

Making Sense of the New Blood Pressure Guidelines

It happened again. Millions of Americans went to bed healthy and woke up with a medical condition that may well require lifelong use of multiple drugs.

No, I'm not talking about a virulent infection or another disease, simply a change in the diagnostic criteria for hypertension. According to new guidelines from the American College of Cardiology and American Heart Association (ACC/AHA), if your blood pressure is higher than 130/80 mm Hg, you have hypertension.

This new definition adds 31 million more people to the ranks of the ailing, raising the number of Americans labeled with hypertension to 103.3 million—almost half of the adult population! Granted, the guidelines recommend lifestyle changes for those on the lower end (130–139/80–89, formerly called pre-hypertension). But when half-hearted advice to diet and exercise fails to produce results, the next step is the prescription pad.

The SPRINT Study

The main clinical trial supporting these new guidelines is the SPRINT study. Researchers randomly assigned more than 9,000 participants with hypertension and high cardiovascular risk to one of two target blood pressure groups: standard (less than 140 systolic) or intensive (less than 120). They were monitored frequently and their medications modified to stay in the target ranges.

The study was stopped early because the intensive control group had 25 percent fewer cardiovascular events and deaths. Reducing risk by a quarter certainly sounds impressive, but let's put it into perspective. Every year of the three-year study, 1.65 percent of the intensive control group and 2.19 percent of the standard treatment group had an adverse cardiovascular outcome. That's the 25 percent difference. Not so impressive when you look at it this way.

Furthermore, SPRINT involved high-risk patients, yet the new ACC/AHA guidelines pertain to everyone—including perfectly healthy people. And there's absolutely no scientific support for that.

Conflicting Research

A more recent meta-analysis, published in January 2018, reviewed 74 clinical trials involving more than 300,000 patients with hypertension. The conclusion was that, for patients with systolic blood pressure higher than 140, treatment reduced risk of major cardiovascular events and death. But for those with no history of heart disease and blood pressure below 140, treatment did not prevent adverse events or save lives. "These results do not support lower BP goals in general..."

Not all physician groups are jumping on the ACC/AHA bandwagon. The American Academy of Family Physicians announced they will stick with earlier recommendations: For the general population with average risk, treatment should be started when blood pressure exceeds 140/90 and for people aged 60 and older, 150/90.

Another disturbing fact about the new guidelines is that they fail to adequately address the harms of intensive blood pressure control. To get blood pressure below 120/80 in the SPRINT study, participants took an average of 2.8 drugs, compared to the standard treatment group's 1.8. This increase in medications was accompanied

by a marked increase in serious side effects such as low blood pressure, fainting, electrolyte abnormalities, and kidney failure. Other common side effects of blood pressure drugs include dizziness, falls, cough, constipation, fatigue, depression, and erectile dysfunction.

The Natural Approach

If you are concerned about your blood pressure, start with diet changes, exercise, weight loss, smoking cessation, alcohol moderation, and stress reduction. The usual diet recommendation is DASH (Dietary Approaches to Stop Hypertension). Low in sodium with an emphasis on plant foods, low- and nonfat dairy, lean meat, fish, and chicken, DASH is not a bad diet. However, because it gives carte blanche to grains, fruit, and starchy vegetables, this diet promotes insulin resistance—the last thing anyone dealing with elevated blood pressure needs.

My Recommendations

- ▶ In addition to diet, exercise, stress management, and other lifestyle factors, the following supplements are recommended for blood pressure support: magnesium 500–1,000 mg, Pycnogenol 50–100 mg, grape seed extract 150–300 mg, olive leaf extract 1,000 mg, fermented/aged garlic extract 800–1,000 mg, stevia extract 800–1,000 mg, reishi mushrooms 500–1,500 mg, and Balance3 2–4 tabs.
- If your blood pressure is over 140/90 (or 150/90 if you're 60 or older) or you are at high cardiovascular risk, you will likely benefit from more intensive treatment.

Fat limitations are also unnecessary and run counter to the most recent research. Even sodium restriction—the Holy Grail of blood pressure control—doesn't apply to everyone. Many people with hypertension are not sodium sensitive, and for those who are, increasing potassium intake is as effective as reducing sodium and a heck of a lot tastier.

A better choice is a higher-fat, lower-carb diet such as the Mediterranean, Paleo, or modified DASH diet, with extra potassium from potassium chloride (Nu-Salt), Low-Sodium V8 Juice, lots of vegetables, and modest amounts of fruit.

Be sure to include daily servings of leafy greens and beets—great sources of nitrates, which convert to nitric oxide, a signaling molecule that dilates the arteries and lowers blood pressure.

Targeted supplements include magnesium, Pycnogenol, and grape seed extract, which relax the arteries, and olive leaf compounds, which inhibit enzymes that constrict the arteries. Fermented or aged garlic extract, reishi mushrooms, Balance3 (a mixture of Chinese herbs), and unrefined stevia extract also have clinically proven blood pressure-lowering properties.

Finally, a high-quality multivitamin, fish oil, coenzyme Q10, and vitamin D are beneficial not only for blood pressure but multiple aspects of cardiovascular health.

“Illness-by-Committee”

Commenting in the January 9, 2018, issue of *JAMA*, John Ioannidis, MD, DSc, of Stanford University wrote, “Expanding the definition of disease to label more people as having medical conditions and in need of treatment has become more common. Many specialties want to increase their volume of patients. Industry also cherishes larger markets for its products through expansive definitions of illness. Guidelines are typically the final step to justify illness-by-committee and treatment overuse.”

Dr. Ioannidis applauds the goal of focusing attention on hypertension and promoting lifestyle modifications. However, he questions whether these new guidelines will fly in the real world.

They won't. We've been here before. Prediabetes, osteopenia, lower cholesterol targets... all ended up slapping disease labels on healthy people and turning them into drug-swilling, side effect-ridden patients who further overburden our healthcare system.

References

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Do Not Be a Victim of False Diagnosis

The last time you had your blood pressure checked in a doctor's office, were you seated in a quiet room five minutes beforehand and told to keep your legs uncrossed and your back supported? Did the nurse avoid chatting with you while testing? If not, your blood pressure readings were probably wrong. A positive aspect of the new ACC/AHA guidelines is a renewed emphasis on getting accurate blood pressure measurements. Here are their recommendations:

1. Do not exercise, drink caffeine, or smoke for at least 30 minutes prior to testing. Empty your bladder.
2. Sit in a chair with your back supported, feet on the ground, and legs uncrossed for at least five minutes before your blood pressure is measured. Do not sit or lie on an exam table.
3. Roll up your sleeve so the cuff is on bare skin. Make sure your arm is supported on a desk or table, not dangling or resting in your lap.
4. Do not talk and ask that the nurse refrain from talking during testing.
5. If your blood pressure is high, ask for a reading in the other arm after a one to two minute rest. The arm with the higher reading should be checked on subsequent visits.

A diagnosis of high blood pressure should be made only after averaging two or more readings taken on at least two separate occasions. If white coat hypertension (elevated blood pressure caused by nervousness of being in a doctor's office) is suspected, home self-monitoring with a validated device or 24-hour ambulatory monitoring is recommended.

If your doctor doesn't follow these protocols, speak up. Far too often patients are measured quickly and inaccurately and stuck with a false diagnosis and a lifetime of unnecessary drugs.