For Refractory HT, Consider Secondary Causes

BY ROBERT FINN
San Francisco Bureau

ATLANTA — Clinicians should consider secondary causes when a patient’s hypertension does not respond to aggressive treatment, Dr. Angela L. Brown said at a meeting sponsored by the International Society for Black Women.

The first rule, though, is that one must be careful in defining when hypertension is truly refractory, said Dr. Brown of Washington University in St. Louis. Hypertension is considered refractory only if a blood pressure under 140/90 mm Hg cannot be achieved despite the use of two to three of their maximal doses, one of which must be a diuretic.

Too often, she said, other physicians refer patients with “refractory HT” who are on only two antihypertensive drugs at the starting doses. There are many secondary causes of hypertension. Renal hypertension and endocrine hypertension are probably the most common, but other causes include aortic coarctation, sleep apnea, and pancreatic dysfunction (epiphrenic).

In addition, there are many exogenous substances that can raise blood pressure. Ethanol and caffeine are probably the most prominent, but these physicians should carefully question patients about other possible causes, including cocaine, nicotine, sympathomimetics, chlorpromazine, erythrophyrin, oral contraceptives, cyclosporine, tricyclic antidepressants, MAO inhibitors, and certain herbal supplements, such as the Chinese stimulant dehydroepiandrosterone (epidrone).

NSAIDs, corticosteroids, and sodium chloride also can interfere with hypertension. “Particularly when you see young men who are athletic or buff, ask them about anabolic steroids,” Dr. Brown advised. But she warned that the physician may not get an honest answer unless the young athlete’s parents are out of the room.

Dr. Brown suggested a number of screening tests that can uncover some of the secondary causes, particularly the endocrine ones. (See box.)

But she placed a special emphasis on renal function.

“I think it’s really important that we know the patient’s level of kidney dysfunction,” she said. “We get the serum creatinine, and we often see a creatinine clearance factor for the patient’s gender and race (black versus nonblack), and there are Web sites where one can calculate the creatinine clearance (www.medcalc.com/ glcr.html, for example).

“Some labs have actually started reporting the estimated GFR based on a patient’s serum creatinine and weight, with correction factors for the patient’s gender and race,” she said. “We get the serum creatinine, and we often see a creatinine clearance factor for the patient’s gender and race (black versus nonblack), and there are Web sites where one can calculate the creatinine clearance (www.medcalc.com/glcr.html, for example).

“The meeting was cosponsored by the American Society of Hypertension.

Narrow Down The Possibilities

For hyperthyroidism or hypothyroidism, test TSH, free T4.

For pheochromocytoma, test plasma normetanephrine, metanephrine, and urinary catecholamines.

For primary aldosteronism, test morning plasma potassium; aldosterone ratio.

For Cushing’s syndrome, administer the dexamethasone suppression test.

For hyperparathyroidism, administer a test for albumin-corrected serum calcium, intact parathyroid hormone; see (epidromine-phosphate)

For renal artery stenosis, use the renal artery duplex scan, captopril renogram.

Source: Dr. Brown

O’ROTHO-MCELWIUUL NEULOGICS, INC.
ORTHO-MCLEWUl NEULOGICS, INC.
505 N. 3rd STREET
TRENTON, NJ 08618
908-691-2800
Ortho-McNeil-Neurologics.com