

Capsule Commentary on Fontil, et al. Physician Underutilization of Effective Medications for Resistant Hypertension at Office Visits in the United States: NAMCS 2006-2010

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Resistant hypertension is defined as elevated blood pressure despite optimal or best-tolerated treatment with at least three antihypertensive agents (one of which is usually a diuretic). Compared to patients with controlled blood pressure, patients with resistant hypertension are 50 % more likely to experience adverse cardiovascular events over a 4-year period.¹ The first management guideline for management of resistant hypertension was published by the American Heart Association (AHA) in 2008.² Currently, there are several guidelines on treating resistant hypertension.

Using data from the National Ambulatory Medical Care Survey, Fontil et al. described trends in physician (general/family practitioners, internists, cardiologists) use of recommended medications for resistant hypertension before and after the 2008 AHA guidelines.³ The authors found that use of recommended medications for resistant hypertension was low and remained low 2 years after guideline publication. Assuming that the contribution of pseudo-resistant hypertension to these results is limited (e.g., minimal white coat hypertension), these findings are unfortunately in line with previous studies that highlighted the limited impact of guideline publications.⁴ Fontil et al. discussed the use of treatment algorithms to encourage prescription of recommended medications including the importance of feedback to physicians regarding patterns of medication use. It is not clear whether it will be sufficient to swiftly improve the care of patients with resistant hypertension. Indeed, the *clinical inertia* of physicians not specialized in hypertension (an inertia due to several factors including misguided acceptance of elevated blood pressure and underestimation of cardiovascular disease risk)⁵ might remain a meaningful barrier to changing treatment of resistant hypertension even after the implementation of a treatment algorithm.

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An alternative would be to consider a “detect and redirect” approach. Non-specialist practitioners could be trained and helped (including by algorithms) to detect patients with resistant hypertension and then be guided to redirect them to physicians (including general internists) or to units/clinics specialized in the management of hypertension. In addition to improving the recommended medication use, this approach could also contribute to improving the investigation of resistant hypertension in general (e.g., diagnosis, secondary causes, target organ damage). Whether this would improve outcomes is worthy of future research.

Conflict of Interest: The author has no conflict with any of the material in this manuscript.

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