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Quo usque tandem abutere, Catilina, patientia nostra?

"How much longer, Catilina, will you try our patience?" [1]

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The thorough study of the SAPALDIA cohort by Walther et al. [2] on prevalence and guideline adherence in a population of Swiss hypertensive patients is devastating testimony to the current state of antihypertensive therapy in Switzerland.

Of the 1866 patients with hypertension, the authors documented that a full 50% were not aware of their disease. This is a stunning number for the 21st century in Switzerland; it is reminiscent of what is currently observed in so-called developing countries or was observed in other westernised countries such as the USA and the UK decades ago. Physicians of course may argue that if patients are not known to have hypertension they simply have never seen a doctor who diagnosed and treated the disease. However, this brings us to the most striking number in the SAPALDIA cohort. Of all patients with doctor-diagnosed hypertension, more than half, i.e. 60%, were uncontrolled – uncontrolled being defined by the rather generous criterion of blood pressure ≥140/90 mm Hg. This reflects an exorbitant degree of either patients' nonadherence to therapy or, worse, physicians' inertia in initiating, up-titrating and combining antihypertensive therapy. There is little, if any, excuse in failing to do so since in this day and age antihypertensive therapy is simple, efficacious, safe and, by and large, free of adverse effects. However, both patients and physicians often do their best and go out of their way to find excuses not to have to treat (table 1). Most patients, when properly informed that therapy does not serve to lower blood pressure only, but also the risk of the most devastating complication, namely a cerebrovascular insult, are more than willing to put up with taking medication. Both physician and patient have to come to grips with the simple fact that hypertension therapy means a pill or two a day, every day, 365 days a year for the remainder of their days.

The second hard-to-swallow finding in the study of the SAPALDIA cohort by Walther et al. [2] is how badly some physicians are treating their patients. A full quarter of surveyed patients were treated with beta-blocker monotherapy. Can we make it clear, once and for all, that uncomplicated hypertension is now not or no longer an acceptable indication for first line beta-blockade [3]? Inefficacy of beta-blockers was documented almost 20 years ago [4]. Beta-blockers are known to have a pseudo-antihypertensive effect, lowering brachial blood pressure similarly to other antihypertensive drugs, but leaving aortic blood pressure unchanged. A seemingly normal brachial blood pressure deceives physicians and patients alike, yet with heart rate lowering aortic blood pressure increases, and the risk of heart attack and stroke remains unchanged [5, 6]. This is not to speak of the fact that beta-blockers belong to the least well-tolerated drug class. We have calculated that for every stroke or heart attack prevented, three patients were made impotent by beta-blockers and eight experienced fatigue to such an extent that they stopped treatment – hardly an acceptable risk-benefit ratio for a completely asymptomatic disease such as mild essential hypertension [7]. Not much better was the prescription pattern with regard to comorbidities in hypertension [2]. Only about one third of

Table 1: Common excuses for not treating or failure to adjust treatment even when BP in physician's office is found to be elevated.

Patient's and physician's excuses	Facts
"I didn't take the pill this morning"	Good antihypertensive therapy provides blood pressure control exceeding 24 hours
"My mother-in-law is visiting"	Good antihypertensive therapy controls blood pressure even in stressful situations
"I just walked up the stairs to your office"	Good antihypertensive therapy controls blood pressure even when exercising
"Blood pressure a little high today, you must be nervous"	White coat hypertension is not an innocent condition
"Last night I was not sleeping well, snoring, waking up often"	Obstructive sleep apnoea is a common cause for secondary hypertension
"My blood pressure at home is always normal"	24-hour ambulatory blood pressure monitoring will help to confirm need for treatment
"Last evening I ate Bernerplatte with lard and choucroute"	A one-time high salt intake has no effect on blood pressure

guideline nonadherence could be explained by the presence of comorbidities and about 20% of treated patients with asthma still received beta-blockers for hypertension.

Only with hesitation do we explore the potential repercussions of inappropriate antihypertensive therapy in Switzerland. In the ASCOT study, amlodipine-based therapy reduced stroke by 33% compared with atenolol-based therapy, but erectile dysfunction was 22% higher with atenolol, $p > 0.001$ for both. Yes, blood pressure is reduced with atenolol and so is erectile power. But no, the risk of stroke and heart attack persists unchanged. Is there any reason why for many years Swiss men should suffer from erectile dysfunction while continuing to be at an excessive risk of suffering a stroke? And perhaps even more pertinent is the simple question of how many strokes and heart attacks could have been prevented with proper antihypertensive therapy in the Swiss population over the past few decades. It seems that many physicians are convinced that they know how to treat high blood pressure simply because they have done so for decades. Unfortunately this amounts to what has been called eminence-based medicine, which is defined as "making the same mistakes with increasing confidence over an impressive number of years" [8].

Physicians in Switzerland can and will have to do better. We repeat that this day and age antihypertensive therapy is simple, efficacious, safe and by and large free of adverse effects. All it takes to get there is to now and then brush up your knowledge on modern treatment or, if you are unwilling or unable to do so, to refer your patient to an appropriate special centre. Muddling along or "weiterwursteln" as has been documented in the study by Walther et al. [2] is no longer an acceptable option.

Apologies to Marcus Tullius Cicero for paraphrasing his famous dictum, but as of now the question stands: Quo usque tandem abutimini, medici, aegrotis nostris? "How much longer, physicians, will you try our patients?"

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