

## PREGUNTA 62

**Un hombre de 47 años sin antecedentes de interés, es diagnosticado de hipertensión arterial hace un año. Sigue en tratamiento con amlodipino 10mg (1-0-0) y losartan/hidroclorotiazida 100/25 mg (1-0-0), y realiza dieta hiposódica, con buena adherencia. A pesar de ello tiene cifras de PA 168/92 mmHg. ¿Cuál es el siguiente paso a realizar?**

1. Añadir un cuarto fármaco.
2. Incrementar la dosis de alguno de los que está tomando.
3. Realizar una monitorización ambulatoria de la presión arterial (MAPA).
4. Realizar un estudio para descartar hipertensión arterial secundaria.

Se nos expone sin lugar a dudas un paciente con hipertensión arterial resistente o refractaria, ya que no está controlada a pesar de estar en tratamiento con 3 fármacos, de los cuáles uno es un diurético (hidroclorotiazida). El paciente sigue las medidas generales (dieta hiposódica), es buen cumplidor, y las dosis de los fármacos son plenas según las recomendaciones en ficha técnica (opción 2 falsa).

Ante esta situación es evidente que está indicado descartar una causa secundaria de HTA, más si cabe en un sujeto de 47 años. Consideramos que por la redacción de la pregunta, y por preguntas previas en el MIR, el objetivo de la pregunta era darse cuenta de que a TODO paciente con HTA resistente se le debe realizar un “screening” de causa secundaria.

Sin embargo, la pregunta en sí, especifica claramente “el siguiente paso” a realizar en el algoritmo diagnóstico del paciente con HTA resistente. Realizar un MAPA para confirmar que de hecho se trata de una HTA resistente, o hacer todo a la vez, o incluso añadir un cuarto fármaco (sobre todo la espironolactona) para optimizar el control, son opciones que probablemente sea complejo priorizar o poner a distintos niveles.

### Bibliografía:

Posicionamiento científico de la American Heart Association sobre HTA resistente. Circulation. 2008 Jun 24;117(25):e510-26

## Diabetes

Diabetes and hypertension are commonly associated, particularly in patients with difficult-to-control hypertension. In ALLHAT, diabetes predicted lack of blood pressure control during the course of the study.<sup>5</sup> Clinical trials have indicated that in order to achieve the lower blood pressure goal recommended for patients with diabetes, an average range of 2.8 to 4.2 antihypertensive medications will be needed.<sup>94</sup> The degree to which insulin resistance directly contributes to the development of hypertension versus simply being associated with hypertension because of common underlying causes has not been determined. Pathophysiologic effects attributed to insulin resistance that may contribute to worsening hypertension include increased sympathetic nervous activity, vascular smooth muscle cell proliferation, and increased sodium retention.

## Evaluation

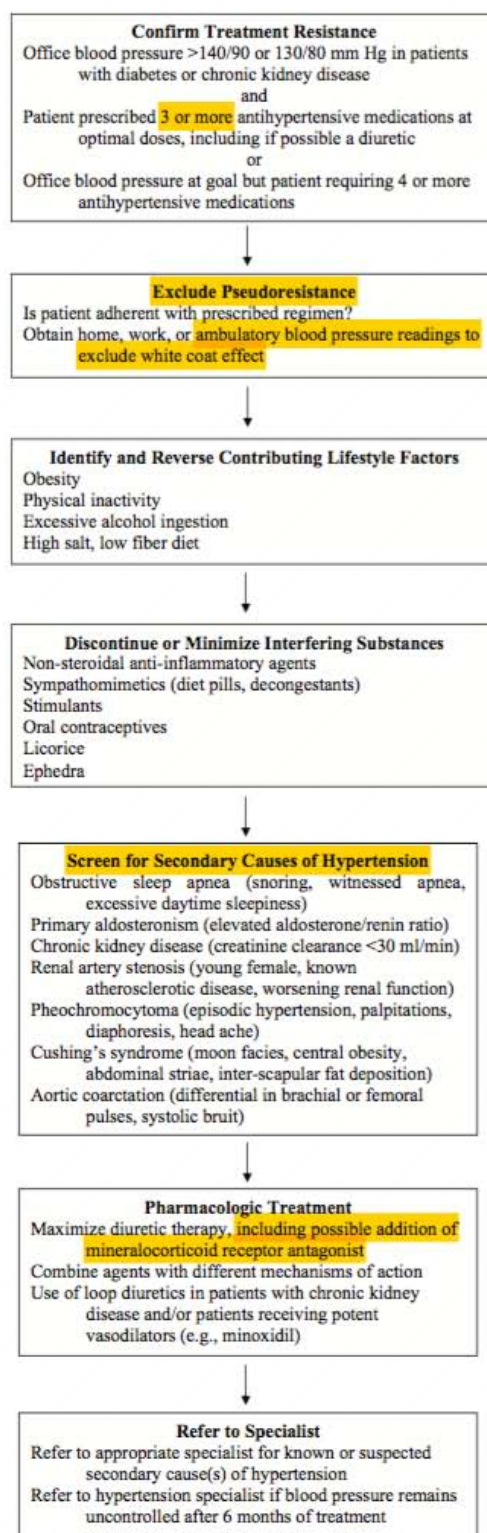
The evaluation of patients with resistant hypertension should be directed toward confirming true treatment resistance; identification of causes contributing to treatment resistance, including secondary causes of hypertension; and documentation of target-organ damage (Figure). Accurate assessment of treatment adherence and use of good blood pressure measurement technique is required to exclude pseudoresistance. In most cases, treatment resistance is multifactorial in etiology with obesity, excessive dietary sodium intake, obstructive sleep apnea, and CKD being particularly common factors. Target-organ damage such as retinopathy, CKD, and LVH supports a diagnosis of poorly controlled hypertension and in the case of CKD will influence treatment in terms of classes of agents selected as well as establishing a blood pressure goal of <130/80 mm Hg.<sup>95</sup>

## Medical History

The medical history should document duration, severity, and progression of the hypertension; treatment adherence; response to prior medications, including adverse events; current medication use, including herbal and over-the-counter medications; and symptoms of possible secondary causes of hypertension. Daytime sleepiness, loud snoring, and witnessed apnea are suspicious for sleep apnea. A history of peripheral or coronary atherosclerotic disease increases the likelihood of renal artery stenosis. Labile hypertension, in association with palpitations and/or diaphoresis, suggests the possibility of pheochromocytoma.

## Assessment of Adherence

Ultimately, adherence in a clinical setting can only be known by patient self-report. Patients should be specifically asked, in a nonjudgmental fashion, how successful they are in taking all of their prescribed doses, including discussion of adverse effects, out-of-pocket costs, and dosing inconvenience, all of which can limit adherence. Family members will often provide more objective assessments of a patient's adherence, but such input should generally be solicited in the presence of the patient.



**Figure.** Resistant hypertension: diagnostic and treatment recommendations.