SPECIAL SATELLITE SYMPOSIUM 03

SSA 03-1 PREVALENCE AND MANAGEMENT OF HYPERTENSION IN SOUTHEAST ASIA

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Similar to the trend worldwide, hypertension (HTN) is also the single most attributable cause for mortality in South-East Asia (SEA). But while in developed regions, the prevalence of HTN appears to be stabilizing or decreasing, the rates in SEA continue to rise. Around a third of the adult population in SEA have elevated blood pressure (BP) with nearly 1.5 million deaths (9.4% of total deaths) attributable to HTN annually.

In several countries in SEA, awareness level of HTN is less than 50% but in the more affluent countries in the region, awareness ranges from 56% to 70%. Of those aware that they have hypertension, about half are on treatment, following the global rule of halves in HTN. Control rates to BP levels below 140/90 mmHg remains dismal low.

HTN is also a common comorbid condition with type 2 diabetes mellitus (T2DM) in the region, with HTN coexisting in 40%-60% of individuals with T2DM, and vice-versa. These dual problem likely accounts for the increased deaths due to cardiovascular disease (CVD), which remains the leading cause of mortality.

At least seven countries in the region have standard national guidelines for the management of hypertension, with some of these countries initiating efforts at reducing salt intake at the population level. These efforts need to be scaled up and adopted by the other countries in SEA.

Considered an urgent public health problem, barriers to effective prevention and control remain a major challenge in the region. These barriers include cultural norms and practices that promote unhealthy behaviors and misconceptions about HTN, the lack of an enabling environment for healthy lifestyle practices, increased tobacco use, disparities in healthcare with inadequate access for early detection and treatment especially primary healthcare facilities, high out-of-pocket cost of treatment, and generally poor adherence to treatment.

Majority of the countries in SEA have already strengthened their public education campaigns and surveillance systems to increase awareness to HTN and other cardiovascular risk factors, and improve management and control. However, prevention and control of hypertension is complex, and has to be approached via a multi-sectoral collaboration.

Professional cardiovascular organizations, together with the rest of civil society can help convince their respective policy-makers and governments to increase allocation of resources to HTN and CVD control programs, particularly primary healthcare approaches. A strong-willed health leadership is imperative to effectively execute population-based integrated approaches that target the risk factors of HTN, especially increased salt in processed foods and the other mentioned barriers to prevention and control.

If these programs and interventions are sustained, this will definitely help achieve the ‘25–25’ vision or goal of global cardiovascular organizations including the International Society of Hypertension, that is, a 25% reduction in the prevalence of HTN and its related complications by the year 2025 in SEA and worldwide.

References:

SSA 03-2 PREVALENCE AND PREDICTORS OF RESISTANT HYPERTENSION IN SOUTHEAST ASIA

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Prevalence and predictors of resistant hypertension in Southeast Asia

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Hypertension is the leading cause of mortality worldwide. It is highly prevalent throughout the world. Even in regions like South-East Asia (SEA) which has been perceived to be less prone to cardiovascular diseases, the prevalence of hypertension has been around 35%. (1) Awareness and control of hypertension in SEA is also low, both being less than 50% each. (2)

Control of hypertension is an interplay between patients, doctors and system factors. One of the reasons for poor control of hypertension is resistant hypertension. Resistant hypertension is defined as blood pressure that remains above goal despite being on three concurrent anti-hypertensive medications preferably one of which is a diuretic. (3)

True resistant hypertension should be differentiated from secondary hypertension and pseudo-resistant hypertension. Resistant hypertension is almost always multi-factorial in aetiology. The exact prevalence of resistant hypertension even in developed countries is not known. It has been estimated that it is as high as 20–30% in clinical trial patients (4)

Not many studies about resistant hypertension have been done in SEA but one done in an outpatient clinic in Thailand found it to be 7.82%. Another study also done in a primary care clinic in Malaysia on 1217 patients with hypertension found the prevalence of resistant hypertension to be 8.8%. (6) Here it was found that the presence of chronic kidney disease was more likely to be associated with resistant hypertension (odds ratio [OR] 2.89, 95% confidence interval [CI] 1.56–5.35).

Other factors like increasing age, female gender, presence of diabetes, obesity and left ventricular hypertrophy which have been found to be predictors of resistant hypertension in other studies in the west were not seen in this study. There are various reasons for these findings.

But whatever the factors are that are associated with uncontrolled hypertension, the task is to sort out true resistant hypertension from pseudo-resistant hypertension and secondary causes of hypertension which may be treatable. A concerted effort is needed to reduce the BP in resistant hypertension. Failure to do so would mean a substantial increase in CV risk for the patient.

References:
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