A General Practitioner's Impression of the Problem of Hypertension

BY

M. I. HIRSCH, Que Que

Over the years many firm advices for the management of hypertension from the experts have fallen into disrepute or irrelevance after enjoying a period of fashion. When I qualified, importance was placed on the elimination of septic foci and many a patient lost his teeth in the process but remained with his hypertension. Purgation, venesection, hydrotherapy, physiotherapy, rest and avoidance of exercise, and fluid and salt restriction have had their run. Diuretics were favoured early on, and the principle has been reviewed in recent years. Later the emphasis on unilateral renal disease placed an onus on one to put a high percentage of cases through the whole gamut of investigation. Then preoccupation with pyelo-nephritis had a vogue. I recall the sympathectomy phase of Smithwick *et al* which availed the hypertensive little in the long term but much initial suffering. Most of the advices were backed by appropriate statistics as is the propaganda in the use of the ever increasing variety by and combination of anti-hypertensive and diuretic drugs in recent years.

Having listened to and read the learned injunctions with the corroborative evidence and subsequent rejection over the years (as has occurred in many other subjects in medicine and surgery) one can be forgiven becoming a little sceptical of the latest hypotensive drugs and for the feeling that these too will join the passing parade. Of more practical importance is the belief that the extent of current reliance on them, narrows one's management of cases with detrimental consequences as occurred with earlier procedures.

One has also noted over the years that the men in medicine's ivory towers have a different perspective of the problem than the general practitioner, their experience being confined largely to selected referred groups of patients and their concern focused on the latest postulates and treatment. The general practitioner's appreciation, especially in a small community,

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differs also because his follow-up of patients even if not statistical is continuous and real. He sees what happens to them and he sees his patient as a whole person in his whole environment.

On the basis of such experience and with these background thoughts I venture some observations and conclusions which may offer a somewhat different approach to that currently presented.

The classification of cases which reflect the general practitioner's outlook is the customery division of hypertension into primary and secondary categories but with the full appreciation that the latter constitute less than 5 per cent of the cases presenting. More important to the doctor of primary care is the division of the primary hypertensives into the temporary or reversible and the established or irreversible groups. The designation "essential" for primary hypertension is in my view a bad one because it tends to exclude the epidemiological aspects of the problem which the general practitioner appreciates but has failed to convey adequately to the academician. In my experience, and I'm confident in that of many G.P.'s, primary hypertension is a disease of gluttony and physical indolence. Overweight from indulgence, alcohol and excessive smoking associated with inadequate physical exercise are major factors in a large proportions of cases. One accepts that there is a genetic factor or factors involved, just as there are in other epidemiological metabolic diseases, e.g. diabetes, obesity and coronary artery disease. But that this is so does not detract from the importance of the provoking etiology. This aspect is given a minor place in the text book literature and symposia on the subject or are omitted. Even in the latest edition of Dunlop and Davidson's *Textbook of Therapeutics* alcohol receives no mention at all as a factor.

The tragedy of emphasis on investigation for primary causes in case the condition is a secondary manifestation of another disease and on drug treatment, is that the significance of the epidemological factors are in practice relegated to a minor place and disregarded. The specialist trend is to investigate for the rarity — he had to be certain; and for the G.P. to prescribe his latest drug fancy — it is easier and less time consuming when under pressure to write a script than to spend time assessing the life style of the patient, explaining the process and persuading him or her to change habits. In my view this is the aspect which should be the major concern of the general practitioner.

Experience has led me to the belief that in the majority of cases of primary hypertension encountered no drug therapy should be commenced until the effect on the blood pressure of return to normal weight, the elimination of alcohol and smoking and the implementation of an appropriate routine of exercise is noted. A high proportion of the reversible group will be found to return to normal levels by this routine alone and those which do not and in the less severe irreversible cases the lowest base will have been established from which the effect of artificial aids can be accurately assessed and the minimum dosages required assured. Neglect to adopt this routine gives false impressions to the doctor of the effects of drugs and to the patient of what his condition is all about and what is required of him to deal with it.

One hastens to record that this approach would obviously not apply to malignant hypertension or severe cases of these complicated by serious cardiovascular or renal pathology. There is also no question that the primary care physician must ever be conscious of the possibility that the case presenting may be a secondary manifestation and in the history-taking and clerical examination he should be on the look out for it, rare though these cases may be. The wiser his selection, the fewer cases will escape his attention and, as important in my view, the less number will be subjected to unnecessary investigation.

Next in importance is the impression gained in general practice that the shortcomings of antihypertensive agents are largely evaded, especially in commercial propaganda and which is not adequately countered in clinical expositions of the subject. Tolerance is a feature of all the drugs and, as with sympathectomy, the hypertension returns after a varying period. One has noticed too, that often when the blood pressure has risen again in spite of continuing the initially effective or even an augmented dose, withdrawal of the drug results in a significant, albeit temporary, drop in blood pressure. These observations are substantiated by the trend to vary the drugs used and the initial success of new rival preparations which in turn are replaced by others. Secondly, in the permanent primary hypertessives major reductions in blood pressure are often not practicable without causing discomfort and misery because of the damaged state of the arterial system, apart from the dangers of cerebral and coronary occulsion in the relative hypotensive state.

In the temporary category of primary hypertension one has learned to include the large group of hypertensive females at the menopause when I believe correction of the epideimological factors as well as oestrogen and thyroid deficiency gives more effective control than reliance on hypotensive agents which are often unnecessary. An appreciable number in this category return to normal sooner or later and one has seen cases with sustained high levels of blood pressure which have spontaneously resolved.

Much play has been made on the stress phenomena as a cause of primary hypertension. But it is interesting to note that hypertension is not a feature of cases of depression, anxiety and other psychoneurosis. And conversely the majority of hypertensives do not fall into these categories. Of all the pyschological reactions perhaps frustration alone may be a casual factor. One wonders too whether it is that the bad living habits, which are a feature of the rat race, are responsible rather than the psychological stress itself.

If these impressions are correct, one returns to the importance of correcting the sloppy habits of modern living and in the psychological sphere to spend time assisting the patient to overcome or avoid the frustrations arising from the circumstances in which he finds himself, rather than being satisfied with platitudious general advices of easing up in activity and involvement.

If I have overstated the case, I make no apology because I believe the points are relevant, important and neglected. I have provided no statistics to support the views held and while this may cause doubt on their validity, it represents the impressions gained over a long period of clinical experience of a subject in which the passage of time is an important yardstick. I have thus not been able to prove anything nor intended to, for nothing I have said is not already known or appreciated. My object has been to stimulate a re-thinking of the relative importance of different aspects of the subject which could alter the approach to management of hypertension especially in the general practitioners field.

From this I hope the association of practitioners will, with the aid of the academicians, embark on a statistical research project to reassess the epidemological aspects of the condition. As regards alcohol in particular, Rhodesia provides an excellent field for this research.