XXXIV Congreso Nacional de la Sociedad Española de Medicina Interna (SEMI)

XXIX Congreso de la Sociedad Andaluza de Medicina Interna (SADEMI)

21-23 Noviembre 2013 Palacio de Ferias y Congresos de Málaga. Málaga

HTA grado 1 no complicada sin lesión de órgano diana

¿Debe tratarse farmacológicamente?

Diego Real de Asúa
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Servicio de Medicina Interna
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CONFLICTOS DE INTERÉS (periodo 2010-2013)

Honorarios por cursos/conferencias: Böhringer/Ingelheim-Lilly, Abbott, Nycomed, Sanofi-Aventis

PUNTOS A TRATAR

1. **¿Qué es HTA grado 1?**: Dos consideraciones iniciales

2. **Argumentos A FAVOR** de tratar farmacológicamente

3. **Argumentos EN CONTRA** del tratamiento

4. **Posicionamiento de las guías de consenso**

5. **Propuesta** de abordaje

TABLE 3. Definitions and classification of office blood pressure levels (mmHg)[a]

Category	Systolic		Diastolic
Optimal	<120	and	<80
Normal	120–129	and/or	80–84
High normal	130–139	and/or	85–89
Grade 1 hypertension	140–159	and/or	90–99
Grade 2 hypertension	160–179	and/or	100–109
Grade 3 hypertension	≥180	and/or	≥110
Isolated systolic hypertension	≥140	and	<90

J Hypertens 2013;31:1281

1º prioridad: CONFIRMAR DIAGNÓSTICO

Clinical indications for HBPM or ABPM
• Suspicion of white-coat hypertension
- Grade I hypertension in the office
- High office BP in individuals without asymptomatic organ damage and at low total CV risk
• Suspicion of masked hypertension
- High normal BP in the office
- Normal office BP in individuals with asymptomatic organ damage or at high total CV risk

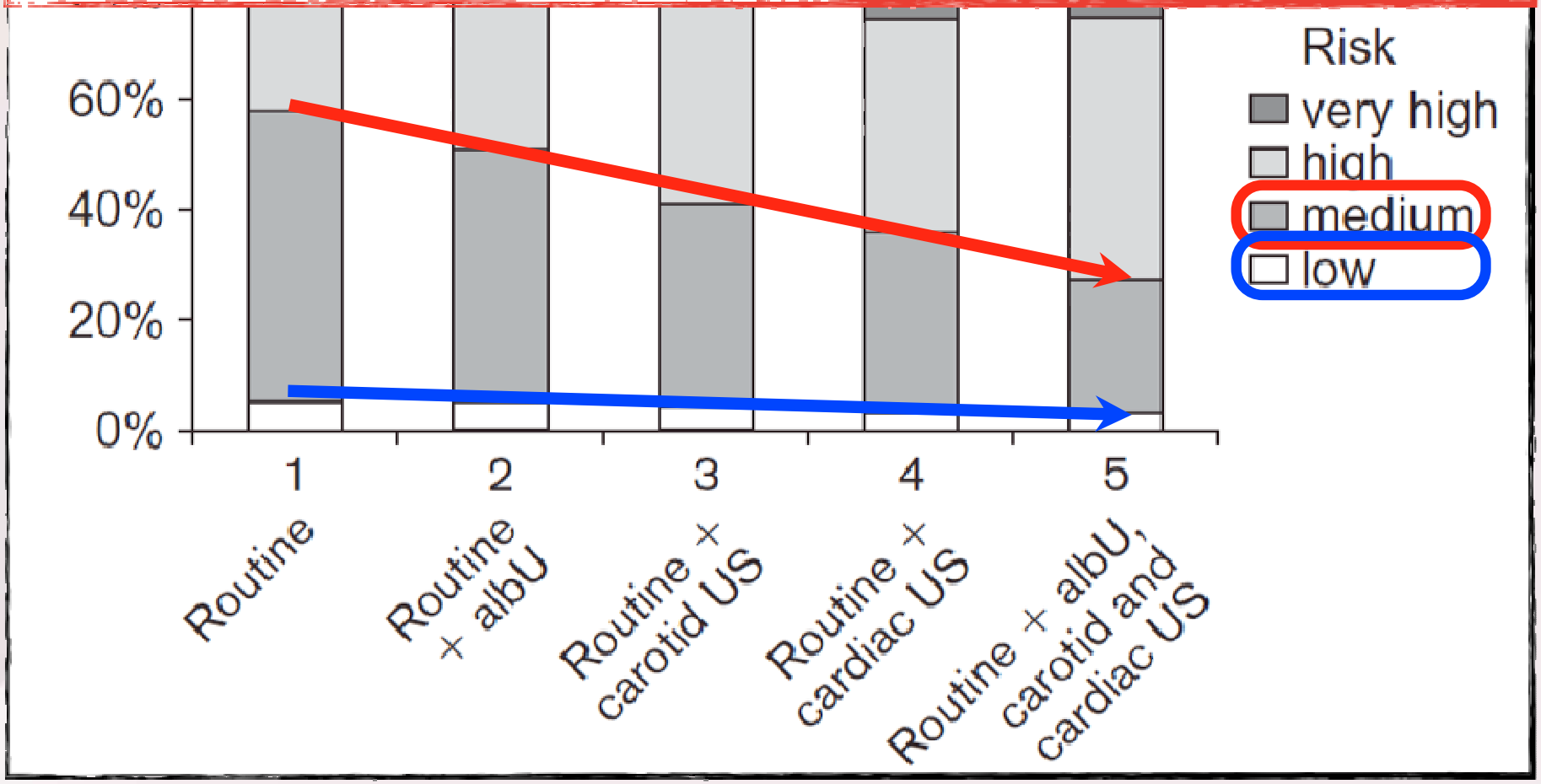
J Hypertens 2013;31:1281

Actitud ante un nuevo diagnóstico de HTA en un sujeto en prevención primaria

Other risk factors, asymptomatic organ damage or disease	Blood pressure (mmHg)			
	High normal SBP 130–139 or DBP 85–89	Grade 1 HT SBP 140–159 or DBP 90–99	Grade 2 HT SBP 160–179 or DBP 100–109	Grade 3 HT SBP ≥180 or DBP ≥110
No other RF		Low risk	Moderate risk	High risk
1–2 RF	Low risk		Moderate to high risk	High risk
≥3 RF	Low to moderate risk	Moderate to high risk	High risk	High risk
OD, CKD stage 3 or diabetes	Moderate to high risk	High risk	High risk	High to very high risk
Symptomatic CVD, CKD stage ≥ 4 or diabetes with OD/RFs	Very high risk	Very high risk	Very high risk	Very high risk

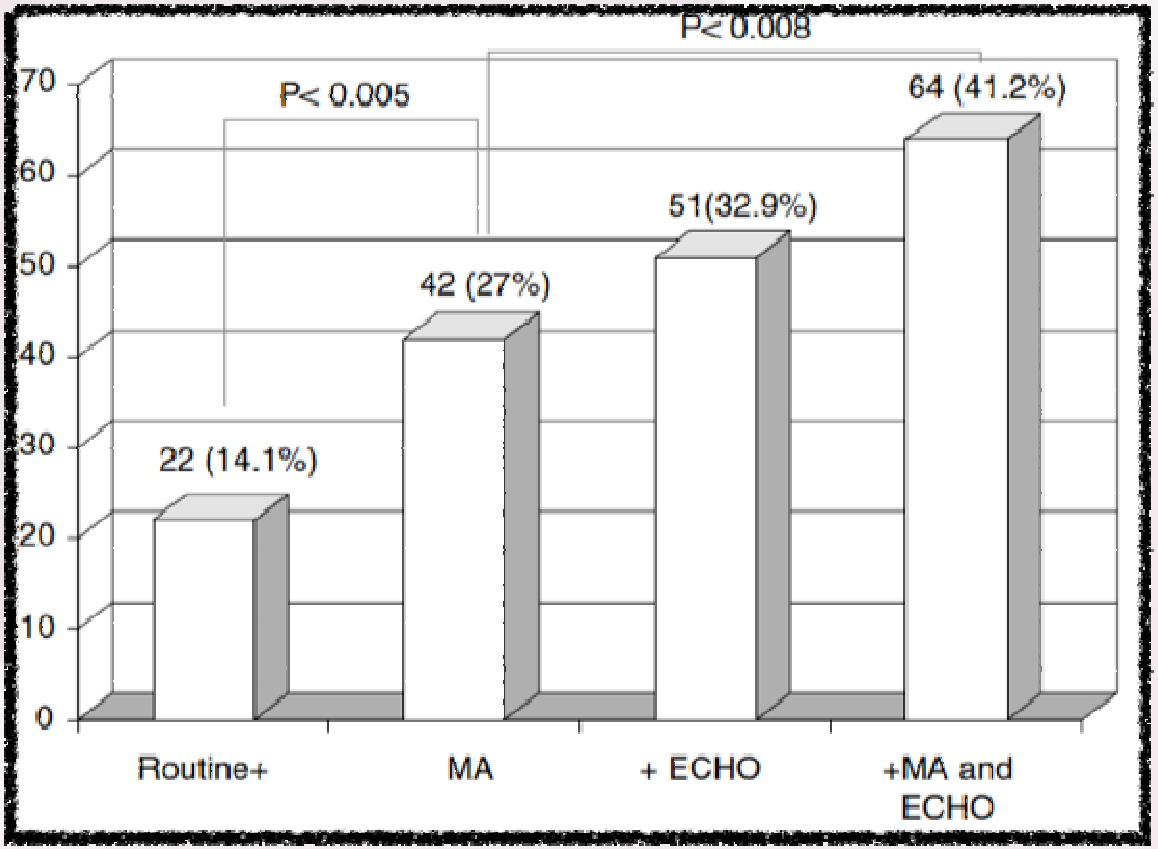
J Hypertens 2013;31:1281

9/21 (43%) bajo riesgo y
118/225 (52%) riesgo moderado se reclasificaron



J Hypertens 2004;22:907

Una correcta ESTRATIFICACIÓN implica CAMBIOS TERAPÉUTICOS



% pacientes con indicación de tratamiento farmacológico

J Hum Hypertens 2006;20:187

2º prioridad: ESTRATIFICAR CORRECTAMENTE

Other risk factors, asymptomatic organ damage or disease	Blood pressure (mmHg)			
	High normal SBP 130–139 or DBP 85–89	Grade 1 HT SBP 140–159 or DBP 90–99	Grade 2 HT SBP 160–179 or DBP 100–109	Grade 3 HT SBP ≥180 or DBP ≥110
No other RF		Low risk	Moderate risk	High risk
1–2 RF	Low risk	Moderate risk	Moderate to high risk	High risk
≥3 RF				ligh risk
OD, CKD stage 3 or dia				High to y high risk
Symptomatic CVD, CKD stage ≥ 4 or diabetes with OD/RFs	Very high risk	Very high risk	Very high risk	Very high risk

Muchos hipertensos grado 1
NO SON de bajo riesgo

J Hypertens 2013;31:1281

MÁS ARGUMENTOS A FAVOR: El *continuum* cardiovascular

In general, early BP-lowering treatment before organ damage develops or becomes irreversible appears a prudent recommendation. This is because, in high-risk hypertensive patients, even intense cardiovascular drug therapy—although beneficial—cannot lower total cardiovascular risk below the high-risk threshold.

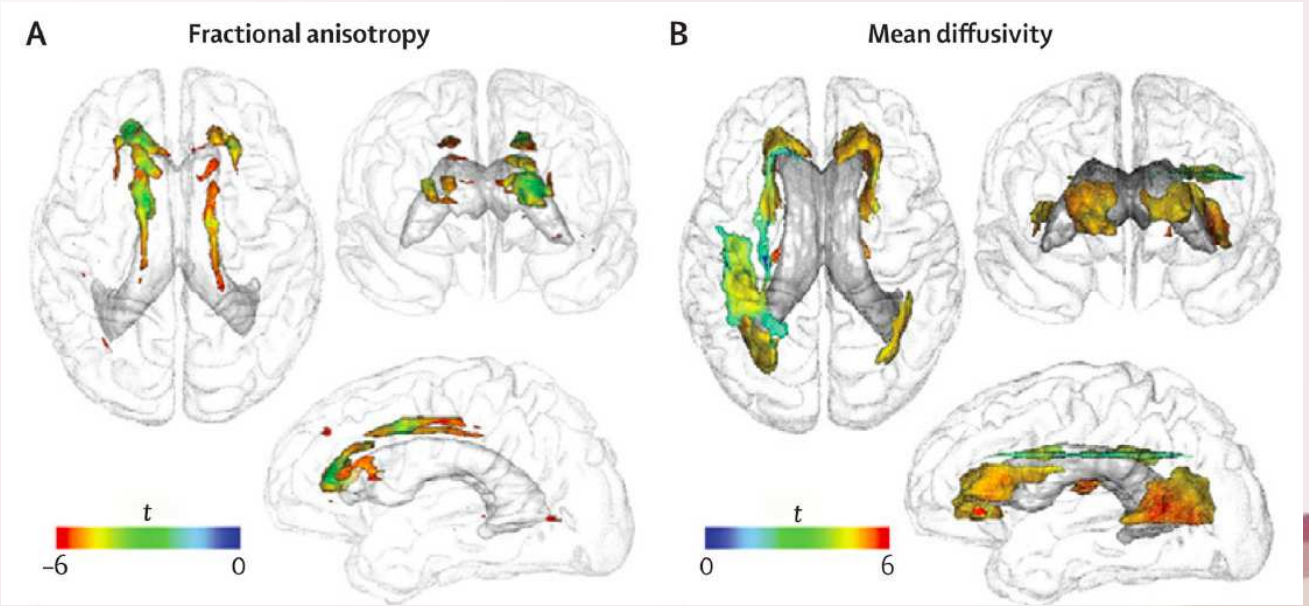
si bien ...

risk. In patients with grade 1 or 2 hypertension at moderate total cardiovascular risk, drug treatment may be delayed for several weeks, and in those with grade 1 hypertension without any other risk factor it may be delayed for several months.

J Hypertens 2009;27:923 **Eur Heart J 2012;33:1635**

Effects of systolic blood pressure on white-matter integrity in young adults in the Framingham Heart Study: a cross-sectional study

Findings—579 (14·1%) of 4095 participants in the third-generation cohort (mean age 39·2 years, SD 8·4) underwent brain MRI between June, 2009 and June, 2010. Age was associated with decreased fractional anisotropy and increased mean diffusivity in almost all cerebral white-matter voxels. Age was also independently associated with reduced grey-matter volumes. Increased systolic blood pressure was linearly associated with decreased regional fractional anisotropy and increased mean diffusivity, especially in the anterior corpus callosum, the inferior fronto-occipital fasciculi, and the fibres that project from the thalamus to the superior frontal gyrus. It was also strongly associated with reduced grey-matter volumes, particularly in Brodmann's area 48 on the medial surface of the temporal lobe and Brodmann's area 21 of the middle temporal gyrus.



Lancet Neurol 2012;11:1039

EL RIESGO DE DEMENCIA

TABLE 3. Duration of Treatment With Antihypertensive Medication and Risk for Dementia, Stratified by Late-Life BP Control Status

	Controlled BP	Noncontrolled BP
No.	408	440
	HR (95% CI)	HR (95% CI)
Duration of treatment (y)	0.95 (0.92–0.98)	0.97 (0.94–1.01)
Stratified by duration of treatment		
Never-treated hypertensives	1.00	1.00
Duration of treatment		
0–5 y	1.03 (0.47–2.28)	0.99 (0.37–2.63)
5–12 y	0.40 (0.14–1.00)	0.82 (0.26–2.49)
>12 y	0.33 (0.14–0.75)	0.55 (0.21–1.50)

Stroke 2006;37:1165

EL REVERSO DE LA MONEDA: Pero... ¿tratar no salva vidas?

1

Mortalidad global

	Treatment n/N	No Treatment n/N	Risk Ratio M-H,Fixed,95% CI	Risk Ratio M-H,Fixed,95% CI
ANBP	17/958	13/874		1.19 [0.58, 2.44]

Abandono

	Treatment n/N	No Treatment n/N	Risk Ratio M-H,Fixed,95% CI	Weight	Risk Ratio M-H,Fixed,95% CI
MRC	980/8700	203/8654		100.0 %	4.80 [4.14, 5.57]
Total (95% CI)	**8700**	**8654**		**100.0 %**	**4.80 [4.14, 5.57]**

	n/N	n/N	M-H,Fixed,95% CI	M-H,Fixed,95% CI
MRC	63/3012	59/3049		1.08 [0.76, 1.54]
SHEP	0/3	0/4		0.0 [0.0, 0.0]
VA-NHLBI	8/508	5/504		1.59 [0.52, 4.82]
Total (95% CI)	**3523**	**3557**		**1.12 [0.80, 1.57]**

Total events: 71 (Treatment), 64 (No Treatment)

Diao D. Cochrane Database Syst Rev 2012;8:CD006742

Pharmacotherapy for mild hypertension (Review)

THE COCHRANE COLLABORATION®

- Incluye 4 estudios (ANBP, MRC, SHEP, VA-NHLBI)
- Estrategia de tto subóptima, basada en diuréticos
- Morbi-mortalidad a 4-5 años
- Clasifica sujetos por HTA de bajo y alto riesgo (aunque no todas son grado 1).

SUJETOS BAJO RIESGO:

- NNT para evitar una muerte: **500 sujetos durante 5 años**
- NNT para evitar un evento: **indeterminado**

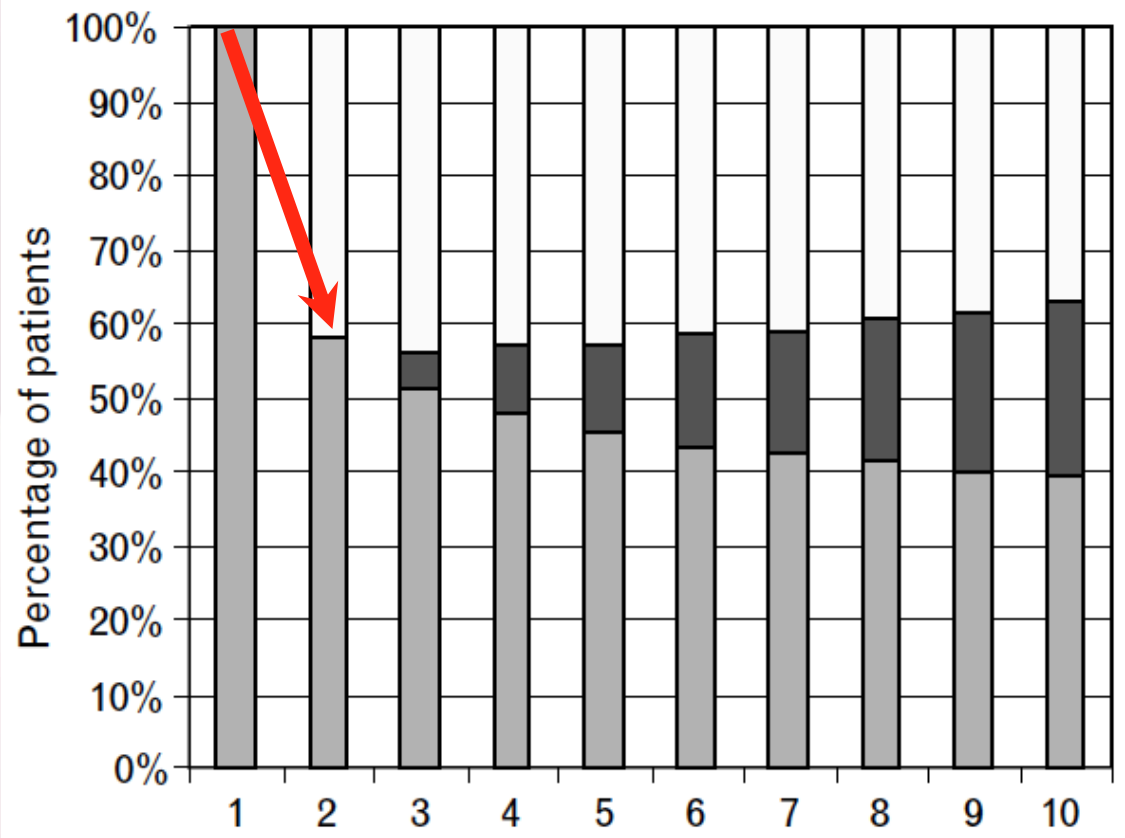
ABANDONOS:

- 15 episodios adversos/1000 ptes vs. **72/1000**.
- RR de efecto adverso: **4.8**

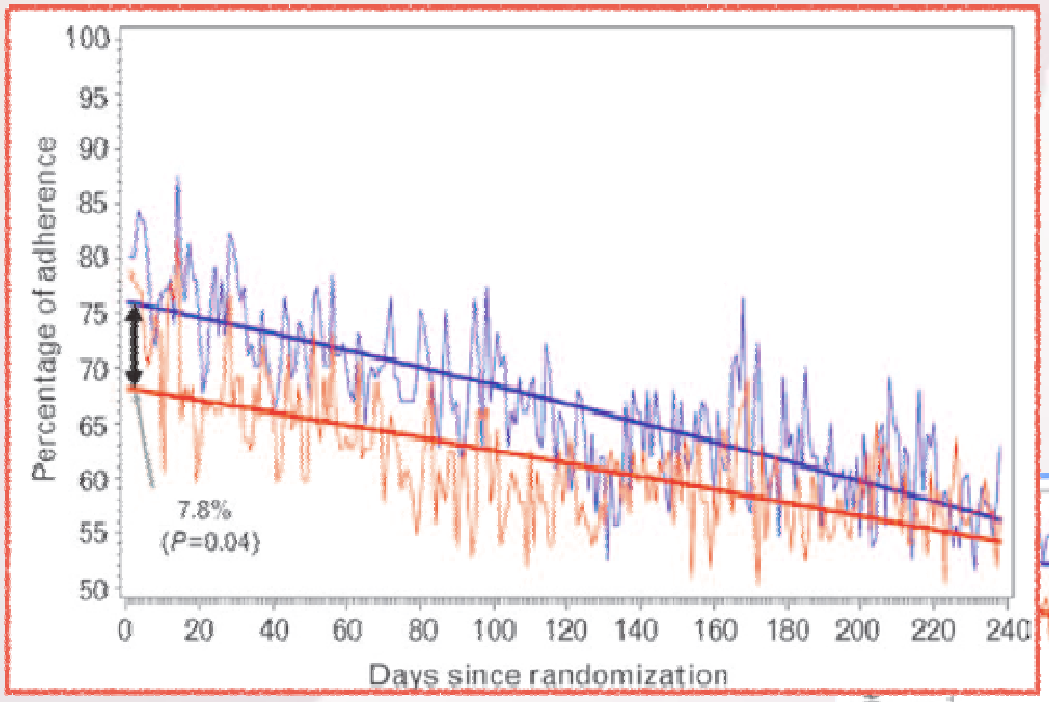
Diao D. Cochrane Database Syst Rev 2012;8:CD006742

Rate and determinants of 10-year persistence with antihypertensive drugs

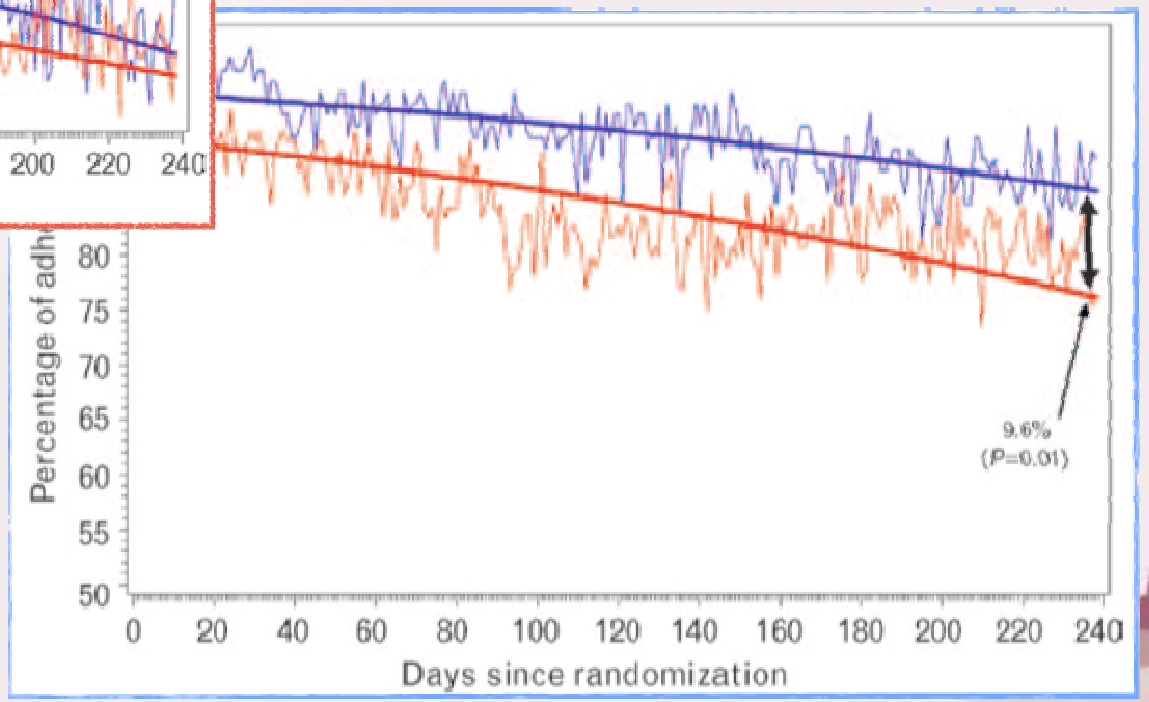
2



J Hypertens 2005;23:2101



Toma de tratamiento a la hora apropiada

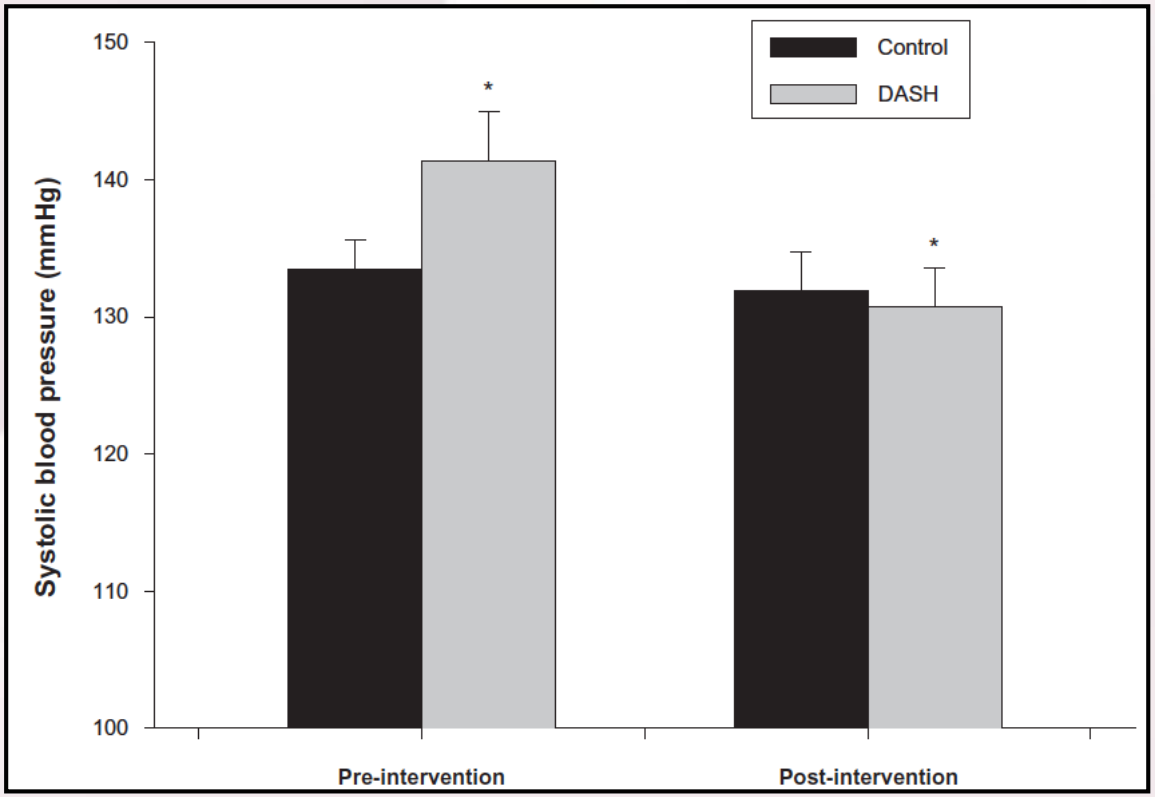


Toma de tratamiento en cualquier momento del día

J Hypertens 2009;27:901

Effect of the DASH Diet on Pre- and Stage 1 Hypertensive Individuals in a Free-Living Environment

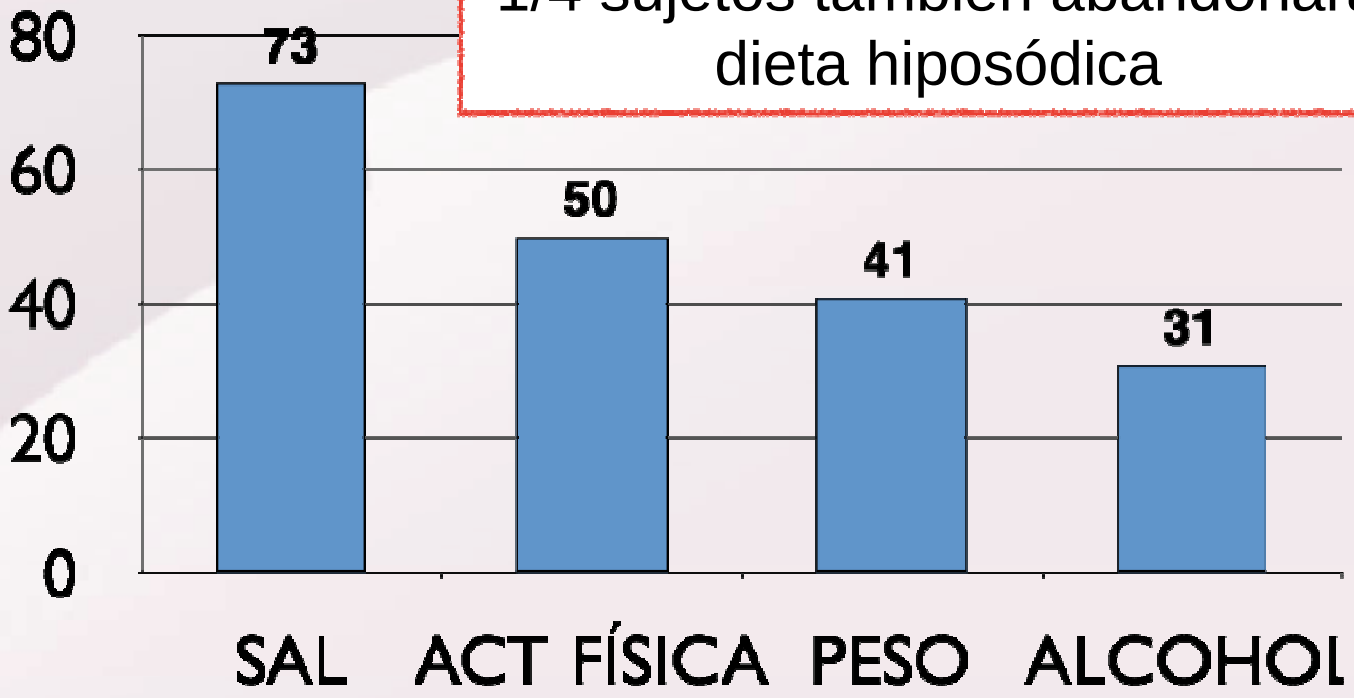
3



Nutr Metab Insights 2010;3:15

ADHERENCIA A MEDIDAS HIGIÉNICO-DIETÉTICAS EN POBLACIÓN HIPERTENSA >65 AÑOS

1/4 sujetos también abandonará dieta hiposódica



J Hypertens 2002;20:2157

ARGUMENTOS PARA TODOS

A FAVOR:

- Muchos pacientes no son de bajo riesgo.
- Evita la aparición de LOD y un exceso de riesgo indeleble posterior.
- Previene progresión a demencia en sujetos mediana edad.
- Tolerabilidad aceptable de tratamientos actuales.

EN CONTRA:

- ¿No beneficio clínico a medio plazo?
- NNT para prevenir eventos muy elevado.
- Alta tasa de abandonos precoces de tto.
- Eficacia demostrada de medidas dietéticas.

2013 ESH/ESC Guidelines for the management of arterial hypertension

En población anciana, todos los RCT incluyeron a pacientes con cifras PAS basal >160 mmHg

used a different grading of hypertension (based on DBP only) [266–268] or included patients at high risk [268]. The possible benefit of treatment is unproven. Further arguments in favour of treating even low-moderate risk grade 1 hypertensives are that: (i) waiting increases total risk, and high risk is often not entirely reversible by treatment [272], (ii) a large number of safe antihypertensive drugs are now available and treatment can be personalized in such away as to enhance its efficacy and tolerability, and (iii) many antihypertensive agents are out of patent and are therefore cheap, with a good cost-benefit ratio.

J Hypertens 2013;31:1281

PROPUESTA DE ABORDAJE

1. **Confirmar diagnóstico**: Medida correcta en consulta - MAPA/AMPA

2. **Estratificar correctamente**: Buscar LOD (EUA / HVI)

3. Si no hay LOD - **factores corregibles en estilo de vida.**

4. **¿Y después, qué?**
   - Bajo RCV: **Estilo de vida 1 año** - si no control, tratar.
   - Moderado o alto RCV: **tratar** farmacológicamente.

Let the patient revolution begin

Patients can improve healthcare: it's time to take partnership seriously

"Far more than clinicians, patients **SHOULD** *understand the realities of their condition, the impact of disease and its treatments [...], and how services could be better designed to serve them."*

"We need to accept that expertise in health and illness lies outside as much as inside medical circles and that working alongside patients [...] is essential to improving health."

El umbral para considerar HTA y su necesidad de tratamiento debería ser considerado flexible, basado en el riesgo vascular global del paciente.

BMJ 2013;346:f2614

A HOMBROS DE GIGANTES

Mi agradecimiento a todos los que componen (y han compuesto) la **Unidad de Riesgo Vascular** del **Hospital Universitario de La Princesa**:

Patricia Ibañez, Pedro Casado, Daniel Abad, Iluminada García Polo, **Carmen Suárez**