CLINICAL PRACTICE

Objective for 2015: 70% of treated and controlled hypertensive patients. Seven key points to reach this goal in practice. A joint call for action of the French League Against Hypertension and the French Society of Hypertension

Objectif 2015 : 70 % des hypertendus traités contrôlés. Les sept points pour y parvenir en pratique. Une campagne conjointe du Comité français de lutte contre l'hypertension artérielle et de la Société française d'hypertension artérielle

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Summary For the past 50 years, the implementation of therapeutic advances to the largest number of people has made it possible to have an exemplary reduction in cardiovascular mortality, contributing to extension of life expectancy observed in France. Nevertheless, such gains are fragile, and largely dependent on the quality of blood pressure control. The relative stagnation of blood pressure control in France for the last 5 years is potentially one of its early markers. The French League against Hypertension and the French Society of Hypertension, with the support of the French Ministry of Health, have decided to combine their efforts to provide a new impetus to management of this disease and to make blood pressure control a priority. An ambitious improvement of the percentage of controlled hypertensive patients from 50% to 70% in 2015 is targeted. To achieve this goal, a simplified decisional algorithm is proposed: seven key points dedicated to general practice are emphasized.

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Cardiovascular diseases have long been seen as a fatality whose sudden occurrence upsets personal and family plans. For the past 50 years, the implementation of therapeutic advances to the largest number of people has made it possible to have an exemplary reduction in cardiovascular mortality, contributing to extension of life expectancy observed in France [1, 2]. Nevertheless, such gains are fragile, and are at the mercy of a gradual decrease in healthcare vigilance regarding this disease, which affects the largest number of persons in the French population, i.e. arterial hypertension. The relative stagnation of blood pressure control in France for the last 5 years is potentially one of its early markers [3].

The French League against Hypertension and the French Society of Hypertension, with the support of the French Ministry of Health, have decided to combine their efforts to provide a new impetus to management of this disease and to make blood pressure control a priority objective in order to improve the health of the general population by a decrease in the most feared diseases affecting French people, i.e. stroke, disability and dementia.

Control of treated arterial hypertension: an urgent need for improvement in France

Currently, 15 to 16 million French persons have arterial hypertension. According to the 2006–2007 ENNS survey on subjects from 18 to 74 years of age, among patients with treated hypertension, only 50.9 % were normalised by treatment [4]. The normalisation of blood pressure was more frequent in women (58.5 %) than in men (41.8 %). In the latter, a progressive decrease in blood pressure control was observed with age, from 46.8 % in subjects 45 to 54 years of age, to 33.9 % in those 65 to 74 years of age. In the 3C survey on patients 65 years and older, 69 % of hypertensive treated patients were not controlled [5].

After a period of frank improvement in the percentage of patients treated and controlled in France, this percentage has become relatively stagnant in France, while it has continued to progress in the US [6] and in neighbouring European countries [7].

This situation could be explained by many factors – some of which are related to patients; factors such as: lack of information on hypertensive disease and lack of motivation in chronic management, poor adherence with therapy, denial or fear concerning the benefits of therapy used. Other concerns are related to physicians (trivialisation and lack of interest by doctors in a very common disease with management which appears too routine, therapeutic inertia) [8]. Lastly, other factors are related to the health authorities (inappropriate and/or non applicable medical recommendations, medico-economic constraints with contradictory effects).

In France, the mean number of antihypertensive classes is 1.9/patient and nearly 40 % of patients treated with a single class [9]. According to the ENNS survey patients with treated hypertension, 35.9 % of patients whose disease was not controlled were only treated with a single class of antihypertensive agents, 41.4 % with two classes and 22.7 % with three classes [3]. The result of this is a “therapeutic debt” when compared to the usual number of medications uses in the most recent antihypertensive trials to achieve BP control [10].

In fact, the benefits of treatment of hypertensive patients with antihypertensive agents have been widely demonstrated [11]. The level of scientific evidence obtained is one of the highest in medicine. Therefore, substantially increasing the number of patients whose hypertension is under control appears to be one of the most effective measures to reduce cardiovascular mortality, disabling and dependence-inducing disorders (stroke, myocardial infarction, end-stage renal failure and dementias).

Intensifying antihypertensive treatment in patients with uncontrolled hypertension is essential to improve the management of arterial hypertension in France.

The objective set of achieving control of the disease in 70 % of hypertensive subjects is ambitious but can be achieved. Reaching blood pressure goals in over 70 % of treated hypertensive patients is an objective that each doctor can reach if more precise actions are applied to certain stages of management.

Avoiding trivialisation of follow-up of the hypertensive patient

Arterial hypertension is a very common disorder in medical practice which exposes the doctor to the risk of its trivialisation. Showing constant concern for the disorder presented by the hypertensive patient will make it possible for the
latter to comply with proposals for management and to follow prescriptions.

**A positive response concerning duration of treatment**

The recurring phrase “treatment for life” summarises anti-hypertensive therapy with a constraint which is very difficult to accept. Providing the patient with a positive vision of therapy which makes it possible “to live longer and without disabling illness” is a means which will promote durable management.

**Optimising strategies for management**

Recent analysis of practice demonstrates that doctors do not always adjust their prescription to the hypertensive patient who does not reach blood pressure goals (therapeutic inertia) [8]. Several explanatory factors have been proposed: the limited informative value of blood pressure measured in the doctor’s office, partial adherence to the specified blood pressure goals, absence of a treatment regimen beyond a two-drug therapy. Simplified algorithms developed in Canada [12] and in Great Britain [13] have demonstrated certain efficacy to improve the percent of hypertensive subjects controlled in general medical practice. The following seven points could be applied to a majority of clinical situations encountered in general practice.

**Confirmation of high blood pressure outside the office**

Current recommendations [14] indicate “measuring BP outside of the doctor’s office to confirm arterial hypertension, before the start of antihypertensive pharmacological therapy, but also during the follow-up of the hypertensive patient treated, particularly when BP is not under control at a visit”. The use of ambulatory methods of BP measurement (ABPM or self-measurement) should be supported by healthcare professionals to titrate antihypertensive treatments in complete safety.

**Screening for poor adherence**

Poor adherence with therapy is more common than doctors believe and is observed in all types of patients. Screening for imperfect adherence should be done actively at each visit and at least should include the question “have you missed one or more of your doses of treatments since the last visit?” Similarly, lack of adherence with dietary measures, which can play a favourable role on blood pressure control, should be sought in particular when blood pressure is not at the goal (intake of salt, and quantity of alcohol). To aid in detecting the principal reasons for poor compliance, administration of specific questionnaires should be promoted [15]. In the latter, frequent reasons for poor adherence will be explored: lack of organisation, denial of the disease, intolerance to treatment. Knowledge of the causes of the lack of compliance is the first step to correct such obstacles.

**Switching from monotherapy to fixed combination therapy in case of lack of control after initial treatment**

A single pharmacological agent makes it possible to control only 25% of hypertensive treated patients. If a hypertensive treated patient is not controlled with initial monotherapy, a switch to a two-drug therapy will be more effective than simply doubling the dose of the initial monotherapy in most cases. The choice of a fixed drug combination is to be preferred because it makes it possible to keep the prescription of a single tablet simple, promoting compliance with therapy.

**Proposing a prescription of a three-drug therapy of hypertension in patients not controlled by a two-drug therapy**

The use of three pharmacological classes in combination is necessary to achieve the blood pressure goal in some hypertensive patients not controlled with a two-drug therapy. When arterial hypertension is not controlled by a two-drug therapy, a three-drug therapy is specified in the majority of patients. The trio consists of a combination of a renin-angiotensin system inhibitor, a calcium channel blocker and a thiazide diuretic [13,16]. This choice can be reconsidered if a specific indication exists for use of a medicinal product in the beta-blocker group, or if there exists a contraindication, or if adverse effects have been observed with medicinal products recommended for their preferential use in three-drug therapy.

**Screening for signs in support of a cause of uncontrolled hypertension**

At all stages of management, and in particular in case of resistance to three-drug therapy, it will be necessary to look for the existence of a specific cause for arterial hypertension:

- in case of serum kaliemia less than 3.7 mmol/l, or in case of chronic prescription of potassium supply, in particular even though treatment consisting of a renin-angiotensin system inhibitor is prescribed with partial efficacy to obtain blood pressure control, primary hyperaldosteronism will be suspected. Appropriate investigations will be performed with the aid of a specialist in arterial hypertension;
- the existence of sleep disorders and of disorders of daytime attentiveness subsequent to a sleep apnoea syndrome will be suggested by Epworth’s questionnaire. Screening for sleep apnoea is to be performed systematically in case of uncontrolled, treated hypertension [17].

**Organising a healthcare course for hypertensive subjects and access to specialists**

In the current healthcare system in France, no systematised healthcare course of action has been defined for patients with hypertension. Referral to specialists is most often related to the occurrence of a complication. A specialist’s advice should be requested in: a hypertensive patient not controlled with a three-drug antihypertensive therapy, in patients suspected of having a specific cause for arterial hypertension, in screening for disorders of target organs of arterial hypertension in hypertensive subjects with a high cardiovascular risk. Usually, specialists in arterial hypertension are those who have training in the following fields: cardiology, nephrology, endocrinology, internal medicine. Hospital departments have been recognised by
Uncontrolled arterial hypertension in primary prevention

- Screening to detect lack of adherence
- Confirmed uncontrolled BP by ambulatory blood pressure methods
- Progressively titrate up to three-drug therapy, including a RAAS inhibitor, a thiazide diuretic and a calcium channel blocker
  * Except for contraindications or intolerance
- Specialist advice

Figure 1  Proposed step-by-step strategy in case of apparent uncontrolled arterial hypertension.
Stratégie proposée en cas d’apparente hypertension artérielle non contrôlée.

the European Society of Arterial Hypertension and the French Society of Hypertension as "centres of excellence in arterial hypertension". Specialised activity in arterial hypertension makes it possible to adjust the management of patients with severe arterial hypertension with cardiovascular complications and/or uncontrolled arterial hypertension.

Evaluation of management
Setting the objective of controlling 70% of treated hypertensive patients requires that each doctor in the setting of his patient practice set up the means to evaluate his performance. According to current recommendations, "electronic measurement of blood pressure (BP) should be preferred in the setting of diagnosis and follow-up of patients with hypertension in the doctor’s office and in ambulatory practice". Therefore, in addition to the measurement of blood pressure in the doctor’s office, it is necessary that in the treated hypertensive patient there be a "Measurement of blood pressure outside of the doctor’s office by ABPM or a self-measurement to be performed in the setting of follow-up of the hypertensive patient" [14]. Computerisation of the patient’s medical records combined with modern measurement of blood pressure will make it possible to accurately determine the performance of the healthcare system in the management of arterial hypertension (Fig. 1).

Disclosure of interest
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References

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[8] Okonofua EC, Simpson KN, Jesri A, Rehman SU, Durkalski VL, Egan BM. Therapeutic inertia is an impediment to achieving the Healthy People 2010 blood pressure control goals. Hypertension 2006;47:345–51.


