Over-Treatment of Hypertension in Elderly Patients Without Significant Cardiovascular Risks

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Story from the Front Lines:

A 71 year old man with a past medical history of hypertension, dyslipidemia and hypothyroidism presented to our clinic for follow up from the emergency department (ED). He had recently gone to the ED after running out of his anti-hypertensive medications and observing blood pressures at home that were higher than normal. He reported that he ran out of these medications two weeks prior to going to the ED with systolic blood pressures ranging between 135mmHg and 155mmHg during that time. Previously, his blood pressure had been well controlled on hydrochlorothiazide 25mg daily and propranolol 40mg twice daily. In the ED hydrochlorothiazide and propranolol were refilled and losartan 25mg daily was added.

After starting the losartan, the patient reported increasing dizziness. This was most noticeable when he woke up in the morning and whenever he stood up from a chair. While he didn’t have any falls, there were several incidences while standing or walking that he became so dizzy that he had to lean against a wall for support. He quit taking losartan on his own accord and the dizziness resolved shortly thereafter.

Teachable Moment:

Hypertension is one of the most common medical problems encountered in the outpatient setting and is defined as a systolic blood pressure greater than 140mmHg or a diastolic blood pressure greater than 90mmHg. Previously, treatment guidelines recommended treating to a goal below these pressures, or lower if the patient had certain comorbid conditions such as diabetes, chronic kidney disease or previous stroke (1).

However, the recent Eighth Joint National Committee has made new recommendations. In patients over the age of 60, systolic blood pressure of less than 150mmHg is advised (2). Additionally, a recent Cochrane review of 4 Randomized Controlled Trials showed no reduction in total mortality or cardiovascular morbidity in treating mild hypertension over 4-5 years (systolic blood pressure (BP) 140-159 mmHg and/or diastolic BP 90-99 mmHg) in adults without cardiovascular disease (3). The review also noted that over the same period, 9% of patients were likely to discontinue therapy because of adverse effects.

The definitions and treatment goals of hypertension have been ever evolving over the past few decades and across countries (4). In our needed effort to judiciously allocate healthcare resources, we must not only think about the cost of not treating but the cost of treating as well. Far beyond the cost of losartan itself, there are human costs that must be taken into account. What if he had fallen because of orthostatic hypotension? What if he had sustained a serious injury from a fall such as a hip fracture?
What about the emotional distress incurred as a result of feeling worse as a result of an intervention meant to achieve an “ideal” blood pressure? Considering the Cochrane review cited above, the cost of treating mild hypertension in this patient probably was in excess of any benefit.

There are many potential drivers contributing to the overtreatment of mild hypertension. There may be reluctance to implement new guidelines and clinical evidence – so-called clinical inertia. Pharmaceutical companies also have a vested interest in promoting aggressive treatment goals thereby ensuring a steady revenue stream from anti-hypertensive medications. Some patients and clinicians may be unwilling to accept a “less is more” approach, reflecting widely held beliefs that more is better in health care. Ultimately as physicians, we need to make the necessary difficult transition and become more comfortable with the unfamiliar when it is in the patient’s best interest and cautiously avoid a “one sized fits all” approach in the treatment of hypertension.

References:


