Editorial

LOOKING AFTER PATIENTS WITH HIGH BLOOD PRESSURE

IT is now just over a year since Tudor Hart's gold medal essay on the management of hypertension was published in this *Journal.* Inevitably when a new and highly organised method of approaching some common clinical problem is introduced, time is needed to consider the aims, to review the methods, and judge the price of the proposed system of care.

The growing interest in high blood pressure in general practice is becoming clear as in the last 12 months alone there have been several articles in the *Journal* (Fry, 1975a and 1975b; Adler, 1976; Hodes and Rogers, 1976). Kark *et al.* (1976) have just described another community-orientated screening programme based on general practice which includes even more stringent criteria for the control of high blood pressure among its aims.

The dangers of hypertension are the effects on vital organs in the body especially the brain, the heart, and the kidneys. Men are much more susceptible than women to cardiac complications.

The indications for treatment are not yet generally agreed, but Tudor Hart's policy is to treat all those with evidence of end-organ strain such as left ventricular hypertrophy or paresis, however transient. He then advises using Pickering's (1968) criteria for initiating treatment on the grounds of raised pressure alone, i.e. for men, diastolic pressures of 100mm of mercury when aged under 40 and 105mm mercury when aged between 40 and 64; for women the levels are 110mm of mercury for the under 40s and 115mm between the ages of 40 and 64. Hart feels the evidence at present does not justify initiating treatment for either sex over the age of 65 in the absence of left ventricular failure or neurovascular damage, but that it is reasonable to continue good control in a patient already on treatment. These criteria are not only simple and easy to remember, but have the advantage of being based on logical cut-off points (the statistical association of a 250 per cent increase in the mortality rate after standardisation for age and sex).

Initial consultations

The technique of waiting for three separate readings before accepting the label of ' high ' blood pressure greatly reduces the size of the population and hence the work involved. It is likely that in most practices the numbers involved will be just under two per cent of all patients, i.e. about 45 patients for a general practitioner with an average list size. There is now increasing agreement that as the majority of patients needing treatment according to these criteria will not have any symptoms, so the onus will have to move to the primary health care team to identify these patients.

The initial clinical examination should include: a history of headaches, chest pain, breathlessness, smoking, and occupation. The findings to be recorded from the

examination are: height, weight, the presence of an arcus, the appearance of the fundi, and the examination of the urine.

Base-line investigations can be reduced as the primary treatable causes of hypertension are so rare in general practice. The blood urea, glucose, and cholesterol, with perhaps lipid studies if possible, are useful and a chest x-ray for heart size and an electrocardiogram, to be checked especially for left ventricular strain, are always indicated.

Management

Once the diagnosis is finally confirmed, the plan of management should be discussed and agreed with each individual patient. The top priority is to stop smoking and to reduce weight to normal levels. Drug treatment varies in different practices, and many practitioners still start with a thiazide diuretic such as bendrofluazide 5mg twice daily. However, increasingly β blockers are emerging as the first line of treatment and this group has been recently reviewed (Davies, 1976). Among these propranolol (' Inderal ') is most used in general practice. The other drugs which are often used are methyldopa, or a ganglion blocker. An appropriate aim is to maintain the diastolic blood pressure at under 100mm mercury, and long-term follow-up can well be undertaken by ancillary staff—the practice nurse in particular has a major role to play in ensuring a check every three months.

While the exact criteria of care must be the responsibility of each practitioner, there are many advantages in partners agreeing a common practice policy especially when ancillary staff are involved. Such topics are ideal for the " mutual education " described by Stott and Davies (1975).

Clinical challenge

High blood pressure is a condition which can be detected in general practice without special or expensive equipment, which is common enough to occur in about two per cent of the population, serious enough to kill many patients, and for which there is a treatment which does not require hospital referral or investigation. It is, in short, a clinical challenge calling for a doctor and team who know and like their patients, who understand the pattern of their lives, and who can organise efficient long-term medical care.

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