

DESPITE THE FACT THAT THERE IS CURRENTLY CLEAR HYPERTENSION TREATMENT STRATEGY, WHY DOES BP CONTROL RATES REMAIN POOR WORLDWIDE?

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Abstract

of disability and death. Despite the fact that the causes of hypertension have been studied at the molecular level and precise treatment strategies have been developed, the level of blood pressure control remains low worldwide. What could be the reason? This article is about that.

Keywords: Hypertension, blood pressure, Poor adherence, White-coat phenomenon, Marked brachial artery calcification, Clinician inertia, Lifestyle factors.

Introduction



Hypertension is defined as office SBP values ≥ 140 mmHg and/or diastolic BP (DBP) values ≥ 90 mmHg. Based on office BP, the global prevalence of hypertension was estimated to be 1.13 billion in 2015. The overall prevalence of hypertension in adults is around 30 – 45%, with a global age-standardized prevalence of 24 and 20% in men and women, respectively, in 2015. This high prevalence of hypertension is consistent across the world, irrespective of income status, i.e. in lower, middle, and higher income countries. Hypertension becomes progressively more common with advancing age, with a prevalence of $>60\%$ in people aged >60 years. As populations age, adopt more sedentary lifestyles, and increase their body weight, the prevalence of hypertension worldwide will continue to rise. It is estimated that the number of people with hypertension will increase by 15–20% by 2025, reaching close to 1.5 billion. Elevated BP was the leading global contributor to



premature death in 2015, accounting for almost 10 million deaths and over 200 million disability-adjusted life years. Importantly, despite advances in diagnosis and treatment over the past 30 years, the disability-adjusted life years attributable to hypertension have increased by 40% since 1990. SBP \geq 140 mmHg accounts for most of the mortality and disability burden (~70%), and the largest number of SBP-related deaths per year are due to ischaemic heart disease-4.9 million, haemorrhagic stroke-2.0 million, and ischaemic stroke-1.5 million.

Therefore, despite the specific treatment strategies of hypertension by cardiologists around the world, why is hypertension spreading, why is the level of blood pressure control low even in developed countries?

So, based on the conducted surveys and trials, we came to the following conclusions:

1) Poor adherence to prescribed medicines is a frequent cause of poor control of hypertension, occurring in $<$ 50% of patients assessed by therapeutic drug monitoring, and is directly related to the number of tablets prescribed. There are many reasons for this. For example, the financial side, many patients do not have enough money to buy antihypertensive drugs, or many elderly people with dementia forget to take their drugs on time. Or another common reason: instead of antihypertensive drugs, many patients try to use traditional medicine as best they know at home.

2) White-coat phenomenon(in which office BP is elevated but BP is controlled at ABPM or HBPM) is common in some patients, hence the recommendation to confirm office hypertension with ABPM or HBPM before confirming the diagnosis of poor hypertension. We must admit that many of our young doctors prescribe antihypertensive drugs to people who come to their office with high blood pressure for the first time. But in fact, when some people see doctors, the SAS is triggered and the blood pressure rises for a certain period of time. It is necessary to determine the risk factors in such people, observe them dynamically, and then have to conclude.

3) Poor office BP measurement technique, including the use of cuffs that are too small relative to the arm circumference, can result in a spurious elevation of BP. Using techniques that clearly do not work: Many patients have hypertensive disorders as well as atrial fibrillation. In such patients, due to arrhythmic contraction of the heart, erroneous results are often obtained when blood pressure is measured. Or in a lot of elderly people, due to atherosclerosis and calcification, blood vessel elasticity is lost, and blood pressure readings are taken incorrectly and treatment steps are also taken incorrectly.

4) Marked brachial artery calcification, especially in older patients with heavily calcified arteries, as mentioned above this is often not taken into account.

5) Clinician inertia, resulting in inadequate doses or irrational combinations of BP-lowering drug therapies. It is not a secret that some doctors can't control blood pressure due to laziness or lack of knowledge, giving unnecessary drugs or wrong dosage or wrong combination. Of course, such an approach to the work of doctors increases distrust among people and increases the incidence of hypertension.

So, we didn't talk about the risk factors that cause high blood pressure above, but we focused on why blood pressure control is low around the world.



Literatures:

- 1) Braunwald-HEART DISEASE,eleventh edition
- 2) A.G.Gadayev-INTERNAL DISEASES.2021
- 3) Medical News Today journals.
- 4) www.esc.org.

