

Medicine — is this what we practise?

Gerald Lapinsky

Do you not think it is time we stopped allowing drug companies and other financially involved institutions from taking over the practice of honest medicine? When last did a patient leave your rooms without a prescription? It is no wonder that so-called 'alternative' medicine is taking hold in this and other countries.

Take the diagnosis and treatment of hypertension. There is surely no better field for pharmaceuticals, as the client is

committed to lifelong treatment. In the early 1950s there was no medical treatment for hypertension and many people underwent sympathectomies and/or undertook the rice diet, with no salt whatever. Then came the thiazide diuretics which changed the whole practice of medicine. We no longer gave injections of Mersalyl and no longer had to slash grossly oedematous feet to get the water out. This was a really major advance. Since then many other drugs have been developed to add to the diuretics in the control of blood pressure. Some were very effective and still are today. We have now added the angiotensin-converting enzyme (ACE) inhibitors and their parent blockers and the calcium antagonists (which were available from the 1960s but were not used for this purpose).

For the pharmaceutical industry this meant sales to 25% of the population. How could they increase sales with better marketing? Articles in the early 1980s told us that treatment for

Gerald Lapinsky is a former general practitioner, physician and cardiologist, who since retirement over 10 years ago has been heavily involved in the insurance industry, where he can view the work and results of his colleagues. Although some work is excellent, others put the medical fraternity to shame with horrendous reports.



hypertension had greatly diminished the stroke rate and the renal failure rate, but had done little for the incidence of myocardial infarction. By the way, textbooks of the 1940s did not consider hypertension a cause of infarction. So the guys said that beta-blockers and thiazides did not help as they allowed cholesterol to rise. Enter a whole new range of antihypertensives. These were much more expensive than beta-blockers and thiazides and did not include ACE inhibitors, which were still to come and to prove effective. Whoopee for the pharmaceuticals!

This brought about a whole new range of trials, with wonderful eponyms. If you care to look at journals of the 1960s you will see a few trials where the placebo did better than the drug in question, double-blind trials where the doctor had decided mentally that the placebo was the drug, and transferred this belief (unwittingly) to the patient, thus bringing about a better result. When last did you see a trial reporting failure of a drug? So these exceptionally gloriously titled trials, that burst on the scene regularly, heavily backed by pharmacies, and written by doctors who have been forced to admit personal interest in these firms, are to be our guidelines to enable the elderly to be punished. It may be true that the aged can get a few years added to their lives, but they will be heavily penalised for 35 years (from age 55) by expensive and side-effect-producing drugs, making that little extra life almost unbearable, while providing us and the pharmacies with a good living . . .

How can the pharmaceutical industry increase its profits when it already has 25% of the available market? Add the old people! The SHEP study proved that systolic blood pressure was the problem in the elderly, and one could now add them to the list. We followed like SHEEP! But this was not enough. Let us define the term 'elderly' as people over 55 — that is you, not me, as I am really elderly. The summary of their report is that we all need to be on treatment as even among those with a normal blood pressure at age 55, 90% will become hypertensive.

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure provides a new guideline for hypertension prevention and management. The following are the key messages.

1. In persons older than 50 years, systolic blood pressure (BP) of more than 140 mmHg is a much more important cardiovascular disease (CVD) risk factor than diastolic BP.

2. The risk of CVD, beginning at 115/75 mmHg, doubles with each increment of 20/10 mmHg; individuals who are normotensive at 55 years of age have a 90% lifetime risk for developing hypertension.

3. Individuals with a systolic BP of 120 - 139 mmHg or a diastolic BP of 80 - 89 mmHg should be considered prehypertensive and require health-promoting lifestyle modifications to prevent CVD.

4. Thiazide-type diuretics should be used in drug treatment for most patients with uncomplicated hypertension, either alone or combined with drugs from other classes. Certain high-risk conditions are compelling indications for the initial use of other antihypertensive drug classes (ACE inhibitors, angiotensin-receptor blockers, (beta)-blockers, calcium channel blockers).

5. Most patients with hypertension will require two or more antihypertensive medications to achieve goal BP (< 140/90 mmHg, or < 130/80 mmHg for patients with diabetes or chronic kidney disease).

6. If BP is more than 20/10 mmHg above goal BP, consideration should be given to initiating therapy with two agents, one of which is usually a thiazide-type diuretic.

7. The most effective therapy prescribed by the most careful clinician will control hypertension only if patients are motivated. Motivation improves when patients have positive experiences with and trust in the clinician. Empathy builds trust and is a potent motivator. Finally, in presenting these guidelines, the committee recognises that the responsible physician's judgment remains paramount.

Whoopee for the pharmacies! This is even better advertising than the Scots came up with some hundred years ago when they claimed that whisky is good for you! This has not been sucked from my thumb, but can be confirmed by the latest *JAMA* available free on the Net. Some of you, registered on Medscape, may be able to get through to this site (<http://www.medscape.com/viewarticle/455849>).