Will Diagnosing Prehypertension Help?

To the Editor: I thank Dr. Wexler for his letter and agree that it is important to continue to improve hypertension recognition and blood pressure (BP) control in hypertensive patients. In such patients we have solid evidence that intervention improves outcomes. Given that optimal BP is approximately 115/75 mm Hg, there is also relatively increased cardiovascular disease risk in people with prehypertension. What is lacking is evidence that intervening earlier than we would normally intervene will actually lead to improved patient-oriented outcomes. In other words, I wonder if diagnosing prehypertension will actually help people.

For primary prevention of hypertension (as well as other health benefits), it makes sense that every person—regardless of current BP level—should maintain a healthy weight; increase fruit, vegetable, and fiber intake; decrease saturated fat and sodium intake; exercise regularly; and drink alcohol in moderation. The recommendation that clinicians diagnose prehypertension and provide counseling on these lifestyle modifications rests on the assumptions that clinicians will be more motivated to provide targeted advice and that targeted advice will motivate patients more.

Prehypertension turns out to be extremely common in adults seen in the outpatient setting where time is precious and resources are few. Patients presenting to clinics have their own agendas, often sparked by an acute problem, and recommendations by clinicians to lose weight, eat healthier, and exercise often seem to fall on deaf ears. Motivated individuals, such as those in some clinical trials, can adopt lifestyle modifications that lead to reductions in BP.[1] Among undifferentiated primary care populations, it is unknown whether diagnosing patients (labeling them) with prehypertension will be a motivating factor leading to increased adoption of lifestyle modifications.

We must also consider the potential negative effects of labeling people with prehypertension. Although the benefits of diagnosing and treating hypertension generally outweigh the risks, there is evidence that being labeled as hypertensive has some negative effects. Patients labeled as hypertensive miss more days of work, report more marital discord, demonstrate lower self-rated health and health-related qualify of life, and take longer to recover from unrelated acute illnesses.[2–7] Although the effects of labeling patients with prehypertension are yet unknown, it is possible they may be similar to the effects on those labeled as hypertensive. The prehypertension label could also have no effect, in which case it might not matter whether people are diagnosed or not.

Lifestyle counseling in prehypertensive patients does pose a very serious challenge. We need to know if counseling in the context of prehypertension works to motivate people and if it improves health. I also worry about a bit of a slippery slope here. For other problems for which counseling is a first step in the treatment plan, when counseling fails to work or is too cumbersome, clinicians turn to what they know best. They write prescriptions. After all, that's quicker and easier. Patients also seem to prefer pills. Pharmaceutical companies would undoubtedly like us to use pills. It has already been deemed "feasible" to treat prehypertension with a medication.[8] If we end up treating a large number of people whose absolute benefit is going to be exceedingly small, we can be sure that we will harm more people than we help.

Anthony J. Viera
Department of Family Medicine, University of North Carolina at Chapel Hill
Chapel Hill, NC

References

1. Elmer PJ, Obarzanek E, Vollmer WM, et al. Effects of comprehensive lifestyle modification on diet, weight, physical fitness, and blood pressure control: 18-month results of a randomized trial. Ann Intern Med 2006;144:485–95.
2. Haynes RB, Sackett DL, Taylor DW, et al. Increased absenteeism from work after detection and labeling of hypertensive patients. N Engl J Med 1978;299:741–4.
3. Monk M. Blood pressure awareness and psychological well-being in the health and nutrition examination survey. Clin Invest Med 1981;4:183–89.
4. Bloom JR, Monterossa S. Hypertension labeling and sense of well-being. Am J Pub Health 1981;71:1228–32.
5. Barger SD, Muldoon MF. Hypertension labeling was associated with poorer self-rated health in the third US national health and nutrition examination survey. J Human Hypertension 2006;20:117–23.
6. Francisco M, Martin-Escudero JC, Simal-Blanco F, et al. Health-related qualify of life of subjects with known and unknown hypertension: results from the population-based Hortega study. J Hypertension 2003;21:1283–9.
7. Mold JW, Hamm RM, Jafri B. The effect of labeling on perceived ability to recover from acute illnesses and injuries. J Fam Pract 2000;49:437–40.
8. Julius S, Nesbitt SD, Egan BM, et al. Feasibility of treating prehypertension with an angiotensin-receptor blocker. N Engl J Med. 2006;354:1685–97.

doi: 10.3122/jabfm.2007.03.070052