Comment on the Management of Resistant Hypertension in a Multidisciplinary Unit of Renal Denervation: Protocol and Results

Comentario al manejo de la hipertensión resistente en una unidad multidisciplinaria de denervación renal: protocolo y resultados

To the Editor,

I have read with great interest the article entitled “Management of Resistant Hypertension in a Multidisciplinary Unit of Renal Denervation: Protocol and Results” (“Manejo de la hipertensión resistente en una unidad multidisciplinaria de denervación renal: protocolo y resultados”), in which the authors report an improvement in arterial blood pressure similar to that observed in previous studies, as well as a more marked reduction in the use of antihypertensive drugs in patients who undergo renal denervation performed within a multidisciplinary program. The reported findings are highly interesting; however, I feel that certain observations could be clinically relevant.

First, the authors consider pseudoresistant hypertension (HT) to be present in patients with mean arterial blood pressure values of less than 140/90 mmHg coinciding with a period of activity occurring during ambulatory blood pressure monitoring (ABPM). However, in the current recommendations, HT is defined as arterial blood pressure values greater than 130-135/85 mmHg in an ABPM recording during the period of activity. Thus, HT in which the patients have a mean arterial blood pressure in ABPM greater than 130-135/85 mmHg cannot be considered pseudoresistant. This bias in the inclusion of patients with resistant HT may have affected the observed findings.

Secondly, it is noteworthy that, despite the definition of resistant HT as the condition in which the arterial blood pressure values exceed 140/90 mmHg even with the intake of 3 or more drugs, including a diuretic, 10% of the patients in the published report who underwent the procedure were not being treated with diuretics, and the percentage of subjects receiving diuretics after renal denervation is not disclosed. The pharmacological optimization of these patients in later visits may have altered the reported findings.

Finally, the authors administer aldosterone antagonists to counteract possible secondary hyperaldosteronism. However, my attention is drawn to the absence of staging of other secondary forms of HT, especially when it is known that 27% of the population that undergoes the procedure is diagnosed as having obstructive sleep apnea syndrome. In fact, as the authors point out, there could be a placebo effect in the response to the denervation, an occurrence that would not only be related to greater adherence to the treatment or to the low-sodium diet, but to an improvement in the obstructive sleep apnea syndrome with better dietary adherence. Likewise, drug-induced HT was not tested in the study population, a circumstance that could also influence the results obtained.

In agreement with the authors and the Symplicity HTN-2 trial, renal denervation results in a decrease in the arterial blood pressure and a reduction in the drug therapy. However, an exhaustive search for secondary forms of HT and an optimization of drug therapy could avoid the need for the renal denervation procedure which, although it has been shown to be feasible and safe, is not free of complications.

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