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Editorial

Monotherapy still useful in a bunch of patients with arterial hypertension

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The maintenance of an adequate blood pressure (BP) control during the life-time in the general population still constitutes the most relevant challenge in the prevention of cardiovascular disease and new goals are considered in clinical practice [1,2]. This must be accompanied by the adequate management of the associated risk factors and comorbidities that so frequently accompany the elevation in BP. It is well established that the joint effect of genetic component and inadequate life-style underlie the progressive increase in BP. The new thresholds and goals described in the new American and European Guidelines BP levels [3,4] are actually widely considered in young and middle age men and women, not only in people at higher ages as was the case in the past. In theory, an adequate change in life-style, including principally a low salt intake, quit smoking, adequate alcohol intake, a decrease in body weight fundamentally due to a diminished visceral fat and the adequate performance of physical activity at least three times weekly can contribute to control elevated BP in the early stages of hypertension in the absence of the use of pharmacotherapy. However, compliance with adequate life-style requires time, personnel and as a consequence money and makes this possibility poorly efficacious in daily clinical practice forcing the need to use pills to control BP.

Actually the armamentarium disposable to treat pharmacologically arterial hypertension is sufficient and fortunately cheap (due to the transformation of most drugs and combinations into generic forms) and allows if adequately used the control with a maximum of three drugs in up to 90% of the hypertensive population [5]. Since the initiation of pharmacological therapy to lower BP, for decades monotherapy constituted the elective form to start treatment that was maintained frequently by an adequate up-titration of the drug. The following step had two possibilities, the first of which was to practice sequential monotherapy that if adequately performed, testing a second, a third or even a fourth drug, could contribute to control a relevant percentage of patients, as described by Morris Brown et al. using four different monotherapies (angiotensin-converting-enzyme inhibitor (A), beta-blocker (B), calcium-channel blocker (C), and diuretic (D)) ABCD design [6]. However, sequential monotherapy required as life style changes time, personnel (due to the number of visits required) and as a consequence money. For these reasons, the second step more amply used has been the use of combination therapy starting with two drugs and followed by up-titration of the two components. The need of triple therapy defined the existence of difficult to control hypertension [6] where adequate changes in the components could avoid the recognition of resistant hypertension in patients with an adequate compliance.1

The new Guidelines from US and Europe recommend the initial use of combination therapy in the great majority of the hypertensive population and leaving monotherapy for clinical situations that apparently could make us think that it represents a very minor percentage of patients. The reasons to act in this way depend on a better early control followed by a significant diminution of cardiovascular morbidity and mortality.

In this issue of the journal, Massimo Volpe et al. [6] perform an excellent review devoted to the actual use of initial monotherapy following the advice of recent Guidelines. Their conclusion is that the use of only one drug is still valid for quite a big bunch of hypertensive patients consisting mainly on subjects with BP in the high-normal range or grade 1 hypertension, young adults with estimated low cardiovascular risk, women during pregnancy or menopause, elderly patients aged >80 years or with frailty parameters following American and European Guidelines. The concept contained in this article is relevant because an early intervention in >20% of the hypertensive population with monotherapy could be able to control BP. This would save time and money while diminishing the side effects of combination therapy.

On the other hand, we cannot leave aside the fact that for primary care doctors who are in charge of initial pharmacotherapy in hypertensives, to abandon the routine used for decades consisting in using monotherapy in the first step of pharmacological intervention in hypertension requires time to get adapted. In this case, they must be insisted that it can be done but if in 4 to 6 weeks the control is not attained, the patient must be put on combination therapy to make sure that according to Guidelines in 3–4 months the patient attains the expected goal, or if needed being on the best tolerated doses of triple combination albeit control is not yet attained.

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In summary, in agreement with Massimo Volpe, monotherapy has still room to obtain the expected control of BP in arterial hypertension.

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