JNC VII Creates a New “Prehypertensive” Category

Dear Editor,

JNC VII (The seventh report of the Joint National Committee on Prevention, Detection, Evaluation and Treatment of High Blood Pressure) fashioned a new category termed “prehypertension”, which in 1 keystroke has created millions of “diseased” patients. Prehypertensive patients are those with blood pressure in the 120-139 and/or 80-89 mm Hg range [1]. This blood pressure range making up the prehypertension category now merges “high normal” and “normal” blood pressure ranges from the immediately preceding document (JNC VI). Almost simultaneous publication of European Society of Cardiology and European Society of Hypertension Guidelines in another jointly issued document, created controversy [2]. The points of disagreement basically concerned the classification of hypertension, the choice of treatment strategy on the basis of individual cardiovascular risk, and the choice of initial treatment. A detailed analysis of the three documents, however, reveals more points of concurrence than of actual disagreement. A category between normal blood pressure and established hypertension classified as prehypertension in the VII JNC report and as normal-high BP in the Spanish and European Society of Cardiology Guidelines, includes a population at high risk for developing hypertension and in which lifestyle modifications are needed [3]. It is in the 120-130 mm Hg range of prehypertension that the liveliest debate exists i.e. whether prehypertension truly exists, is a matter of speculation. There is no guarantee that “prehypertension” blood pressure values will automatically progress to Stage 1 hypertension. JNC VII noted that the relationship between blood pressure and the risk of cardiovascular events was continuous, consistent and independent of other risk factors. In fact, studies show that the risk of death from heart disease and stroke begins to rise at blood pressures as low as 115/75 mmHg, and that it doubles for each 20/10 mm Hg increase.

Lifestyle changes are the recommended (but still untested) therapy for prehypertensive individuals. Yet there are inherent difficulties in getting such patients to abide by the recommended changes in diet, exercise and stress management without involvement in a formal program. Moreover, it is not uncommon that such individuals already have successfully incorporated best-case lifestyle changes into their day-to-day existence. Such patients are inevitably

left in a quandary they have a diagnosis and no meaningful therapy available. Whose responsibility does this patient become, particularly if their psyche is such that they need continuous reassurance as to the status of their disease? The health care system is already top-heavy with well-established diseases for which meaningful therapies exist and yet we can hardly reign in such diseases-our health care system doesn't need an additional “predisease” categorization. A final important aspect of the prehypertensive disease state is whether there is evidence of therapeutic benefit of therapy in this group of “patients” if they are preemptively treated. The answer is no. However, in vascular high-risk patients (family history, smoker, diabetic, dyslipidemic, IHD), the prehypertensive state, particularly at its higher levels, warrants attention.

Creating a new “predisease” may have been well intentioned for future hypertensive patients, by “catching them young” and advocating measures that may delay the onset of the disease; but it may be ill-advised for a broader population, especially in our set-up, until future studies confirm the health benefits and cost-effectiveness of this strategy. Yet the debate has started, and from debate generally springs meaningful dialogue and improved educational messages. We should never lose sight of the fact that hypertension education is a critical component in the blood pressure control nexus in our country.

References

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