



GPs reluctant to start blood pressure lowering treatment in the elderly
Blood pressure lowering is beneficial in very elderly patients
Integrating depression and high blood pressure treatments improves both conditions

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GPs appear to accept blood pressure levels in their patients that are higher than those recommended in clinical guidelines, and may be reluctant to initiate drug treatment in patients who are very elderly (Midlöv P, Ekesbo R, Johansson L *et al. Scand J Prim Health Care* 2008; 26:154-159). This study, done in southern Sweden, involved 90 GPs working in primary care centres who were asked to complete a questionnaire about how they manage high blood pressure. A key component of the questionnaire was an inquiry as to why they might delay or avoid treating high blood pressure in their patients. While nine out of 10 GPs were aware of blood pressure target levels as recommended by national guidelines, three out of four reported one or more factors would cause them to postpone or even abstain from initiating blood lowering treatment. Advanced age of the patient was cited as a major barrier, as were concerns that the patient may not be motivated to take their medication. While there are established guidelines for managing high blood pressure that highlight the value of blood pressure lowering in the elderly, there is clearly still much to be done if optimal management is to be achieved.

Expert comment

Therapeutic inertia (the failure of a provider to begin new medications or increase dosages of existing medications when treatment goals are unmet) is a well described phenomenon. It is a major barrier to translating research evidence into practice and contributes substantially to poor health system performance. The reasons underlying therapeutic inertia are complex and occur at multiple levels. Although limited by self-reported information, this study highlights that despite GP acceptance of the evidence there are specific circumstances in which guideline recommendations may be disregarded. Factors identified in this study operate at the level of patients (patient motivation), GP-patient interactions (patient's age, competing illnesses, other medications) and GPs (awareness and training in risk assessments). The challenge for us as GPs is to scrutinise when therapeutic inertia is occurring, whether it is inappropriate and how we can best work with our patients to overcome it. Importantly, these challenges also extend to the health system where support mechanisms need to be in place to assist GPs in providing best practice care.

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Blood pressure lowering treatment in very elderly patients can significantly reduce the risk of stroke, heart failure and death (Beckett NS, Peters R, Fletcher AE *et al.* *N Engl J Med* 2008; 358:1887-98). Definitive evidence about the effects of blood pressure lowering in the very elderly had not previously been available. Furthermore, there was some concern that while blood pressure lowering might reduce the risk of stroke it might elevate the risk of death from other causes in the very elderly group. The Hypertension in the Very Elderly Trial (HYVET) was a large international study involving 3845 patients aged 80 years or older with high blood pressure. Half were treated with a diuretic (indapamide) with or without an ACE inhibitor (perindopril), and the remainder with placebo. The results, published late last year, clearly showed that blood pressure lowering treatment in these patients reduces the risks of vascular deaths with no increase in risks from other causes. There were also important reductions in the risks of other vascular events. After a mean follow-up of 2 years patients receiving blood pressure lowering treatment had a 30% reduction in the rate of stroke, and a 64% reduction in the rate of heart failure. The rate of death from stroke was reduced by 39%, the rate of death from heart disease by 23%, and the rate of death from any cause by 21%.

Expert comment

There is a dearth of evidence about the balance of risks and benefits of treatments for very old people, yet our society is rapidly ageing. This paper is therefore very welcome. Before commenting on the specifics, it is worth mentioning an important principle of medical treatments for the elderly: treatment effects rarely change direction but the size of the benefit commonly attenuates with increasing age. What this means is that a treatment that is definitely beneficial in adulthood, rarely becomes definitely harmful in old age. But what does happen is that the relative risk reduction tends to get smaller (as there are other competing comorbidities). In recent times some observational studies have questioned whether antihypertensive treatment is really of benefit in old age but these types of studies can be notoriously unreliable. There are numerous examples where observational studies have given different answers to rigorously designed randomised controlled trials (RCTs), perhaps the best recent examples are hormone replacement therapy (beneficial in observational studies, harmful in RCTs) and cholesterol lowering for vascular patients (uncertain results from observational studies and clear benefit in RCTs).

The trial by the HYVET group was well conducted and the key aspects for those of us treating older people with hypertension were: how frail were these trial participants?; What blood pressure readings governed eligibility?; and what treatment was used? Frailty is easy to observe but more difficult to measure objectively. We know that the HYVET trial subjects were not demented, were not requiring nursing home care and were able to give informed consent. Whilst these criteria eliminate many elderly patients, a typical older individual able to attend the surgery would be the sort of person included in the trial. The blood pressure had to be consistently above 160mmHg systolic in the seated position and not less than 140mmHg standing. This is important as postural hypotension can be a major problem in the elderly, and a standing BP check is excellent practice. The drugs used were the same combination as used in the PROGRESS stroke secondary prevention trial. The combination of an ACE-I (perindopril) and a diuretic (indapamide) is clearly a well-tolerated and effective antihypertensive combination. How will this change my practice? I will have increased confidence that treatment of hypertension is a widely generalisable policy, in the absence of major frailty, dementia or dependency, and the use of an ACE-I and a diuretic remains an excellent choice of therapy.

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Integrating depression and high blood pressure treatments improves both blood pressure control and depressive symptoms in older adults (Bogner HR, de Vries HF. *Ann Fam Med* 2008; 6(4):295-301). In a 6-week study conducted in a large primary care practice in the US, patients who received integrated care for their depression and high blood pressure had fewer depressive symptoms at 6 weeks, lower diastolic and systolic blood pressure and were also more likely to be taking their medication than patients who received usual care. The study involved 64 patients aged 50 to 80 years who were taking medication for depression and high blood pressure. The patients either received usual care for 6 weeks, or they were assigned an integrated care manager. The care manager worked with the treating physicians and the patient to improve adherence to treatment, to provide patient education about depression and high blood pressure, to monitor the patient's clinical condition and to provide appropriate follow up. Depression is often present in patients with chronic medical conditions such as high blood pressure. Integrating treatment for these conditions may be an effective and feasible approach to improving patient outcomes in general practice.

Expert comment

This study demonstrates very nicely what has been widely suspected for many years, that is, that there is a close interaction between the management of depression and other medical conditions. The study shows that it is not only important to manage each condition in its own right but that an integrated approach to treating the two will reap additional benefits. In this study utilizing an integrated approach to the treatment of depression and hypertension maximised benefits for the patient because it led to improved treatment adherence and clinical outcomes. It is known that depression is common among patients with cardiovascular disease, particularly following myocardial infarction; yet, currently, the majority of cases go undetected. Hopefully, the results of this study will help primary care physicians to do a better job of detecting and treating depression and managing it an integrated fashion.

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