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Medical News & Perspectives

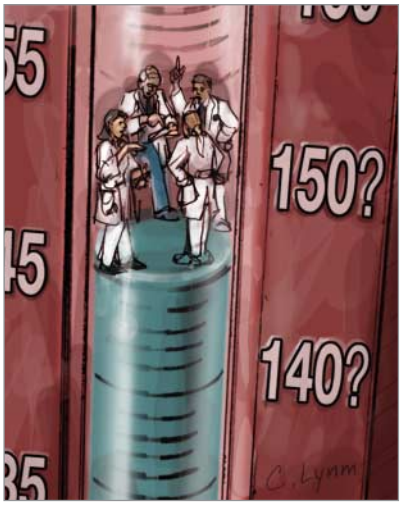
Groups Spar Over New Hypertension Guidelines

Mike Mitka, MSJ

After years of waiting by clinicians, an update to the US guideline for the management of high blood pressure in adults was finally released in December. But it appears the cardiology community wants nothing to do with it. The elements underlying this reluctance appear to be turf battles and disagreement with a recommendation to ease the hypertension treatment threshold for individuals aged 60 years or older.

Released December 18 in *JAMA*, the guideline crafted by panel members appointed to the Eighth Joint National Committee (JNC 8) (http://tinyurl.com/qylsjdw) updates the previous guideline from the JNC 7, published in 2003 by the National Heart, Lung, and Blood Institute (NHLBI). But the NHLBI did not publish the JNC 8 update. The institute announced on June 19, 2013, that it was getting out of the guideline writing business to concentrate on developing systematic evidentiary reviews, which scientific associations could then use to create their own guidelines. The NHLBI's decision left the JNC 8 panel members in limbo without a sponsoring agency, so they published independently in *JAMA*.

This independence by the JNC 8 panel members, however, appears to have come at a price. None of the major national scientific associations with a particular interest in hypertension—the American Heart Association (AHA), the American College of Cardiology (ACC), or the American Society of Hypertension (ASH)—has accepted all the JNC 8 recommendations. Indeed, on December 17, the day before the new guideline's release, the AHA and ACC announced that their Task Force on Practice Guidelines had begun the process of "developing the collaborative model to updating the national hypertension guidelines in partnership with the NHLBI, which will provide an updated systematic evidence review." The same day, ASH published an article titled "Clinical Practice Guidelines for the Management of Hypertension in the Community: A Statement by the American Society of Hypertension and the International Society of Hypertension" (Weber MA et al. *J Clin Hypertens*. doi: 10.1111/jch.12237 [published online December 17, 2013]).



Some cardiology groups are challenging a guideline that advises raising the hypertension treatment threshold from 140 mm Hg to 150 mm Hg systolic for individuals aged 60 years or older.

Then, on January 13, JNC 8 took a further hit with publication in the *Annals of Internal Medicine* of a commentary by 5 members of the original 18-member JNC 8 panel that criticized the majority's recommendation to change the treatment goal for individuals aged 60 years or older with hypertension. The new guideline sets goals for systolic and diastolic blood pressures at less than 150/90 mm Hg, a sizable increase from the JNC 7 goals of less than 140/90 mm Hg. (JNC 8 recommends keeping treatment goals to less than 140/90 mm Hg for younger adults.) Publication of the minority view led the AHA and ACC, later that day, to issue a statement saying the commentary raised concerns with the new recommendations for higher blood pressure goals in older individuals and that they will "recognize the most recent hypertension guidelines" published by JNC 7 as the national standard.

Suzanne Oparil, MD, JNC 8 cochair and a professor of medicine at the University of Alabama at Birmingham, expressed displeasure that the AHA and ACC issued its statement based on the minority commentary in the *Annals*. "It is very annoying that the AHA and college accept this paper in the *Annals*, which is not evidence based," Oparil said in an interview.

Lead author of the *Annals*' commentary and JNC 8 member Jackson T. Wright Jr, MD, PhD, director of the clinical hypertension program at University Hospitals Case Medical Center in Cleveland, said his group agreed with all the other recommendations in the JNC 8 report but felt the need to express disagreement over the change in treatment goals for older individuals. "We believe the recommendation is inconsistent with the evidence for using the dividing line of age 60," Wright said. "The evidence was clearly insufficient to raise the blood pressure target, and we believe we'd be putting patients at increased risk."

But Paul A. James, MD, JNC 8 cochair and professor of family medicine at the University of Iowa Carver College of Medicine in

Iowa City, said there was not robust evidence suggesting benefit to setting the lower target goal for older adults and that calls to do so rely more on expert opinion, which is something the NHLBI wants to move away from for making guideline recommendations. "When there was evidence, we'd hold that as the higher standard than our opinion, but not all members supported the recommendation based on the available evidence," James said. "For the first time for the NHLBI, this was to be an evidence-based panel, so it's not unusual that there wasn't consensus on every recommendation."

An interested bystander to the situation has been ASH. The society has been wanting to have a say in hypertension guideline creation but had appeared to remain sidelined until a verbal understanding was reached that it would assist in production of the AHA/ACC guideline. William B. White, MD, ASH president and professor of medicine at the University of Connecticut School of Medicine in Farmington, said JNC 8 on the whole was a "fine document," but that the proposed 2015 AHA/ACC guideline may be able to address more elements of hypertension than the JNC 8 authors were able to consider because of the space limitations associated with publication in a peer-reviewed journal. "JNC 8 is very nicely written and easy to follow, and the algorithm is very clear," White said. "I had some concerns about some issues, but it's hard to argue against [JNC 8] with the evidence base they used."

White also wanted to downplay the status of its December 17 article, the title of which suggested it might be a guideline as well. "It was originally a paper developed by the International Society of Hypertension for guidance for clinicians working in low-resource countries. It was not considered appropriate as a guideline for care in the United States and was not intended to be a competitive document to JNC 8," he explained.

So is the NHLBI pleased at the rollout of hypertension guidelines since its June announcement? Yes, said Michael Lauer, MD, the institute's director of the cardiovascular sciences division. "The publication of multiple hypertension guidelines demonstrates the need for increased evidence and reflects a legitimate scientific debate and helps us set our priorities for allocating resources for further study," he said. ■

Firearm-Related Hospitalizations: 20 US Children, Teens Daily

Mike Mitka, MSJ

Every day, an average of 20 children and adolescents in the United States sustain firearm-related injuries serious enough to warrant hospitalization, said researchers whose findings appeared in *Pediatrics*.

Researchers from Yale School of Medicine in New Haven, Connecticut, and Boston University School of Medicine in Boston estimated that in 2009, the latest year such data were available, 7391 children and adolescents younger than 20 years were hospitalized because of firearm-related injuries (Leventhal JM et al. Pediatrics. doi: 10.1542/peds.2013-1809 [published online January 27, 2014]). Although previous studies have focused on firearm-related deaths (3459 deaths in 2010 among children and adolescents younger than 21 years) and emergency department visits for firearm-related injuries (almost 21 000 visits among children and adolescents in 2011), the researchers said there has been little focus on hospitalizations for this type of trauma, which typically occurs when injuries are severe and costly to treat.

Lead author John M. Leventhal, MD, a professor of pediatrics at Yale, said his team's findings highlight the need to adhere to the American Academy of Pediatrics' recommendation that "the absence of guns from children's homes and communities is the most reliable and effective measure to prevent firearm-related injuries" in those populations.

The results of the study are based on statistics from the 2009 Kids' Inpatient Database. This source, which releases data every 3 years, is a nationally representative sample of discharge data related to children and adolescents treated at acute care hospitals. Hospitalizations were analyzed by age groups, sex, race, and insurance coverage. Types of injuries and causes—unintentional, suicide attempt, assault, or undetermined (could not distinguish whether the injury was accidental or purposeful)—were also tracked.

The study found the overall hospitalization rate was 8.87 per 100 000 individuals younger than 20 years; the rate was far greater for males (15.22 per 100 000) than for females (1.93 per 100 000). In addition, the hospitalization rate for black males was more than 10 times the rate for white males (44.77 per 100 000 vs 4.28 per 100 000, respectively).

Nearly half of the hospitalizations (49.6%) were covered by Medicaid; 25.3% were covered by private insurance, 16.6% were self-paid (uninsured), and 8.5% were covered by other types of insurance. The direct hospital cost for all hospitalizations was $147 million, with an average cost per hospitalization of $19 755.

As for causes, 61.7% of hospitalizations were due to assault (66.8% for adolescents aged 15-19 years), 29.1% to unintentional injury, 5.6% to undetermined causes, and 3.7% to suicide attempt. Unintentional injury was the most common cause of firearm-related hospitalization for all age groups except those aged 15 to 19 years. The most common types of injuries were open wounds (52.0% of the hospitalizations) and internal injuries of the thorax, abdomen, or pelvis (34.2%).

Of the 7391 children and adolescents hospitalized for firearm injures, 4545 (61.5%) underwent a major procedure in an operating room and 453 (6.1%) died. About 35% of children and adolescents hospitalized for a firearm injury during a suicide attempt died while only 5.0% presenting due to an assault injury died.

"These data highlight the toll of gun-related injuries that extends beyond high-profile cases and those children and adolescents who die before being hospitalized," Leventhal said in a release. "Pediatricians and other health care providers can play an important role in preventing these injuries through counseling about firearm safety, including safe storage." ■