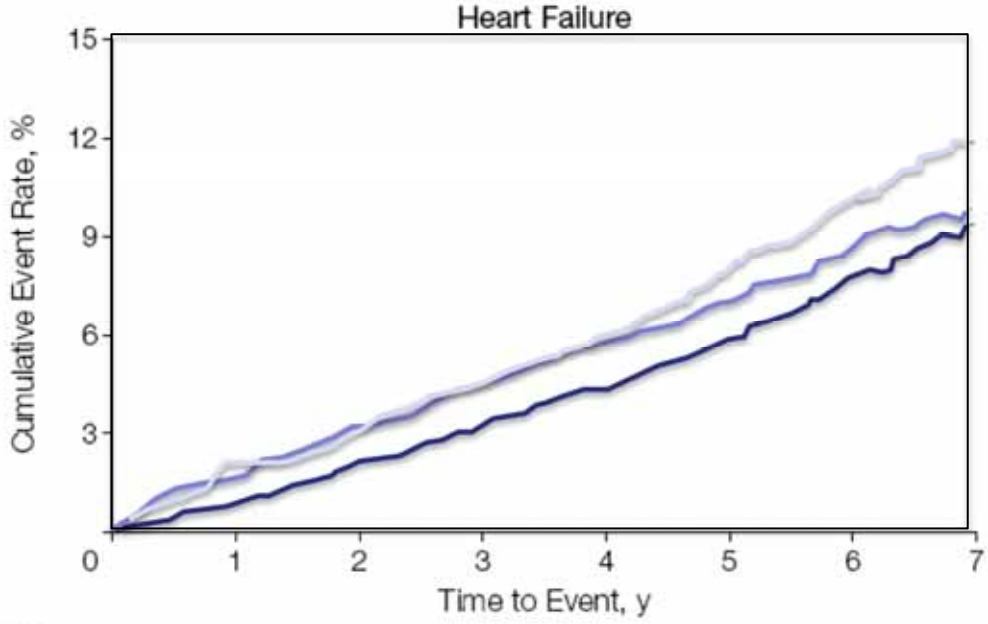



***ALLHAT JAMA 2002; 288: 2981-2997***




*ALLHAT JAMA 2002; 288: 2981-2997*

| | Amlodipine vs Chlorthalidone | | | Lisinopril vs Chlorthalidone | | |
|---|---|---|---|---|---|---|
| | RR (95% CI) | Z Score | *P* Value | RR (95% CI) | Z Score | *P* Value |
| Heart Failure | 1.38 (1.25-1.52) | 6.29 | <.001 | 1.19 (1.07-1.31)‖ | 3.33 | <.001 |




Amlodipino

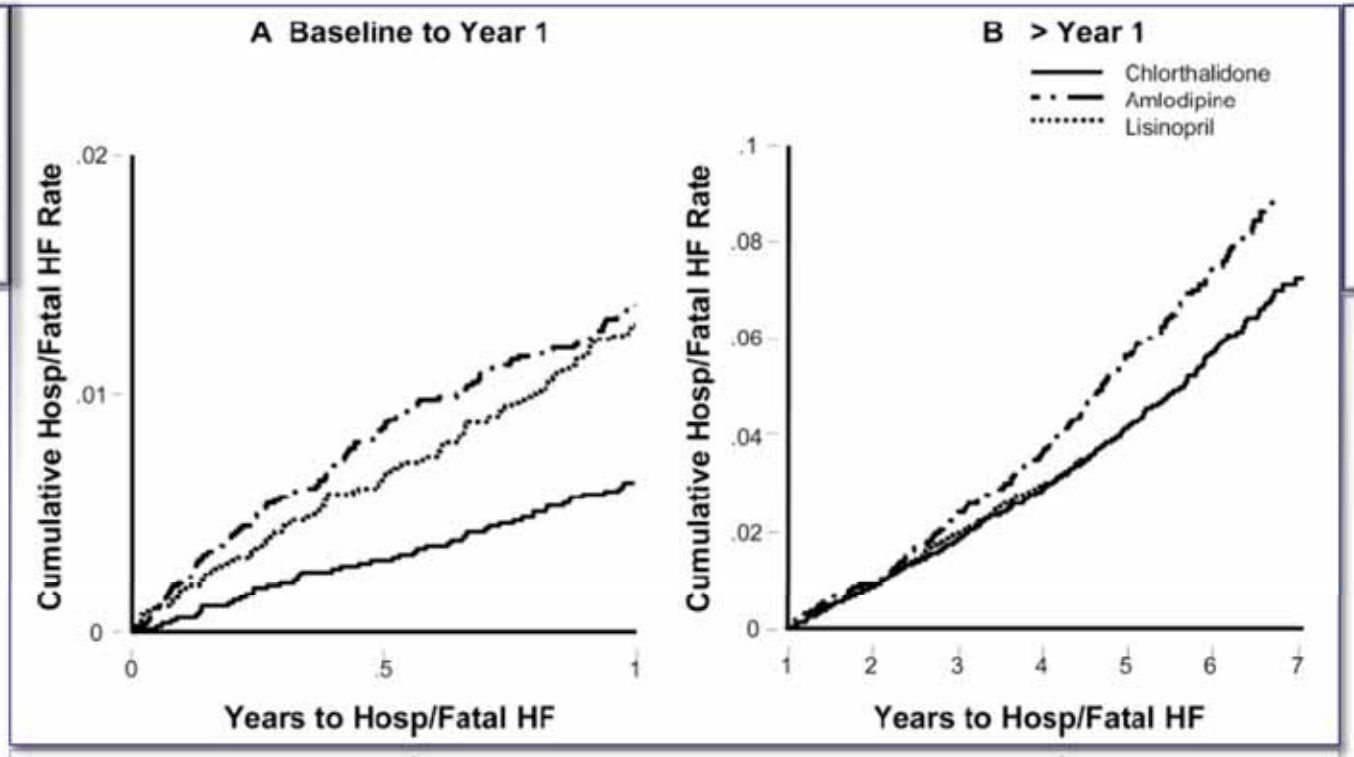
Lisinopril

Clortalidona

| No. at Risk | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Chlorthalidone | 15255 | 14528 | 13898 | 13224 | 11511 | 6369 | 3016 | 384 |
| Amlodipine | 9048 | 8535 | 8185 | 7801 | 6785 | 3775 | 1780 | 210 |
| Lisinopril | 9054 | 8496 | 8096 | 7689 | 6698 | 3789 | 1837 | 313 |

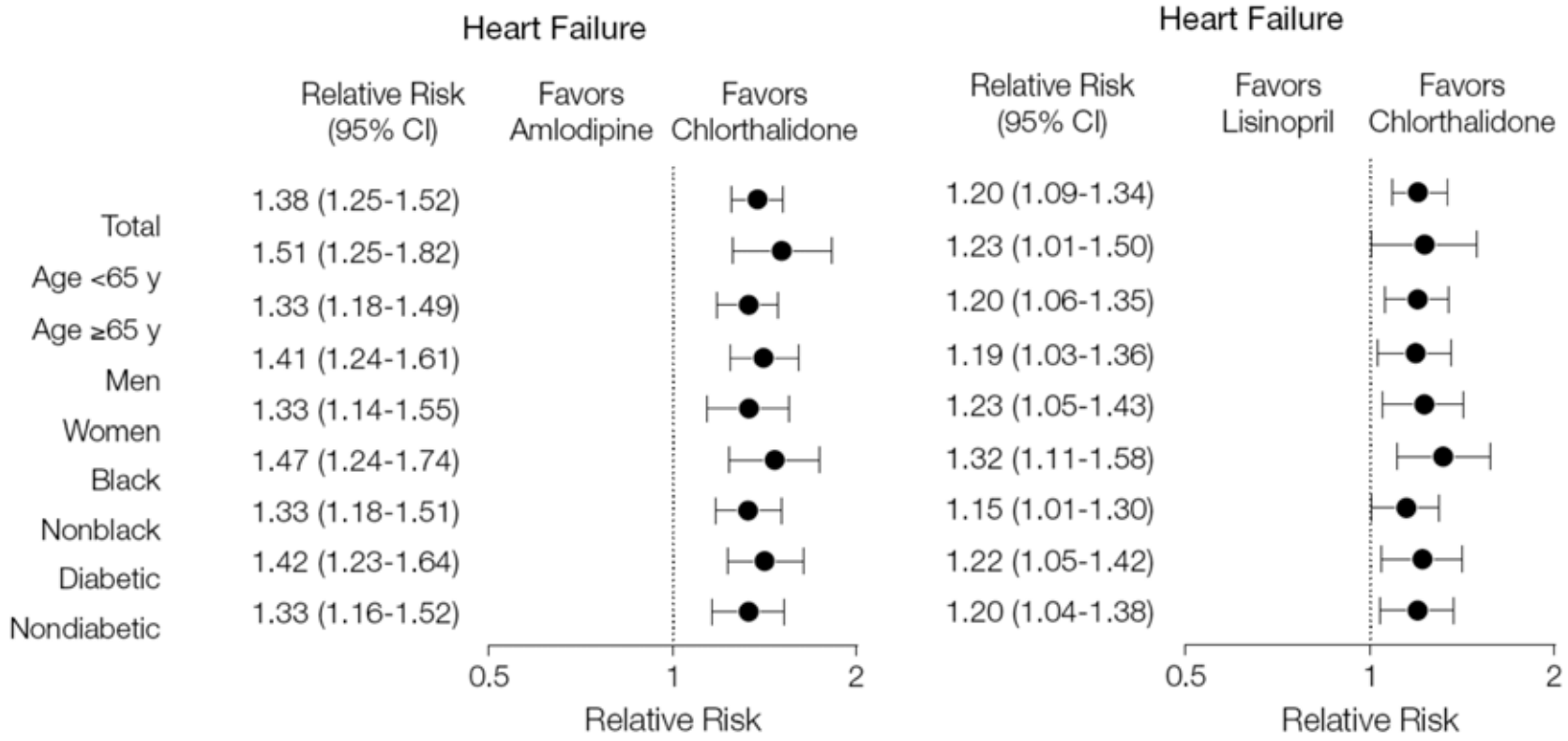
***ALLHAT JAMA 2002; 288: 2981-2997***

| RR | |
|---|---|
| Clort | 1 |
| Amlo | 2.22 |
| Lisino | 2.08 |




| RR | |
|---|---|
| Clort | 1 |
| Amlo | 1.22 |
| Lisino | 0.96 |

*BR Davis, et al. Circulation 2006; 113: 2201-2210*




*ALLHAT JAMA 2002; 288: 2981-2997*
*JT Wright, et al. Arch Intern Med 2009; 169: 832-842*

**"NETWORK** **s de Tx**

PLACEBO

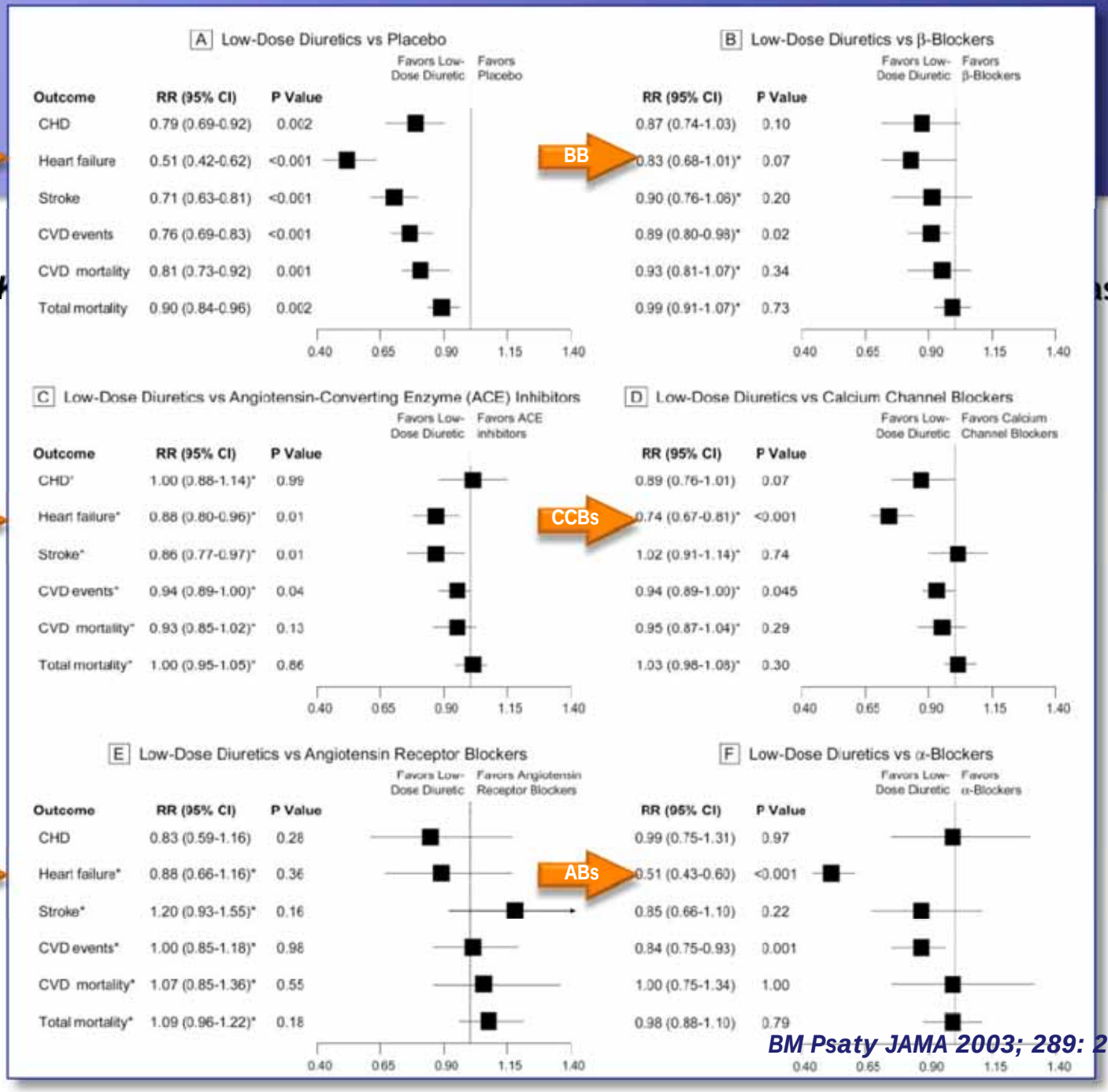
BB

IECAs

CCBs

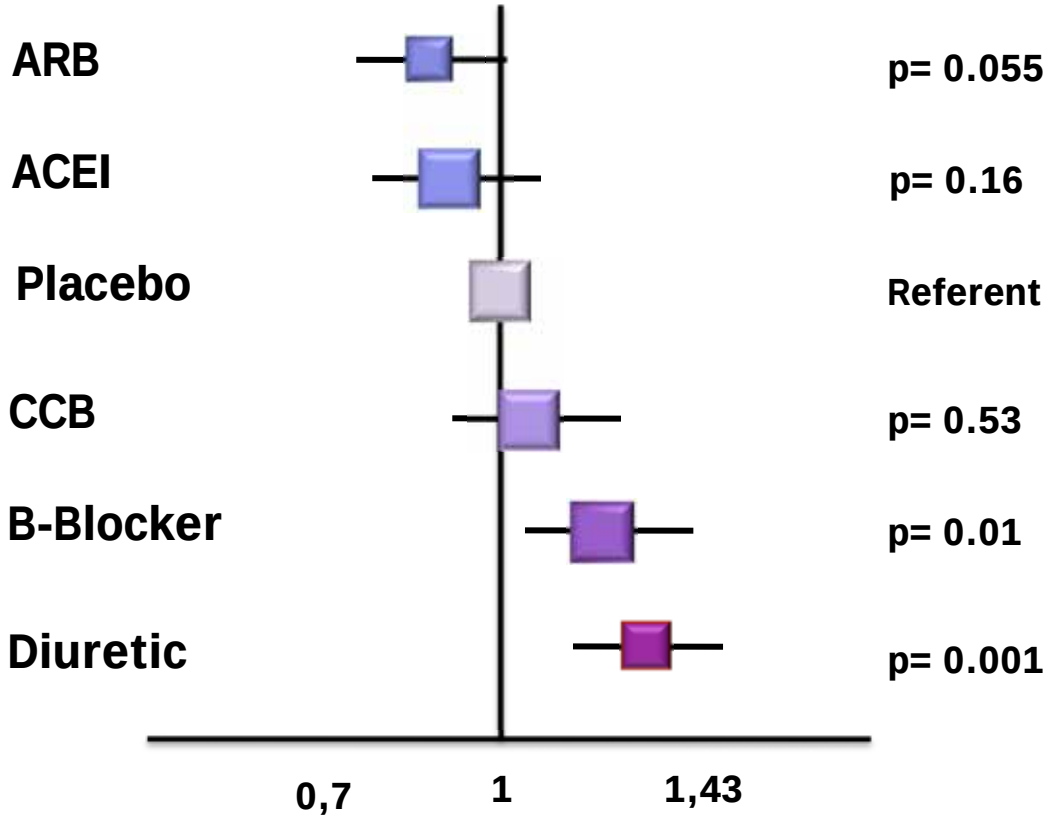
ARBs

ABs




*BM Psaty JAMA 2003; 289: 2534-2544*

# ANTIHIPERTENSIVOS Y DIABETES



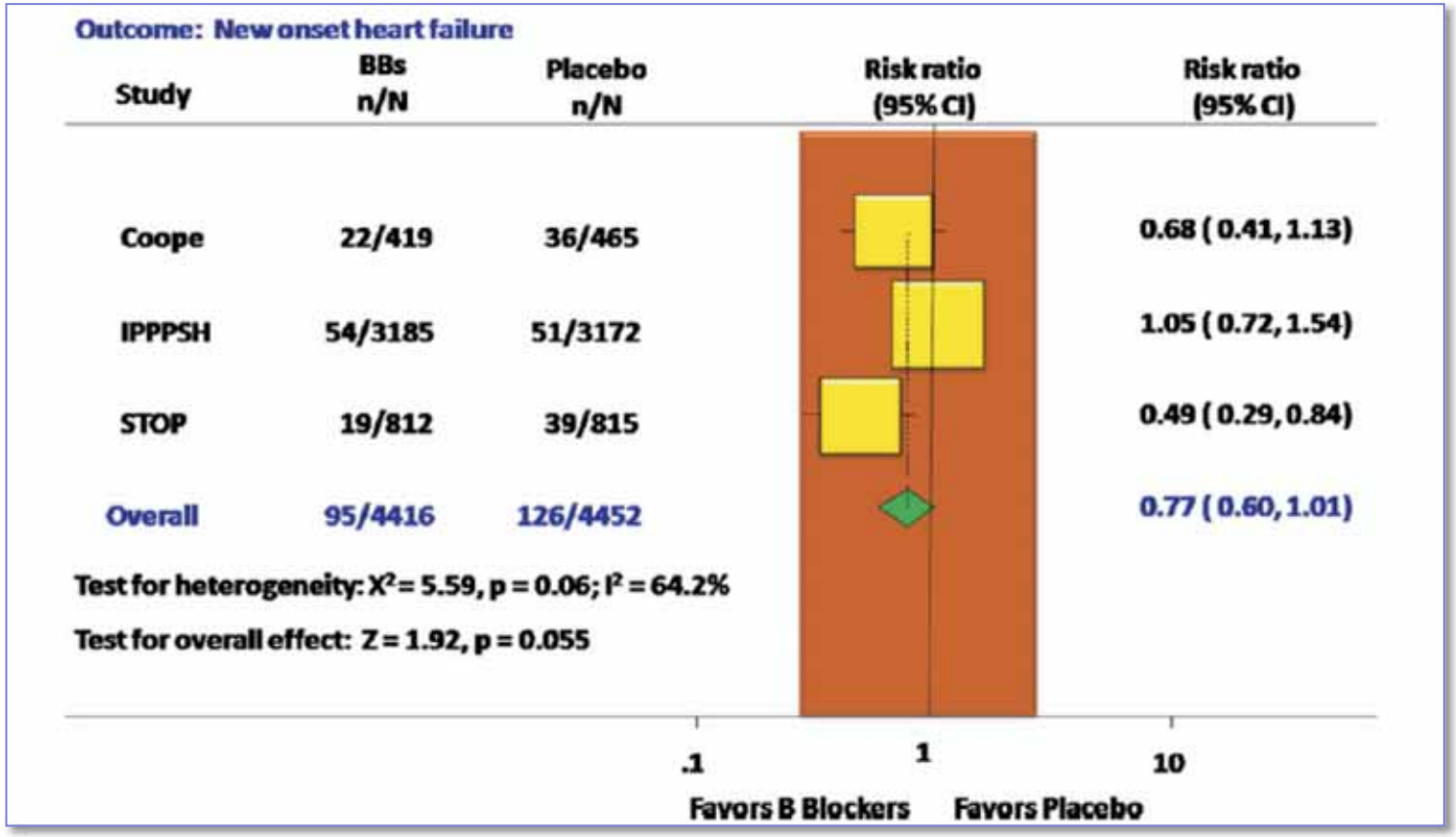

*WJ Elliot Lancet; 2007; 369: 201-2017*

| | |
|---|---|
| OBJETIVOS | Evaluar eficacia de los BB para prevención primaria de IC |
| DISEÑO | Metanálisis de 12 ensayos clínicos randomizados |
| RESULTADOS | 112.177 pacientes hipertensos.<br>Reducción de la PA 12,6/6,1 mm Hg<br>Reducción de IC de nueva aparición un 23% p=0,055<br>Comparado con otros grupos RR= 1 (IC95% 0,92-1,08)<br>Incremento riesgo de ACVA en ancianos de un 19% |
| CONCLUSIÓN | La prevención primaria de IC con BB en hipertensos depende de la reducción de la PA<br>La eficacia de los BB es similar al resto de grupos<br>Dado que aumentan el riesgo de ictus en ancianos no deben considerarse agentes de primera línea para prevenir la IC |

JACC
Journal of the American College of Cardiology

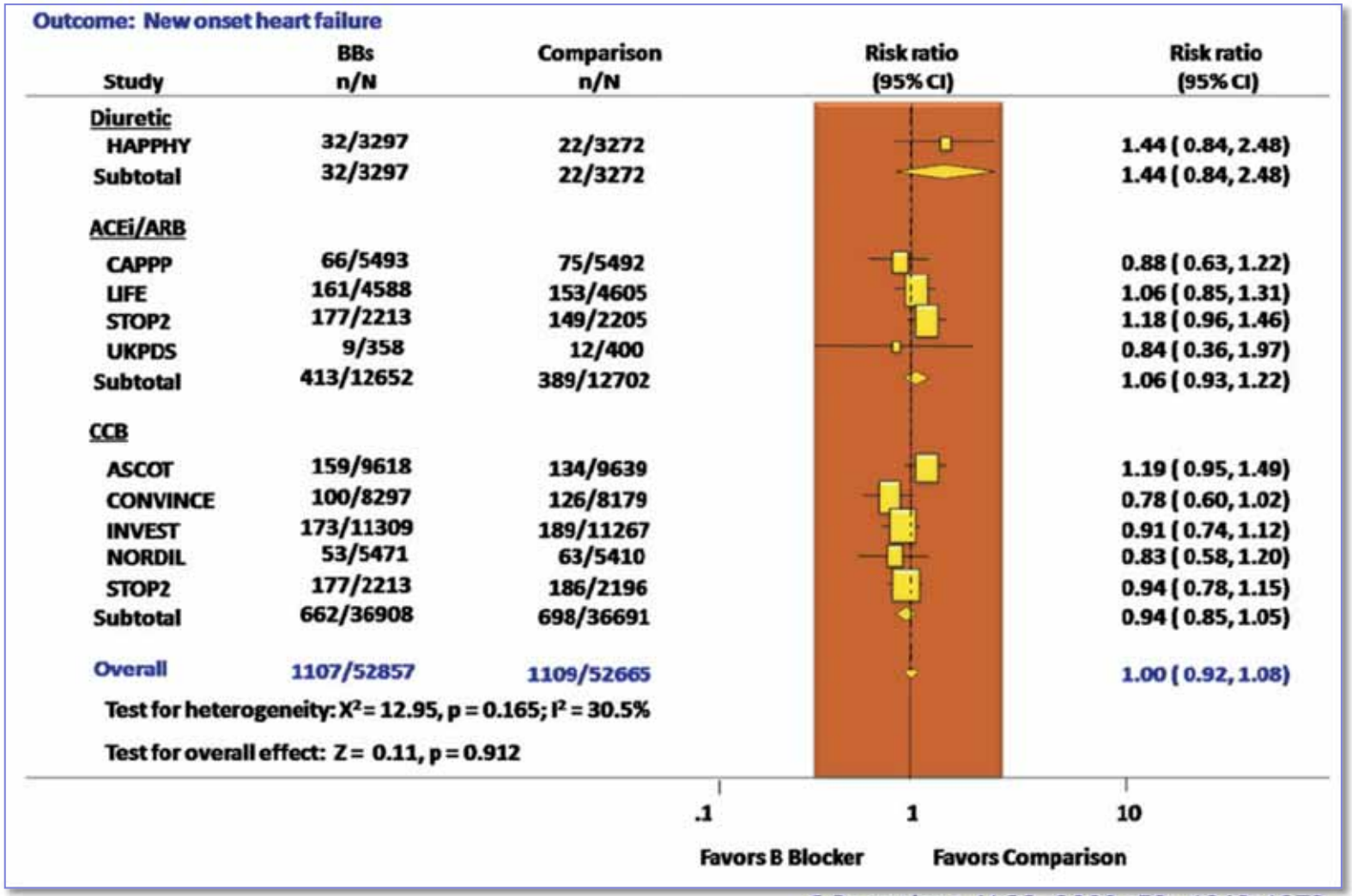
*S Bangalore JACC; 2008; 52: 1062-1072*

# BB vs PLACEBO




*S Bangalore JACC; 2008; 52: 1062-1072*

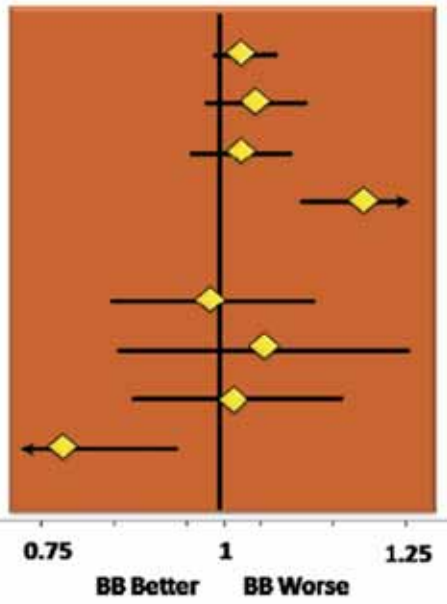
# BB vs OTROS




*S Bangalore JACC; 2008; 52: 1062-1072*

# OBJETIVOS SECUNDARIOS

| Outcome | No. studies | BB n/N | Comparison n/N | RR (95% CI) | P value | Heterogeneity Chi² | P Value |
|---|---|---|---|---|---|---|---|
| **ELDERLY (>= 60 y)** | | | | | | | |
| Death | 6 | 3429/43709 | 3304/43501 | 1.03 (0.99-1.08) | 0.146 | 7.46 | 0.281 |
| CV Death | 6 | 1707/43709 | 1619/43501 | 1.05 (0.98-1.12) | 0.145 | 12.90 | 0.053 |
| MI | 6 | 1469/43709 | 1425/43501 | 1.03 (0.96-1.10) | 0.459 | 12.09 | 0.063 |
| Stroke | 6 | 1608/43709 | 1346/43501 | 1.19 (1.11-1.28) | <0.0001 | 10.39 | 0.109 |
| **YOUNG (< 60 y)** | | | | | | | |
| Death | 3 | 345/9148 | 360/9164 | 0.98 (0.85-1.13) | 0.745 | 0.80 | 0.669 |
| CV Death | 3 | 176/9148 | 169/9164 | 1.06 (0.86-1.31) | 0.567 | 4.26 | 0.119 |
| MI | 3 | 341/9148 | 341/9164 | 1.01 (0.88-1.17) | 0.846 | 1.52 | 0.402 |
| Stroke | 3 | 198/9148 | 255/9164 | 0.78 (0.65-0.94) | 0.009 | 0.23 | 0.893 |

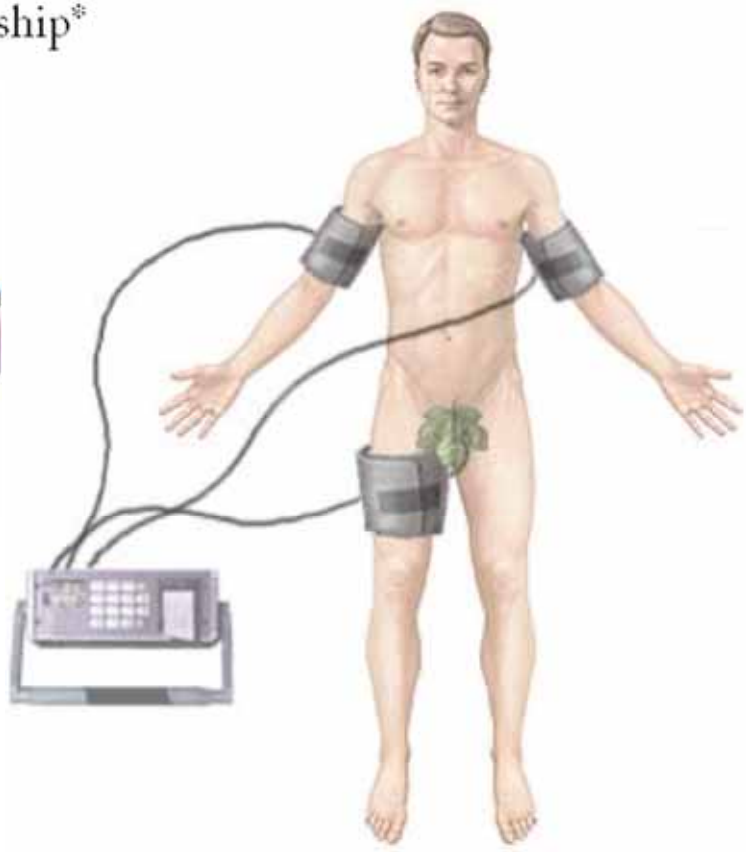


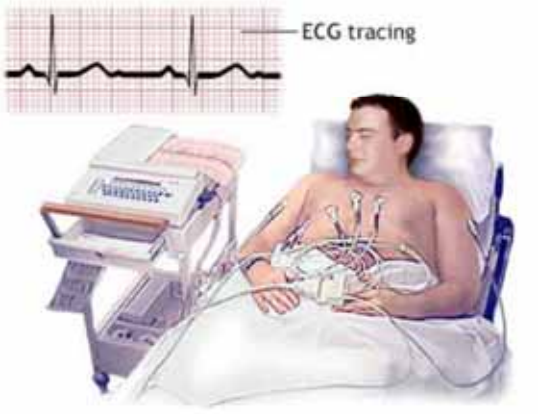

*S Bangalore JACC; 2008; 52: 1062-1072*

# BP in HF: a love-hate relationship

## Blood Pressure in Heart Failure

A Love-Hate Relationship*






*FH Messerli Circulation; 2008; 117: 2706-2715*

*MA Pfeffer JACC; 2007; 49: 40-42*

CONTROVERSIES IN CARDIOVASCULAR MEDICINE

# Should β-blockers and diuretics remain as first line therapy for hypertension?

## *Thiazide-Type Diuretics and β-Adrenergic Blockers as First-Line Drug Treatments for Hypertension*

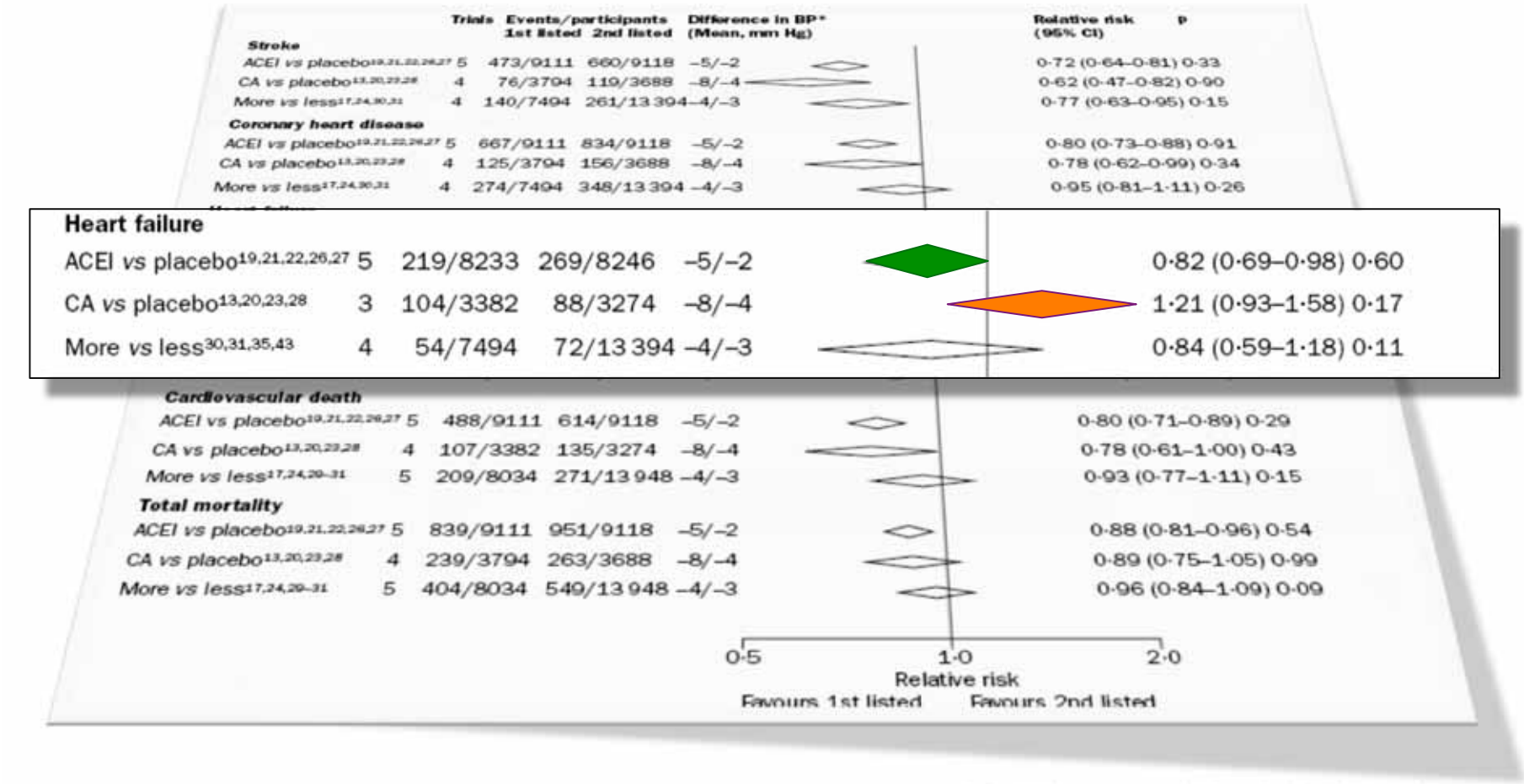
*Jeffrey A. Cutler, MD, MPH; Barry R. Davis, MD, PhD*

## *Risk/Benefit Assessment of β-Blockers and Diuretics Precludes Their Use for First-Line Therapy in Hypertension*

*Franz H. Messerli, MD; Sripal Bangalore, MD, MHA; Stevo Julius, MD*

*Circulation; 2008; 117: 2706-2715*

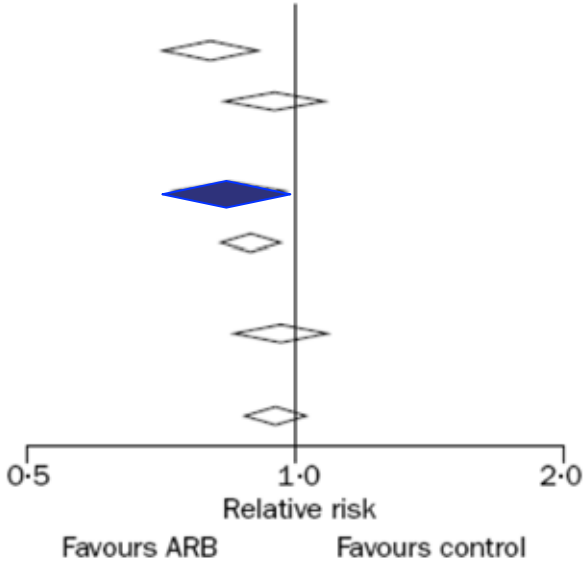
# IECAs y CAA




*BPLTTC. Lancet 2003; 3621527-1535*
*JA Staessen. J Hypertens 2003; 21: 1055-1076*

# ARB

| | Trials | Events/participants ARB | Control | Difference in BP* (mean, mm Hg) | Relative risk (95% CI) | p |
|---|---|---|---|---|---|---|
| Stroke[12–15] | 4 | 396/8412 | 500/8379 | –2/–1 | 0·79 (0·69–0·90) | 0·46 |
| Coronary heart disease[12–15] | 4 | 435/8412 | 450/8379 | –2/–1 | 0·96 (0·85–1·09) | 0·43 |
| Heart failure[13–15] | 3 | 302/5935 | 359/5919 | –2/–1 | 0·84 (0·72–0·97) | 0·26 |
| Major cardiovascular events[12–15] | 4 | 1135/8412 | 1268/8379 | –2/–1 | 0·90 (0·83–0·96) | 0·78 |
| Cardiovascular death[12–15] | 4 | 491/8412 | 511/8379 | –2/–1 | 0·96 (0·85–1·08) | 0·34 |
| Total mortality[12–15] | 4 | 887/8412 | 943/8379 | –2/–1 | 0·94 (0·86–1·02) | 0·59 |




*BPLTTC. Lancet 2003; 3621527-1535*
*JA Staessen. J Hypertens 2003; 21: 1055-1076*

# DIUR+BB, IECAs, CAA

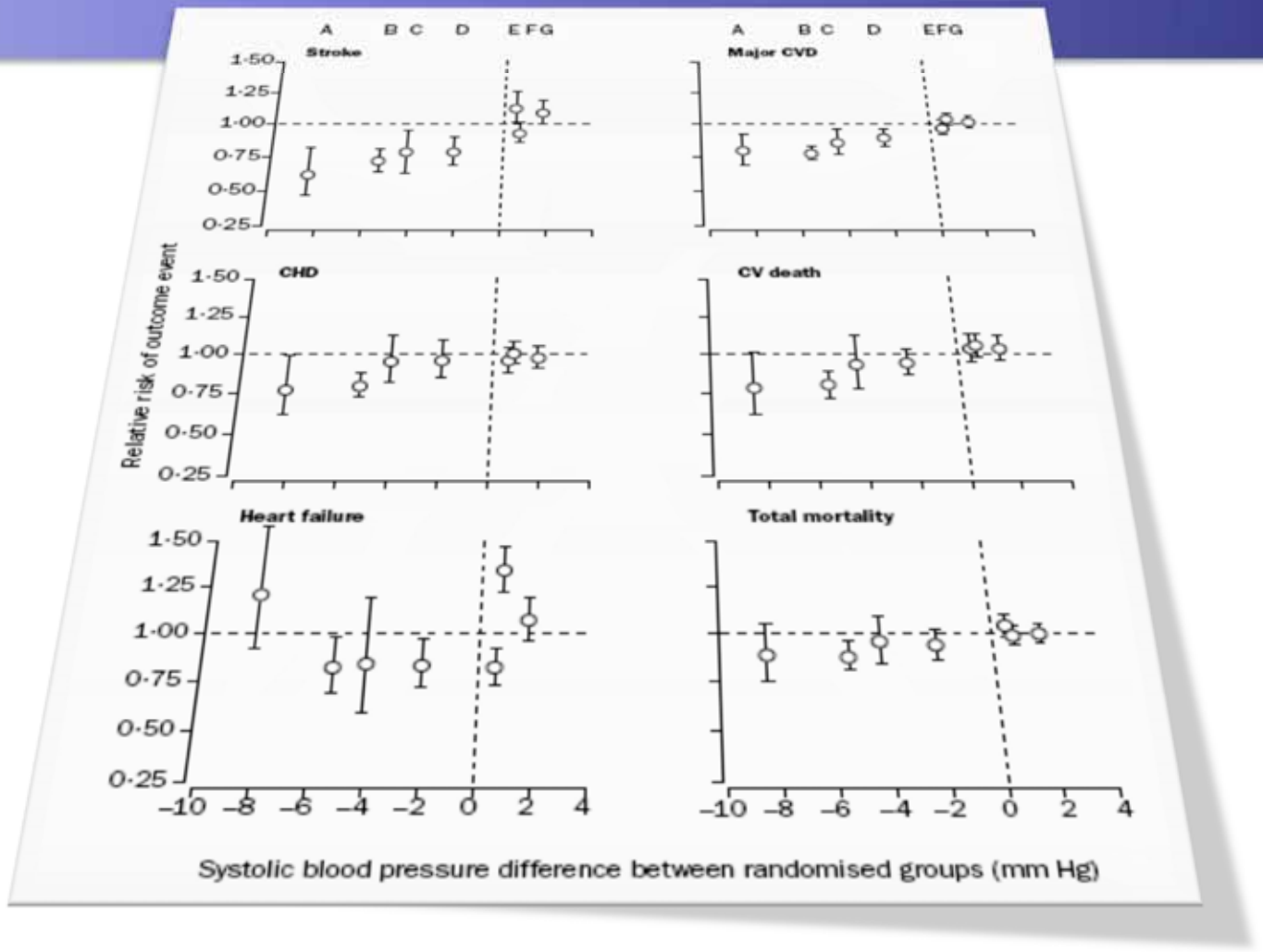
| | | | | | |
|---|---|---|---|---|---|
| **Heart failure** | | | | | |
| ACEI *vs* D/BB[32,33,44] | 3 | 547/12 498 | 809/18 652 | +2/0 | 1·07 (0·96–1·19) 0·43 |
| CA *vs* D/BB[18,25,32,36–38,40] | 7 | 732/23 425 | 850/29 734 | +1/0 | 1·33 (1·21–1·47) 0·92 |
| ACEI *vs* CA[30–32,41] | 4 | 502/10 357 | 609/10 345 | +1/+1 | 0·82 (0·73–0·92) 0·75 |

*BPLTTC. Lancet 2003; 3621527-1535*
*JA Staessen. J Hypertens 2003; 21: 1055-1076*

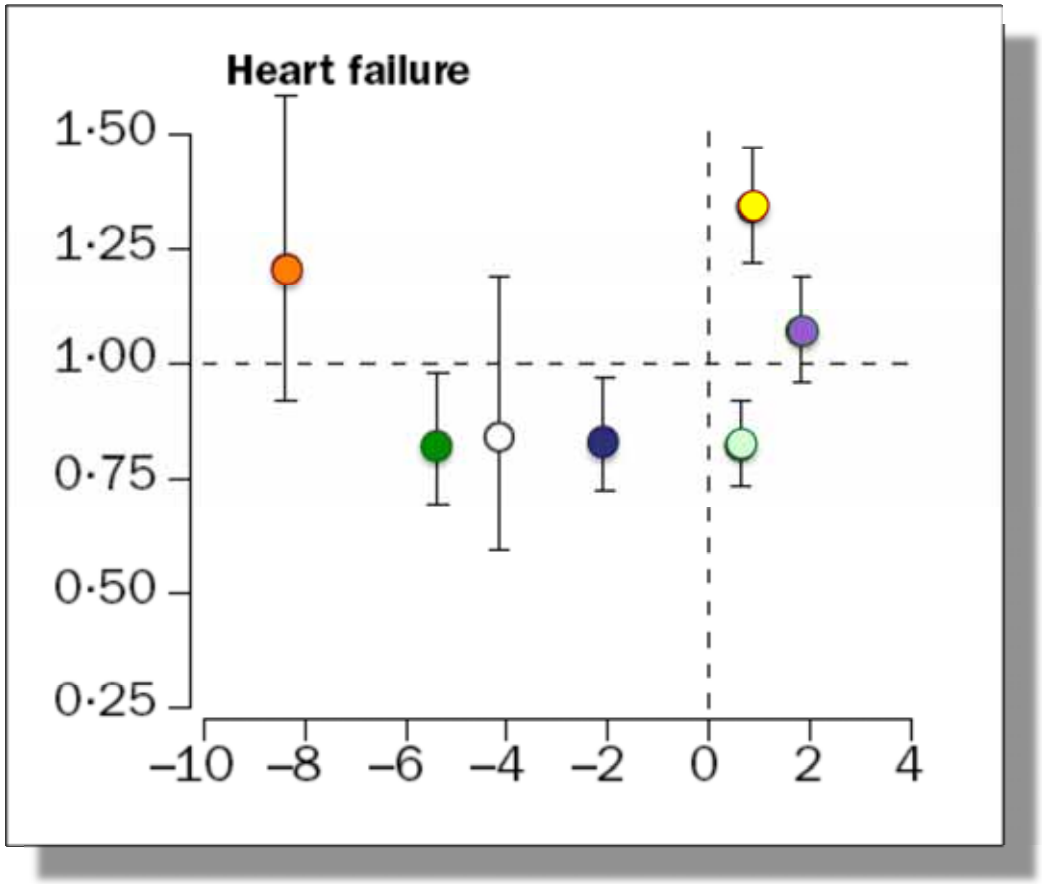
| Class of drug | No of trials | No of episodes | Relative risk* (95% CI) |
|---|---|---|---|
| **Blood pressure difference trials** | | | |
| Single drug therapy: | | | |
| Calcium channel blockers | 13 | 1519 | 0.81 (0.69 to 0.94) |
| Thiazides | 5 | 222 | 0.59 (0.45 to 0.78) |
| β blockers | 13 | 2846 | 0.77 (0.69 to 0.87) |
| Angiotensin converting enzyme inhibitors | 16 | 3834 | 0.74 (0.68 to 0.81) |
| Angiotensin receptor blockers | 3 | 1675 | 0.82 (0.73 to 0.92) |
| All drug classes except calcium channel blockers | 36† | 8553† | 0.76 (0.72 to 0.81) |
| **Combination drug therapy** | 7 | 144 | 0.57 (0.36 to 0.92) |
| **Drug comparison trials** | | | |
| Calcium channel blockers *v* any other drug class | 21 | 4572 | 1.22 (1.10 to 1.35) |
| Drug comparisons not involving calcium channel blockers: | | | |
| Thiazides | 2 | 2335 | 0.91 (0.64 to 1.30) |
| β blockers | 2 | 335 | 1.04 (0.84 to 1.29) |
| Angiotensin converting enzyme inhibitors | 9 | 5063 | 0.98 (0.91 to 1.06) |
| Angiotensin receptor blockers | 7 | 2436 | 1.00 (0.93 to 1.08) |

*Relative risk <1.0 indicates specified drug class reduces risk of heart failure; >1.0 increases risk.
†All trials totals are less than column totals because one trial had two treated groups sharing same placebo group.


*MR Law. BMJ 2009; 338: 1665-1683*

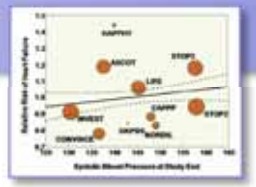



*BPLTTC. Lancet 2003; 3621527-1535*
*JA Staessen. J Hypertens 2003; 21: 1055-1076*

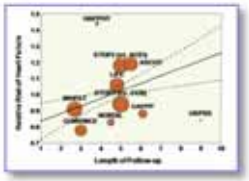



**Diferencias en la PAS entre grupos randomizados**

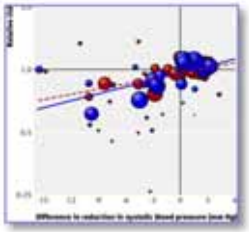
*BPLTTC. Lancet 2003; 3621527-1535*



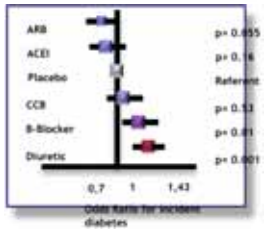
*EFICACIA*



*TOLERANCIA*



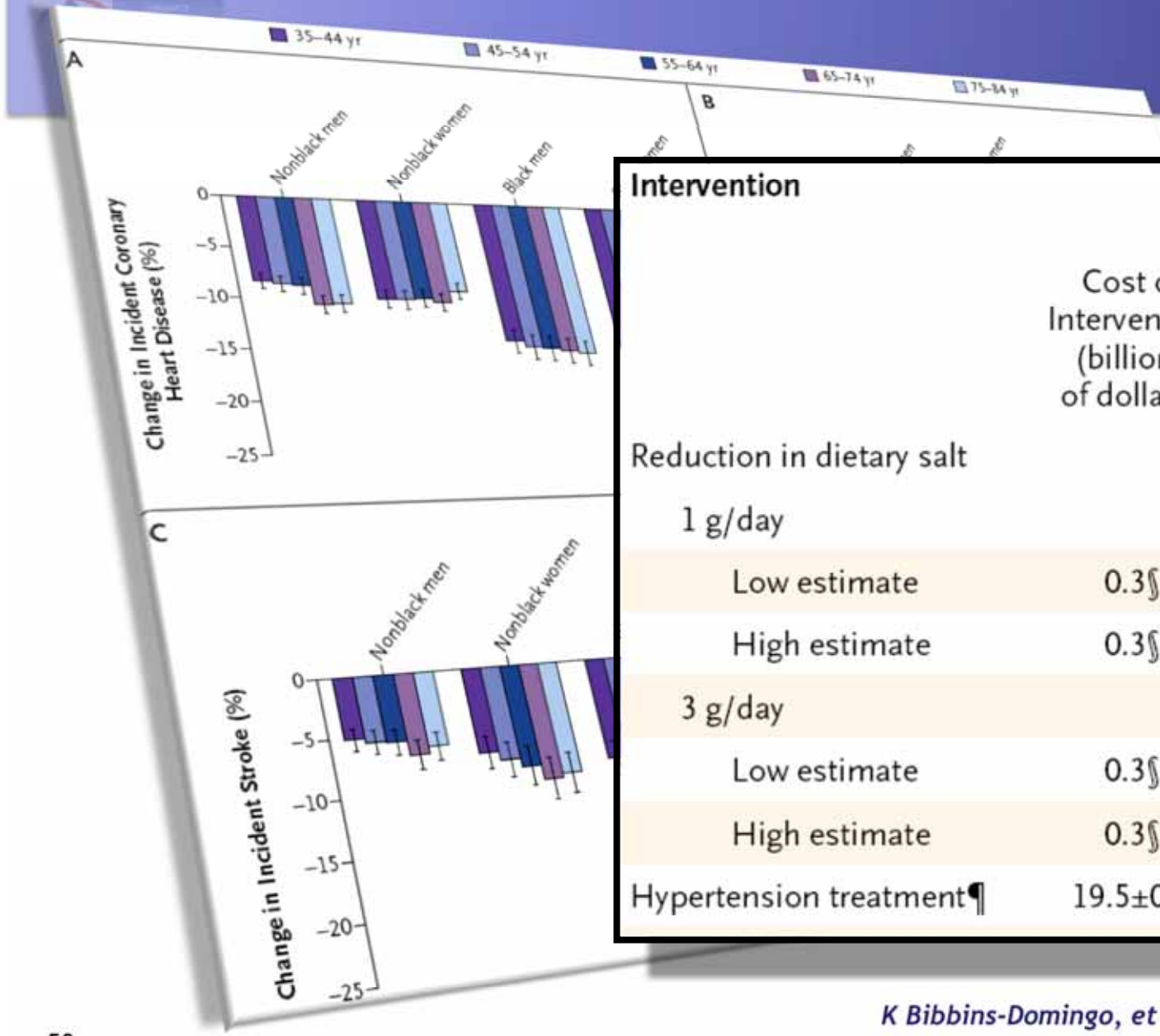
*EDAD INDEPENDIENTE*




*EFECTOS METABÓLICOS*


*CONTEXTO CLÍNICO*

*COSTE*




| Intervention | Cost of Intervention (billions of dollars) | Reduction in Health Care Costs (billions of dollars)† |
|---|---|---|
| Reduction in dietary salt | | |
| 1 g/day | | |
| Low estimate | 0.3§ | 4.1±0.8 |
| High estimate | 0.3§ | 7.0±1.4 |
| 3 g/day | | |
| Low estimate | 0.3§ | 12.1±2.4 |
| High estimate | 0.3§ | 20.4±4.1 |
| Hypertension treatment¶ | 19.5±0.1 | 14.2±2.7 |

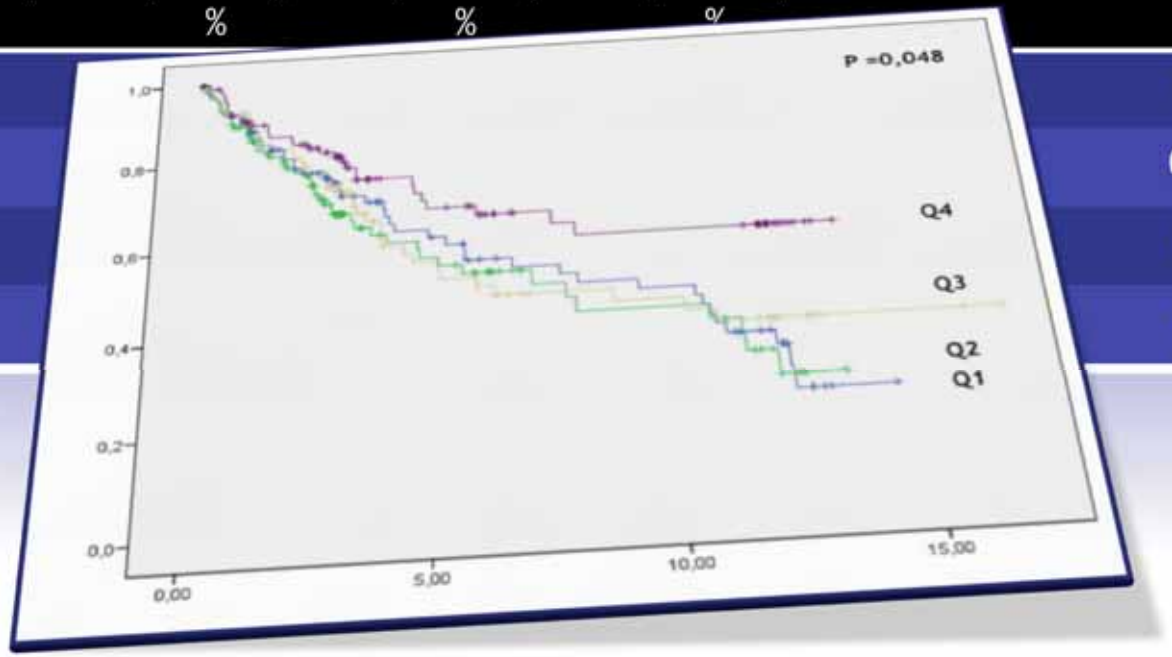
*K Bibbins-Domingo, et al. NEJM. 2010; 362: 590-599*

# ¿ … Y DESPUÉS ?


Touareg

**N = 581 pacientes**

| | Q1 (110/60) % | Q2 (131/71) % | Q3 (145/82) % | Q4 (178/98) % | RR | p |
|---|---|---|---|---|---|---|
| UCI | 14 | | | | | 0,34 |
| Muerte | 15 | | | | | 0,017 |
| Reingreso | 20 | | | | | 0,37 |
| Combinado | 31 | | | | | 0,02 |




GRACIAS!