Introduction

These new guidelines update the 1993 version and are in accordance with the 1997 publication from the US Joint National Committee (JNC 6) (1). For the first time the WHO/ISH guidelines are produced in two versions, an extensive 30 page, heavily referenced review (2), intended for specialist physicians, and a condensed practical oriented guide for primary care, which has been made widely available, mainly through national leagues or societies.

What are the main new messages from these?

First, the classification of hypertension has been harmonized, so that the cut off levels of BP are the same for both JNC VI stages and WHO/ISH grades. Optimal is <120/80, normal <130/85, and high normal is 130-139/85-89 mmHg. Hypertension remains defined as >140/90, with three grades 1, 2, and 3 being 140-159/90-99, 160-179/100-109, and >180/110, respectively.

Secondly, these latest guidelines emphasize the importance of other concomitant risk factors, in making decisions regarding the level of BP at which to start treatment and the importance of correcting reversible risks other than BP. This is important since BP is not just an isolated marker of pressure risk, but also a powerful marker for other risk factors such as age, obesity, glucose intolerance, etc., with which pressure is strongly correlated.

Thirdly, they emphasize the importance of a lower treatment target of 130/85, especially for
Comments on the WHO/ISH Guidelines 1999 continued

those at high risk due to, e.g., diabetes or prior overt vascular disease.

Fourthly, they review the evidence which shows that it is necessary to use two or more drugs to achieve normal BP levels in the majority of patients, and that this does not impair quality of life – rather the reverse (3, 4).

Fifthly, the new advice favors the use of any of the 6 main classes of drugs, including the new angiotensin receptor blockers (ARB’s) if, for example, ACE inhibitors give rise to cough or other side effects.

Sixthly, the guidelines emphasize lifestyle changes such as reduction in weight, alcohol, and intake of salt. They encourage exercise, and above all, smoking cessation and healthy eating. These lifestyle measures are recommended for all, and particularly for milder hypertensives without overt risk factors, during an extended assessment period for the need of pharmacological therapy.

The Guidelines come at a time of worrying evidence of increasingly poor control of BP, and even of a halt in the previous downward trend in the numbers of strokes in the community. There is widespread evidence of physicians tolerating uncontrolled BP in their patients, even in the setting of the free healthcare of the US Veterans Administration. A recent study of five VA sites in New England with a survey period of two years found that in 800 white male veterans BP was above 140/90 mmHg in 75% (5). Over the next two years each patient was seen an average of six times per year. In this population, of which half had clear evidence of vascular disease, the physicians increased medication in only 6% of visits. When the physician increased the medication the SBP fell by 6.5 mmHg; when the therapy was left unchanged BP rose 4.5 mmHg. This shows that it is physician inertia, rather than patient side effects, or non-compliance which is at fault. Although the HOT study (3) failed to show significant benefits from lower treatment targets (because of insufficient BP differences between groups), it did show that with the use of two or three drugs it was possible to control BP at below 140/90 in over 90% of the more than 19,000 patients, without any increase in side effects or adverse consequences.

The two publications also give clear guidance on the diagnosis, investigation, epidemiology, and categorization of high blood pressure, and the main factors which help determine the choice of therapy (including fixed dose combinations – which are now encouraged for the first time).

The latest trial evidence is reviewed, particularly for diabetes, where the UK PDS study (4) underscored the substantial benefits of tight control of glucose and particularly of blood pressure.

The Guidelines received some criticism that the committee was short of general practical advice, and also that there was insufficient hard evidence on the benefit of targets lower than 140/90. However, there was in fact considerable GP input into the practical guidelines. The wisdom of lower targets for high risk patients (which was primarily based on strong epidemiologic data) has been confirmed by the results of the HOPE study regarding Ramipril versus placebo (6).

Finally, the documents emphasize that they are not to be taken as rigid rules, but rather as balanced information to guide clinicians and to form the baseline for local discussion, adaptation, and implementation, based on local budgets, policies, and hypertension prevalence.

The WHO/ISH Guidelines Committee was widely representative and was chaired by Professor John Chalmers (Sydney). Peter Sleight represented the World Hypertension League and was a member of the writing committee for the shorter Practice Guidelines.

References

Comments on the WHO/ISH Guidelines 1999 continued


WHL News continued

ational programs which are regarded as an important tool to increase the awareness of blood pressure control. Support for the national leagues in these efforts will be provided by the WHL through the following activities:

- Development of educational brochures.
- Assistance for local or regional hypertension conferences by the Board members.
- Adaptation of the WHL Newsletter to a stronger supportive tool.
- Increasing the internet based services via the WHL website.

Furthermore, the WHL encourages the national leagues to promote research projects that aim at the control of hypertension.

Third, the WHL continues to act as a clearing house for international contacts and will continue to interact with other international societies.

Finally, the Board will attempt to strengthen its competence by electing a representative of nurses and general practitioners to the Board, and by strongly involving the presidents of the national societies in WHL activities.

With this set of goals the WHL Executive Board hopes to enhance the local, regional, national, and international efforts to decrease the burden of hypertension throughout the world.

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People

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Impressum

The objectives of the WHL are to promote the detection, control and prevention of arterial hypertension in populations. The World Hypertension League (WHL) is a federation of leagues, societies and other national bodies devoted to this goal. Individual membership is not possible. The WHL is a division of the International Society of Hypertension (ISH), and is in official relations with the World Health Organization (WHO).

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Calendar

European Conference on Health Promotion and Health Education
May 10–13, 2000
Santander, Spain
Information: Dr. Maria Sáinz, Asociación de Educación para la Salud, Hospital Clínico San Carlos, 28040 Madrid, Spain
Fax: (+34) 91 543 7504, E-mail: msainz@hesc.es

10th European Meeting on Hypertension
May 29–June 3, 2000
Göteborg, Sweden
Information: AISC S.r.l. Via A. Ristori, 38, I-00197 Roma, Italy
Fax: (+39) 06-808 8491, E-mail: info@aisc.it

7th World Congress on Heart Failure – Mechanisms and Management
July 9–12, 2000
Vancouver, Canada
Information: Secretariat, PO Box 17659 Beverly Hills, CA 90209, USA
Fax: (+1) 310 275 8922

18th Scientific Meeting of the International Society of Hypertension – ISH 2000
August 20–24, 2000
Chicago, IL, USA
Information: Horacio Gavilan
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International Symposium on Hypertension 2000
October 6–7, 2000
Athens, Greece
Information: Triaena Tours and Congress 15 Mesogion Avenue, 115 26 Athens, Greece
Fax: (+30) 1 770 5752
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7th International Symposium on Hypertension in the Community
December 4–6, 2000
Herzlia-on-Sea, Israel
Information: Symposium Secretariat Carmel Organizers of Conferences & Events PO Box 1912, Ramat Gan 52532, Israel
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