Letters to the Editor

Withdrawing antihypertensives on the basis of orthostatic hypotension

SIR—The recent British Women’s Heart and Health Study regarding orthostatic hypotension (OH) and medications suggests that clinicians should be cautious in the context of older adults taking antihypertensives and that OH is a ‘major reason for withdrawal of antihypertensives’ [1]. The corresponding editorial queries whether our treating BP in the elderly can ‘result in OH that could be potentially detrimental’ and proposes a large study to determine the prevalence of OH.

We query these conclusions because the study actually found that the prevalence of OH in those taking and not taking antihypertensives was quite similar and that OH was not significantly associated with falls. Although an association with mortality was demonstrated, this is commonly attributed to co-existent hypertension and ageing rather than any causal relationship with OH itself.

The most notable findings in their study were the strong correlation between OH and hypertension itself, and that after subgroup analysis, thiazides, ACE inhibitors and calcium channel blockers were not associated with OH.

In practice, clinicians often withdraw antihypertensives on the basis of OH, on the assumption that it results in falls or syncope but there have been some excellent reviews challenging the association between antihypertensives and falls [2] and syncope [3], and a recent meta-analysis assessing the impact of medications on falls in almost 80,000 elderly found that the association between antihypertensives and falls was not highly significant [4]. We are not aware either of any evidence supporting the withdrawal of antihypertensives in the context of falls reduction or any other outcome benefit.

We agree with previous authors who reported that postural symptoms correlate much more strongly with falls than does OH. There is good evidence that elderly subjects with postural instability are more likely to have ischaemic lesions on neuroimaging and to have multiple vascular risk factors, so we would hypothesise that reducing antihypertensives in such patients could actually increase their risk of vascular ischaemia and, therefore, aggravate postural instability even further. We therefore do not feel that OH alone should be the basis for withdrawing antihypertensives and that reducing such treatment requires greater justification.

Conflict of interest

None declared.

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References


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Re: Withdrawing antihypertensives on the basis of orthostatic hypotension

SIR—We appreciated Dr MacMahon and colleagues’ letter commenting on our paper and the accompanying editorial [1]. We agree that there is no strong evidence on the effects on falls of withdrawing antihypertensive medication in people with postural symptoms or in those with asymptomatic orthostatic hypotension (OH). We did not conclude that OH alone should be a criterion for withdrawing antihypertensive treatment. Data from the British Women’s Heart & Health Study have shown that falls are more strongly associated with co-morbidity than with polypharmacy [2, 3]. We did show that OH was twice as prevalent in women with undiagnosed and uncontrolled high blood pressure. On the basis of the findings presented in our paper, we concluded that ‘uncontrolled hypertension, use of three or more antihypertensives and multiple co-morbidities are predictors of OH in older women. Detection or monitoring of OH in these groups may prevent women from suffering its adverse consequences’.

Conflict of interest

None declared.

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