Prehypertension: A necessity !!!

We read with concern the letter JNC VII creates a new “hypertensive” category in MJAFI 2005; 61: 98[1]. The letter dwells on the “fashioning” of a new category termed prehypertension” including individuals with BP 120-139 and /or 80-89 mm Hg by JNC VII [2].

The author has sought to “create” a controversy where none exists. More importantly it sows doubts in the minds of readers especially those not familiar with the complete JNC VII report. This letter deserves a rejoinder as it deals with an important issue affecting a large population. Without going into each and every point raised by the author we would like to make the following observations-

1. JNC VII is a statement brought out by The National High Blood Pressure Education Program on Prevention, Detection, Evaluation and Treatment of High Blood Pressure which in its VIIth edition has gained widespread acceptance.
2. JNC VII states that prehypertension is NOT a disease category,

rather it defines a group of individuals who have a higher risk of developing hypertension and/or complications thereof and will benefit from follow up and intervention and hence may more appropriately be termed “at risk” category [2].

3. Non pharmacological therapy is not only an accepted modality of treatment but also the cornerstone of management of all lifestyle diseases like hypertension, diabetes, obesity etc [3]. Thus, lifestyle modifications are more than “meaningful therapies” and should be incorporated in all hypertension management programs and not belittled.
4. “Cost effectiveness” cannot be a factor in lifestyle modification. Moreover, prevention or retarding the progress of disease is definitely more cost effective than treatment.

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REPLY

I appreciate the keen interest and concern shown by the readers to my article titled “JNC VII creates a new ‘prehypertensive’ category”. The para wise reply to the observations by the reader are as under:

1. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure, called JNC VII was published in December 2003. Confronted by incomplete evidence, conflicting interpretations, strong professional opinion and the authors suggestion that “the responsible physician’s judgement is paramount in managing his or her patients”, invites dialogue about the document itself [1]. Due to this, though JNC VII report has gained wide acceptance (as written by a writing group of 10 with review by 33 other “hypertension authorities”) it has been equally criticized by other hypertensive societies/ countries in few aspects. At the same time both the European Society of Hypertension/European Society of Cardiology, and the National High Blood Pressure Education Program (NHBPEP) of the National Heart, Lung and Blood Institute published updated consensus recommendations for the prevention and treatment of hypertension.
2. Prehypertension has NOT been mentioned as a disease but as a ‘pre disease’ category, meant as ‘at risk’ group/category. Prehypertensive group patients do not always go on to become hypertensives. Their treatment is only necessary in vascular high-risk patients.
3. It is accepted that Lifestyle modifications are an important and accepted modality of treatment for DISEASES like Diabetes, Obesity and Hypertension, but in a Prehypertensive patient, without any vascular high-risk condition the efficacy of lifestyle modification has not been proved by any formal

studies so far. The results of few studies are to the contrary [2].

4. Cost effectiveness usually is not a factor in lifestyle modification. As the prehypertension group is not always going to progress to hypertension (as per JNC VII report itself, critiques have questioned advice for lifestyle modification in this group, till studies prove the effectiveness of this therapy. Prehypertension ALONE has not been shown to be an independent risk factor in increasing mortality (2).

Creating a new ‘at risk’ or ‘predisease’ category, is definitely well intentioned for future hypertensive patients, but not for people who might never progress to hypertension. It may thus be ill advised for broader populations, till studies, underway, clarify the absolute risks and benefits of management in this group. The decision to treat high blood pressure now mainly relies on individual cardiovascular risk rather than on sole blood pressure level. Thus, antihypertensive drugs could be proposed even to normotensive individuals, provided they have a high cardiovascular risk (>20% at 10 years) [3].

References

1. Alderman MH. JNC 7: brief summary and critique. Clin exp hypertens 2004; 26(7-8): 753-61.
2. Manour AG 3rd, Everett CJ, Liszka H, King DE, Egan BM. Prehypertension and mortality in a nationally representative cohort. Am J Cardiol 2004; 94(12): 1496-500.
3. Krzesinski JM. New American and European 2003 guidelines for the management of arterial hypertension. Rev Med Leige 2003; 58(9): 563-71.

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