

SPC 企画

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Recommended Treatment Protocols for Improving Management of Hypertension Globally

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対象者 医師・後期研修医（卒後3年目以上）・初期研修医（卒後1-2年目）・学生・その他

Target Doctor・Senior resident (3+years after graduation)・Resident (1-2 years after graduation)・
Medical student・Other

高血圧治療を考える ガイドラインの作成から現在の問題点まで

高血圧治療に関しては、様々なガイドラインが作成されている。本邦の最新の高血圧ガイドラインはJSH2014であるが、現在改定がすすめられており、来年にはJSH2019として公表される予定である。一方、米国では2014年にJNC-8が発表されて広く引用されていた。ACPでは2017年に60才以上の高齢者に対する降圧治療ガイドラインを発表した。しかし、同年末にACC/AHAなど11学会による高血圧ガイドラインが発表され、高血圧の基準を130/80mmHgとする新たな指針を示した。そこで、今回、京都大学の中山先生とACPインド支部長のMuruganathan先生をお招きして、ガイドラインの作成方法及び高血圧治療について概説していただき、現在の高血圧治療の論点について検討する機会を設定した。(平和伸仁)

Treatment of high blood pressure: Rethink of hypertension guideline

The hypertension treatment guideline was revised in 2014 in Japan. Last November, eleven society including ACC/AHA published a new hypertension guideline. However, the definition and target blood pressure of hypertension were different from the existing guidelines including those of ACP and JSH. Here we would like to study how to make a clinical guideline through the short lecture by Dr. Nakayama. Furthermore, Dr. Muruganathan (Governor of ACP India chapter, Dean of Indian College of Physicians) will give us a lecture of hypertension treatment. After the two lectures, the issues of new ACC/AHA2017 guideline will be discussed, especially about the blood pressure value for the diagnosis of hypertension and the target blood pressure of patients with different background. (Nobuhito Hirawa)

Recommended Treatment Protocols for Improving Management of Hypertension Globally

Hypertension is a leading cause of cardio vascular disease and contributes to 10 million deaths a year - comparable to as many people as are killed by all infection disease combined or cancers. Young populations are disproportionately affected and it is estimated that CVD costs 2-4 % of gross national income in low and middle income countries. Current statistics reveal that fewer than 15 % of adults in hypertension worldwide have their blood pressure controlled to 140/90 or lower though, some countries and health systems have achieved control rates around 70 %. Accomplishing this target on a global basis could save millions of lives.

Improvement in the management of hypertension not only save most lives and can also reduce spending on management of patients with heart attack, stroke, kidney failure and other preventable complications of uncontrolled hypertension.

Using Treatment Protocols

Practical treatment protocols can increase rates of hypertension control, facilitates team based care, supportive supervision, training and reducing both unwarranted clinical variability and inappropriate therapeutic inertia. By adopting treatment protocols that specify a limited set of carefully selected, effective medications could facilitate simplified logistics, titration, simplicity of procurement, reduce medication costs as well as improve supply chain reliability.

Based on preliminary information from large procurements by various organisations it is estimated that medication costs for one year of hypertension treatment could be as little as \$2 per patient.

Rational for using a simplified treatment protocol

During the 1970s stepped care approach developed in clinical trials but control rates have remained low over the past several decades. There has been interest in expanding the use of hypertension treatment protocols, often including the use of single pill combination (SPC) in the recent years.

This approach is similar to that of specific treatment protocols which have been successful in scaling up treatment of HIV and tuberculosis. WHO HEARTS technical package which is endorsed by the World Hypertension League (WHL), Resolve to Save Lives and many other partners recommend and emphasizes strongly the use of practical simplified treatment protocols.

Rational for Selected Treatment Protocols

Four classes of medications (Angiotensin Converting Enzyme Inhibitors (ACEI), Angiotensin Receptor Blockers (ARB), Calcium Channel Blockers (CCB) and Diuretics) are effective as per the recent hypertension guidelines issued by ACC/AHA. The WHO HEARTS technical package and the best scientific evidence believed the use of the above drug classes at various combinations can reduce blood pressure and prevent cardiovascular complications.

Resolve to Save Lives and partners recommended two protocols, one is using fixed dose Single Pill Combination (SPC) and other is using Single Medications in combination as needed. The same three core medications amlodipine 5 mg, telmisartan 40 mg, chlorthalidone 12.5 mg in slightly different sequences are recommended in both protocols. Both protocols can be modified by changing telmisartan to another RAS inhibitor other diuretics for chlorthalidone and altering the sequence of treatment.

Recommended Medications for Protocols

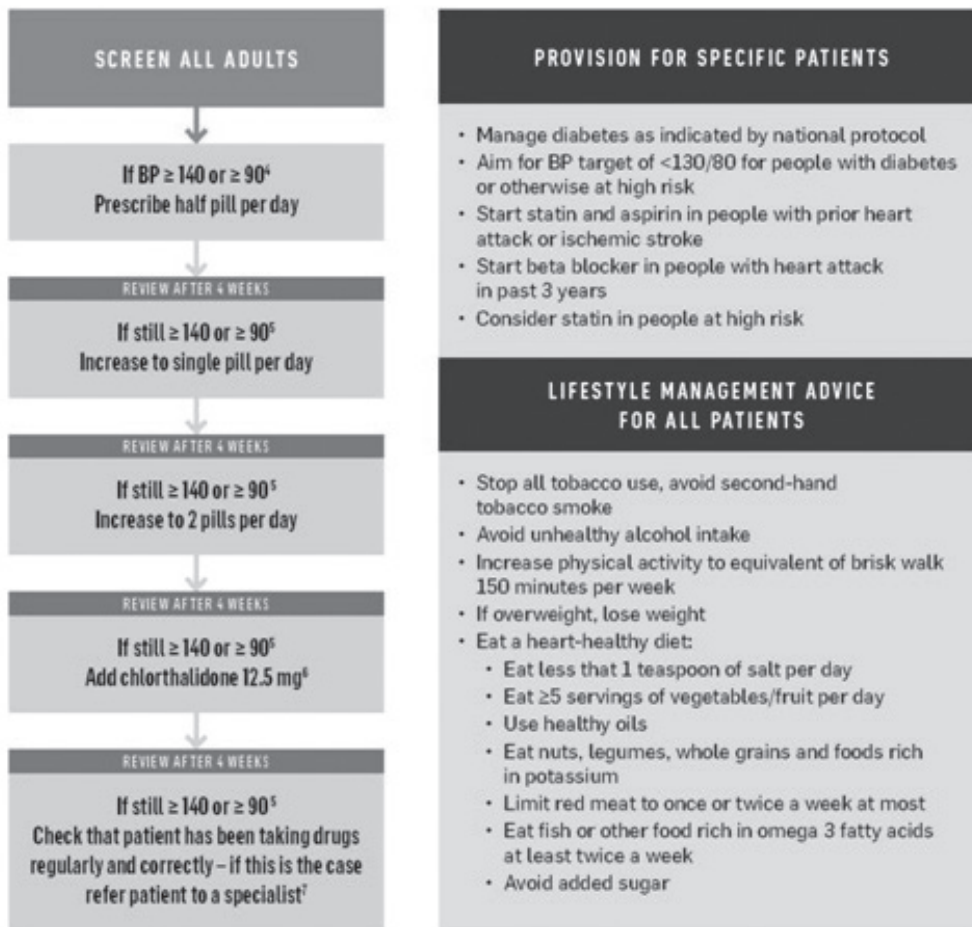
The CCB amlodipine require less monitoring, can be given as once daily as 5 mg tablet and has been studied extensively in clinical outcome trials. The tablet also can be taken as ½ tablet or 1 tablet or 2 tablets. ARB telmisartan is recommended because of low rate of adverse effect and also can be taken once daily. This can also be taken as ½ tablet, or 1 tablet or 2 tablets. Indapamide 1.25 may be alternative to chlorthalidone.

When combined with CCB RAAS inhibitor can reduce pedal edema.

ARBs are recommended due to the much lower incidence of cough and angioedema although ACEIs are better documented to reduce cardiovascular events than are ARBs. The RAS inhibitor (ACEI or ARB) with thiazide diuretic is associated with lower incidence of hypokalemia than a thiazide diuretic when used alone and lower incidence of hyperkalemia than when a RAS inhibitor is used alone.

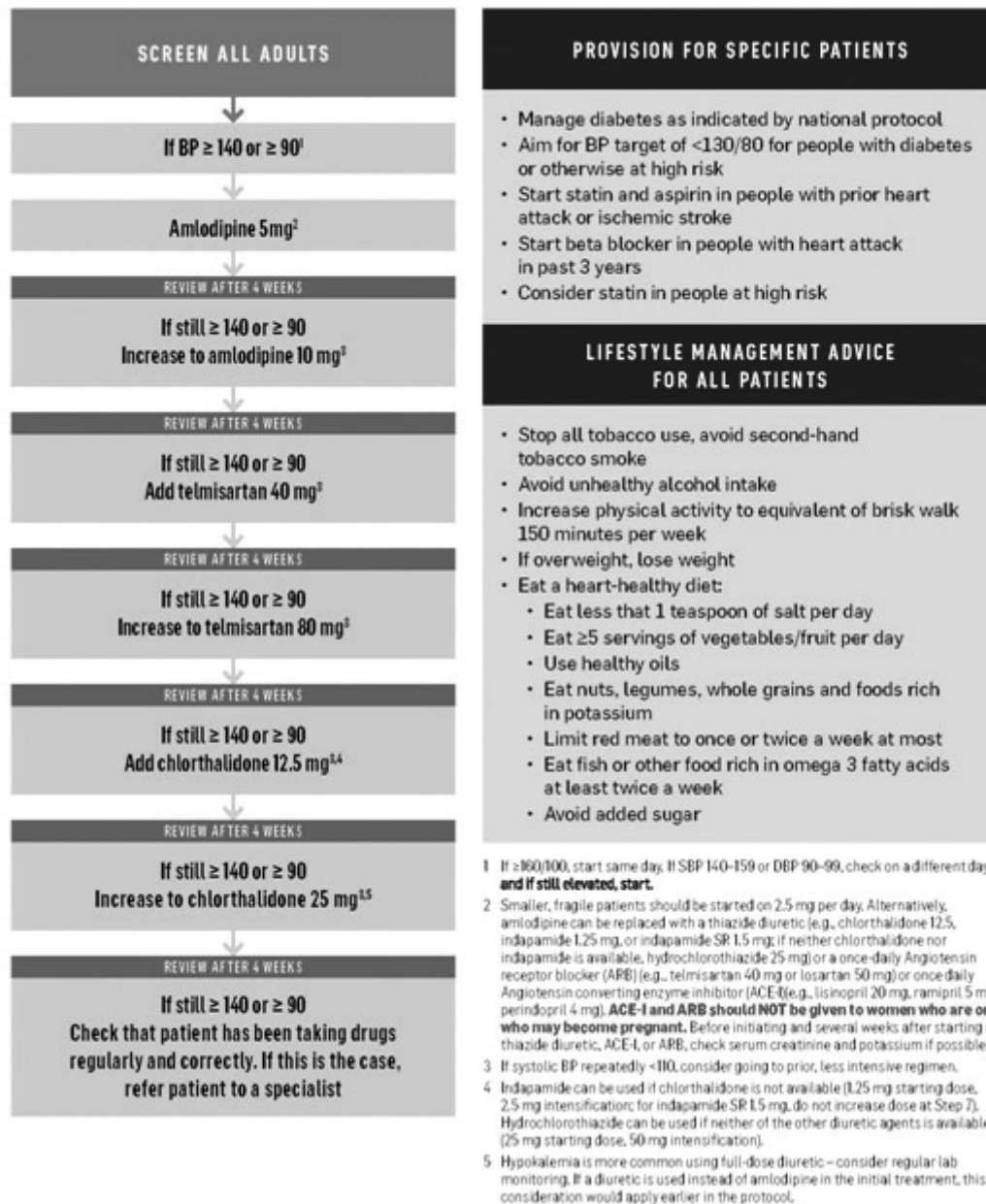
Figure 1. Recommended Single-Pill Combination Hypertension Treatment Regimen.

Telmisartan 40 mg¹/Amlodipine 5 mg² Single Pill Combination³ Regimen



Telmisartan 40 mg can be replaced with any once-daily Angiotensin receptor blocker (ARB) (e.g., losartan 50 mg) or once daily Angiotensin converting enzyme inhibitor (ACE-I) (e.g., lisinopril 20 mg, ramipril 5 mg, perindopril 4 mg). **ACE-I and ARB should NOT be given to women who are or who may become pregnant.** Before initiating and several weeks after starting ACE-Is or ARBs check serum creatinine and potassium if possible. Amlodipine can be replaced with another once-daily dihydropyridine calcium channel blockers. Alternatively, amlodipine can be replaced with chlorthalidone 12.5, indapamide 1.25 mg, or indapamide SR 1.5 mg. If neither chlorthalidone nor indapamide is available, hydrochlorothiazide 25 mg can be used. If a diuretic is used instead of amlodipine, check serum potassium if possible and see 6 below. Medications can be used as individual agents if single-pill combinations are not available. If BP ≥ 160 or ≥ 100 , start same day. If 140-159 or 90-100, check on a different day, and if still elevated, start. If systolic BP repeatedly <110 , consider going to prior, less intensive regimen. If a diuretic is used initially instead of amlodipine, then amlodipine or another once-daily dihydropyridine calcium channel blocker would be used at this step. Consider increase to full-dose diuretic (chlorthalidone 25 mg or indapamide 2.5 mg; indapamide SR 1.5 mg is both the start and the full dose). Hypokalemia is more common using full-dose diuretic – consider regular lab monitoring. If a diuretic is used instead of amlodipine in the initial treatment, this consideration would apply earlier in the protocol.

Figure 2. Recommended Single-Agent Hypertension Treatment Regimen.



Adherence

A major reason for lack of control of hypertension is lack of adherence to antihypertensive drug therapy. Some patients will either not take the drugs or will not take them as prescribed and some will not collect medications

WHO in 2017 highlighted the value of SPC therapy using currently listed essential medicines, including dual agents for hypertension. Several of these treatments already included on their lists of national essential medicines to inform priorities for procurement, reimbursement, and central distribution by low and middle-income countries.

Conclusion

Maximizing control of blood pressure while minimizing both adverse events and the need for monitoring is the main purpose of the scalable protocol. Individualised approaches can be reserved to small proportion of patients who have complicated medical conditions or who experience adverse events and require a more tailored approach.

Improving the global hypertension control rate to 50% from less than 15% as it is at present would save more than a million lives a year. This would require effective treatment of an additional 500 million patients worldwide. The important progress the World Health Organization has proposed is to increase in treatment of more than 200 million patients between 2018 and 2023. This massive challenge can be achieved only if practical and specific treatment protocols are adopted, used, and optimized based on actual experience. (Muruganathan)