EDITORIAL
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JNC 8: Not So Great?

Today I’d like to talk a bit about the new national hypertension guidelines you may have heard about recently. We all have been waiting a long time for the latest set of guidelines to come out. A fair number of people have been quite disappointed with what they finally saw after the inordinately long wait. But are they really right to be unhappy? There are several important perspectives that we need to consider here. Let’s first review how we got to the present point.

The previous set of official recommendations for hypertension management was published way back in 2003. So the practice community has waited very patiently for an updated set of guidelines. The previous guidelines were known as JNC 7, referring to the seventh iteration of recommendations emanating from a group of big-time hypertension experts known as the Joint National Committee (JNC). All the JNC reports have been sponsored by the National Institutes of Health (NIH), and hence, had a high degree of visibility and credibility. However, many practitioners felt that cost considerations mitigating in favor of inexpensive drugs, such as thiazide diuretics, unfairly colored and distorted the JNC 7 recommendations.

In the interest of full disclosure, I should point out that I was one of the several important perspectives that we need to consider here. Let’s first review how we got to the present point. The JNC 8 authors recommended against initiating antihypertensive therapy in patients over the age of 60 unless their blood pressure was over 150/90 mm Hg, which represents a loosening of the earlier recommendations to start drug treatment at the lower systolic level of 140 mm Hg. Also, the new goal for antihypertensive therapy in this age group is sim-
Comparison of JNC 8 With JNC 7 Guidelines

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<td>Recommended selection among 4 specific medication classes (ACEI or ARB, CCB, or diuretics) and doses based on RCT evidence; Recommended specific medication classes based on evidence review for racial, CKD, and diabetic subgroups; Panel created a table of drugs and doses used in the outcome trials</td>
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Adapted from *JAMA*. 2014;311(5):507-520.

ACEI = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; CCB = calcium channel blocker; CKD = chronic kidney disease; CVD = cardiovascular disease; JNC = Joint National Committee; RCT = randomized controlled trial.

I am of two minds about this relaxation of the blood pressure goals. On the one hand, I acknowledge that the recommendations are evidence based, at least in the sense that no incontrovertible data exist to refute this more relaxed goal. There are simply not any credible studies out there that demonstrate better results when the systolic goal is 140 mm Hg rather than 150 mm Hg. It doesn’t mean that it might not be true—140 might really be better than 150—it simply means that the issue has not been studied in any clinical trial. So from a purist, evidence-based standpoint, I can accept that the new recommendation is perfectly valid from a scientific point of view.

But the part of me that values the art of medicine as well as the science is profoundly troubled by this lockstep scientific purity. What I am extremely concerned about is the possibility that the practice community will misinterpret the recommendations and take them as a mandate to loosen blood pressure control in those over age 60. If the target is just to get the systolic below 150 mm Hg, some may conclude that a pressure of 160 or even 165 is “close enough for government work,” to use the convenient phrase that dogs us federal employees. This would be a misinterpretation of the guidelines’ actual recommendation, but nonetheless, a very understandable and almost predictable one. Given that the practice community has never done a bang-up job of getting patients to the goals previously recommended, is it really the time to relax those guidelines and run the risk of even less blood pressure control?

I have to reluctantly conclude that the pseudo JNC 8 guidelines are not so great, at least for hypertensive patients over age 60. Although I cannot quibble with the strict scientific underpinning of the guidelines, they seem very likely to lead to a setback in hypertension control. We may see more heart attacks, strokes, heart failure, and renal failure if practitioners take the new guidelines as license to be less vigilant in treating elevated blood pressure. Treating elevated blood pressure is the low-hanging fruit for most primary care providers, and discouraging them from plucking that fruit from the tree is clearly a step in the wrong direction.

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