Control of High Blood Pressure in Primary Health Care

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Despite the known benefits of lowering blood pressure (BP) in hypertensive patients, control of hypertension in all settings, including primary care, is still far from optimal. A crucial step in control of hypertension is the use of treatment guidelines by physicians, provided that convincing evidence is available to support their efficacy and effectiveness of these guidelines.

In this vein, Grandi et al have reported that BP control rate in a large sample of patients with essential hypertension who were attended by general practitioners (GPs) was only 33%, a figure consistent with that found in other primary care settings. More importantly, after training of GPs in hypertension guidelines, BP control had risen to 53% by 9 months later.

Other studies have assessed the effect of interventions that offered education to primary care providers on improving BP control in hypertensive subject. However, these studies were based on pharmacy and medical claims, were smaller in sample size, were limited to patients receiving antihypertensive medications, or did not follow the same individuals.

Unlike other previous studies, Grandi et al studied a large clinical sample of hypertensive patients directly recruited by their GPs during routine office visits and followed after physicians’ education. Other methodologic merits of this manuscript are the high participation rate of physicians and patients (about 90%), and the large sample size (5500 patients). In addition, the GPs consecutively enrolled known hypertensive patients. These characteristics are important because, in clinical research, a convenience sample can minimize volunteerism and other selection biases by consecutively selecting every accessible person who meets the entry criteria of the study.

The training intervention consisted of many educational activities, and their impact on BP outcome was the main observation of the study. Information on the training content is crucial for understanding reasons behind improvement of BP control after intervention. For example, the training of physicians emphasized the therapeutic relevance of lifestyle changes and reinforced the need of multiple drug therapy to reach the BP goal. In fact, during the follow-up period drug treatment was increased, and GPs paid greater attention to reinforcing healthier lifestyles, and subsequently BP control improved.

Several methodologic weaknesses were acknowledged by the authors. For example, there was the lack of a control group of GPs who were not exposed to the formal training on hypertension guidelines, and thus a causal relationship cannot be established with certainty between the training and the improvement of BP control. Finally, it is difficult to control for other factors that may have accounted for improvement in BP control over the follow-up period, and this should also be recognized as a limitation of the study.

Despite the study limitations, the results suggest that educational efforts targeting primary care physicians may influence the clinical outcomes of hypertension management.

References