Clinical Interventions in Aging

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LETTER

Appropriate blood pressure for the "old-old" (85 years and older)

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Dear editor

Treating hypertension in patients over the age of 85 years, ie, the "old-old", presents a challenge that is different from that encountered when treating any other age group. In 2010, individuals aged over 85 years were estimated to comprise 1.85% of the US population, with an estimate of 2.03% projected for 2025.[1] Clearly, this is a small percentage, but not an insignificant number. When treating hypertension in patients over the age of 85 years, the usual target blood pressure is 150/80 mmHg for reduction of the risk of stroke, heart attack, and other cardiovascular events.[2] In medical practice today, blood pressure is measured by a nurse or health worker using an automated blood pressure device, but not after a short rest, sitting or standing (as recommended to measure orthostatic hypotension, particularly if the patient is on treatment with antihypertensive medications). I will continue to emphasize orthostatic hypotension, since during sleep, the elderly – either under medication treatment, or not – frequently get out of bed during the night to urinate, which is associated with the usual drop in blood pressure during sleep.

Primary care physicians, nurse practitioners, and others caring for the elderly must recalibrate which target and which range to use to treat this group of patients.[3] My feeling is "less is more" in this group of patients. Perhaps one might consider the mantra of the legendary coach of the Green Bay Packers, ie, "When you throw a foot ball, three things could happen, and two are bad". This is not a bad maxim when writing a prescription.

Moving on to consideration of the specifics of this letter, I will present evidence for "less is more" in order to prevent the serious complications of hypertension in the elderly and other age groups. In a recent issue of the *Philadelphia Inquirer*, two distinguished physicians (RT Townsend, Hypertension Program, Hospital University Penn Program, and Muriel L Jessup, Penn Heart and Vascular Center) recommended treatment for people older than 60 years, those with a systolic blood pressure of 150 mmHg, those with diabetes or kidney disease, and those with a blood pressure greater than 140/90 mmHg.

In a recent issue of *JAMA*, a paper entitled "Updated guidelines for the management of high blood pressure"[4] states that hypertension is a major risk factor for cardiovascular disease and stroke, but approximately 50% are not adequately controlled. In the US, the strong beliefs of patients, physicians, and pharmaceutical companies make the production of guidelines for managing hypertension a progressively more difficult and controversial process.[4] Further, it has been commented that current performance measures for blood pressure control modeled after the Joint National Committee guidelines

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indicate that a clinician is expected to lower blood pressure in a hypertensive patient to <140/90 mmHg (or at least treat with 2–3 antihypertensive medications).[4] A potential unintended consequence of this target is that it could encourage physicians to become more aggressive in their management of older patients, simply to meet a specific metric.

I am in no way suggesting collusion to increase the use of medication to treat hypertension in the elderly. A recent essay entitled "Big Pharma–Big Fines/Bigger Profits" indicates that the American Hospital Association spends lots of money to lobby pharmaceutical companies.[5]

My final point is that a study from the University of Leiden in the Netherlands has reported that a systolic blood pressure of 180 mmHg is associated with resilience to physical and cognitive decline in patients with pre-existing disability.[6]

Disclosure

The author reports no conflicts of interest relevant to this communication.

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