

# Too many guidelines?

With the numerous hypertension guidelines available, greater attention needs to be taken in ensuring their conciseness, writes **Prof Eoin O'Brien**

I have said it before and must now say it again – there is a guidelines industry that threatens to submerge us all in a tsunami of evidence-based documentation, which none of us can ever hope to assimilate within our little cerebrums, even with the help of the mightiest cerebrum of all – the Internet. I say this as a member of the “guidelines industry”, having been an author on many of the guidelines on hypertension; though, in fairness, I have pleaded for harmonisation of guidelines. Why do we need both British and European guidelines – is the UK not in the EU?

in another huddle and produce a summary of their deliberations, which though much less verbose than the original guideline, still runs to some five to 10 pages or so.

Now a new phenomenon of the guideline industry has burst upon us. In 2007, the European Society of Hypertension (ESH) and the European Society of Cardiology (ESC) published *Guidelines on hypertension on the detection, diagnosis and management of hypertension*, which are scheduled for revision in full in the near future, but a task force of the ESH has just published what is called a reappraisal of European guide-

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I once made a page count of the current hypertension guidelines – European, British and American – and it exceeded 500 pages. None of us can hope to read, much less interpret and memorise, so much well-intentioned verbosity. And when I say well-intentioned, I do so because that is the reality. The authors of these guidelines sift through hundreds – indeed collectively thousands – of papers ranking the evidence according to strict criteria, and then, after innumerable drafts and international consensus meetings and email communications, regurgitate the guidelines, which often runs to tens of pages. However, being aware of the ability – or should I say inability – of the gyri of the human cerebrum to retain all this knowledge, the authors convene

lines on hypertension; the original guidelines ran to 83 pages and the reappraisal runs to no less than 37 pages.

The rationale of this document is to incorporate the evidence from new trials, such as the benefit of blood pressure lowering in patients with type 2 diabetes (ADVANCE); the role of angiotensin 2 receptor blocker (ONTARGET, TRANSCEND); evaluation of treatment in the very elderly (HYVET) and the comparison between different models for use of combination therapy in hypertension (ACCOMPLISH); and other developments within the rapidly-growing discipline of hypertension. The reappraisal draws attention to the important issue that the “lowest pressure” attainable may not be best and that there might exist a systolic blood pressure



level, below which a further lowering of the blood pressure might induce more harm than benefit in high-risk patients with diabetes or coronary heart disease. The answer to this question must await, however, final data from the ACCORD study, in which patients with type 2 diabetes in whom aggressive lowering of systolic blood pressure (to less than 120 mmHg) are compared to those with usual blood pressure control (less than 140 mmHg).

The reappraisal document also highlights the importance of combination therapy in achieving blood pressure control, and the recent spate of combination drugs with flexible dose options is a welcome innovation from the pharmaceutical industry.

However helpful the reappraisal document may be in alerting doctors to the results of recent trials, I have to look critically at the assumption that clinic blood pressure is used for the cut-off points on which treatment recommendations are made, when it has been demonstrated in numerous publications since the publication of the original guidelines that this technique is not only inaccurate, but highly misleading because of its failure to detect white coat phenomena and masked hypertension; these publications (which are not acknowledged in the reappraisal document) emphasise that greater reliance must be given to out-of-office measurement, especially ambulatory blood pressure measurement (ABPM), which allows assessment of nocturnal blood

pressure, the elevation of which has been shown to carry a poor prognosis. Instead of recognising the technique of blood pressure measurement as the rock on which all decisions – be they diagnostic, management or prognostic – depend, the reappraisal document waxes eloquent on the need for assessing subclinical organ damage in total cardiovascular risk stratification such as protein excretion (including microalbuminuria), eGFR (MDRD formula), ECG, and cardiac and vascular ultrasound.

These quibbles aside, the reappraisal document does highlight the imperative of achieving blood pressure control to prevent stroke and other cardiovascular consequences of hypertension. The document also emphasises the urgent need to implement the changing evidence into clinical practice. It is timely, therefore, that the Irish Heart Foundation are aware of the necessity for instigating evidence-based guidelines and, alert to the bulk of such guidelines, has recently established a Council on the Prevention of Cardiovascular Disease in Clinical Practice, under the Chairmanship of Prof Ian Graham, with the mandate to facilitate the implementation of cardiovascular guidelines in primary care.

*References available on request*

*Prof Eoin O'Brien,  
Professor of Molecular Pharmacology,  
University College Dublin*