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Editorial

Title:

NON-COMPLIANCE AND THERAPEUTIC INERTIA: TWO UNANSWERED QUESTIONS IN CLINICAL PRACTICE

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Non-compliance and clinical inertia are the main causes of poorly-controlled blood pressure in hypertensive patients. Non-compliance fundamentally depends on the patient's decision not to adhere to the prescribed medication regularly. Therapeutic inertia occurs when the physicians do not intensify or modify therapy despite knowing that their patients are poorly controlled. Forgetfulness is the main cause for lack of adherence and the main reason physicians adopt a conservative attitude is because of the acceptance of borderline figures as adequate thus not intensifying the therapeutic treatment.^{1,2}

The Spanish working group on compliance and clinical inertia, dependent on Spanish Society of Hypertension (SEH.LELHA), has been researching these issues in clinical practice for over 20 years.³ Their findings concluded good controlled hypertension targets do not exceed 50% in Spain, lack of adherence is around 50% and lifestyle modifications compliance is between 80 and 95%. They also observed the percentages of clinical inertia vary between 30 and 85%, depending on the study design.

Guidelines emphasize that early control based on overcoming clinical inertia and patient non-compliance is necessary in order to achieve the benefits of therapy, especially in patients at high cardiovascular risk. Today, many research studies⁴ are carried out to analyze difficulties in clinical practice to overcome both problems. Mainly, they are performed with polymedicated patients with multiple diseases as therapeutic complexity may influence on medication adherence and physicians accept borderline figures to avoid complicating treatment.

Marquez et al.⁵ provides relevant information to health professionals about the control of hypertensive patients at high vascular risk. Its methodological strengths lie in the study design, a prospective longitudinal 6-month follow-up study, and in the sample size, 3600 patients from 585 primary healthcare centres through out Spain. Their findings show blood pressure control was associated with the combination of therapeutic compliance and clinical inertia. During the follow-up of this study, blood pressure control increased and clinical inertia decreased resulting in unexpected non-compliance increase. Possibly, the reason for this was that physicians modified treatment, increased therapeutic complexity and as a result, more patients fail to comply with their treatment. Reduction of clinical inertia might influence on blood pressure control more than non-compliance, as these patients partially comply with treatment. This study also showed clinical inertia was associated with the number of diseases suffered and the number of antihypertensive agents taken, and non-compliance was related to the number of antihypertensive agents

taken by patients. As the study progressed, it was expected that the percentage of compliant patients decrease in patients taking more than one drug. However, the most striking result was the fact that the decrease of compliant patients taking one drug was greater, a fact observed by Armario and Waeber ⁶ recently.

To achieve recommended blood pressure targets it is necessary to take medication correctly and if the compliant patient does not meet the targets, physician should intensify treatment. An intervention to consider may be the incorporation of protocols which aim to identify incompliant patients and to select the most effective strategies to modify it. These protocols should suggest questions which make physicians think about the necessity of modifying treatment when patients do not achieve appropriate blood pressure figures. In these protocols would have to dismiss other causes that may influence on the lack of adherence, e.g. drug interactions, white coat.^{7,8}

Blackwell ⁹ stated that much time, effort and money was invested in drugs but nobody ask if the patients take medication. Excellent treatments are not useful if the patient does not take them and if physicians do not intensify treatment of poorly controlled patients they will not achieve the proper targets. The exhaustive study by Marquez et al ⁵ reveals non-compliance and clinical inertia are not isolated problems and new strategies, which provide solutions for both problems, are needed in clinical practice to achieve hypertensive patient good control.

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