Editorial Comment

Physicians of my generation—those who attended medical school in the mid-1960s—were told that the scientific theory behind blood pressure (BP) management had changed. Previously, physicians had been told high systolic BP was *needed* to push blood through sclerotic vessels to perfuse the brain, heart, liver, and kidneys. We, however, were told that elevated systolic BP was *not* normal and that we should consider treating hypertension in older people.

Of course, the population of the United States—and other countries—has also changed. More octogenarians (and even nonagenarians) are living at home or in nursing homes than ever before. Thus, the treatment of hypertension in the elderly has become an even more relevant topic of discussion than it was in my medical-school days.

In this issue, Fisher et al confirm the value of treating older patients for hypertension, concluding that antihypertensive therapy did not increase the risk of orthostatic hypotension, postprandial hypotension, or falls in treated octo- and nonagenarians compared with those whose hypertension went untreated. Because no significant differences were noted between the mean (SD) BP measurements of those who took antihypertensive medications and those who did not, one could argue that the therapy provided in this study did not really control the patients' hypertension. Does this mean physicians must take more of a hard-line approach to lower these patients' BP to the limits set for the population as a whole? Perhaps the answer lies somewhere between the general treatment guidelines and the mean measurements achieved in the present study. Patients in nursing homes today are, in general, frailer than those 20 or 30 years ago. However, even in these more fragile patients, we ought to aim for lower BP control levels.

Another important issue in nursing home care is the phenomenon of recurrent falling. There are no definitive explanations for why some patients seem to fall more often than others. Frequently, these recurrent fallers are not injured—they may not break their hips or even hit their heads. They may not take worrisome medications (eg, benzodiazepines, selective serotonin reuptake inhibitors, tricyclic antidepressants, nitrates, digitoxin) or have cardiovascular or neurologic problems. These patients present a real mystery—to which the present study offers no solution.

The authors were judicious in not overstating the possible protective effects of potassium-sparing diuretics in their study, given the small population size (12 of 119 patients). However, the observed reduction in falls among those who used such therapy does seem to merit further investigation—perhaps even a double-blind, controlled, prospective clinical trial with an active comparison group.

So many classes of antihypertensive medications are now available that we should continue to study which are the best choices for our oldest patients. Fisher et al deserve hearty congratulations for giving us further reason to treat frail, elderly, hypertensive patients without excessive worry that doing so will injure them.

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