Addressing the Guidelines

To the Editor:

We commend you on the publication of these timely guidelines.1 Increasingly, those who are involved in the care of stroke patients are heightening their focus toward prevention strategies because there are many modifiable risk factors we can tackle. There are, however, a few areas in the guidelines we would like to address.

First, in the hypertension segment, the recommendation states “Because this benefit (of antihypertensive treatment) extends to persons with and without a history of hypertension, this recommendation should be considered for all ischemic stroke and TIA patients.” This recommendation is based on Class IIa, Level B evidence, presumably the PROGRESS study.2 However, an important consideration is the definition of hypertension that was used in the PROGRESS study. As stated within the text of the guidelines, patients were classified as hypertensive if their baseline blood pressure was >160 mm Hg systolic or 90 mm Hg diastolic. The mean baseline blood pressure in the nonhypertensive group was 139/79, which according to the JNC VII, is considered prehypertension.3 The JNC VII thereby recommends that patients who have had a stroke and maintain blood pressures above 120/80 should be considered for antihypertensive therapy, and references the PROGRESS study for this recommendation. However, the 2006 stroke guidelines advocate antihypertensive therapy in patients “without a history of hypertension,” which could be erroneously interpreted as applying to patients with normal blood pressure (ie, <120/80) and is not supported by the current evidence. Perhaps the authors did not intend to suggest this; however, the busy clinician scanning the recommendation sections and not closely reviewing the text may be led to believe otherwise.

Second, recommendations in the diabetes segment state “ACEIs and ARBs are more effective in reducing the progression of renal disease and are recommended as first-choice medications for patients with DM”. The supporting reference for this recommendation is the 2004 ADA guidelines, the text of which actually states “Because many studies demonstrate the benefits of ACE inhibitors on multiple adverse outcomes in patients with diabetes, the established practice of choosing an ACE inhibitor as the first-line agent (for the management of hypertension) in most patients with diabetes is reasonable.”4 The ADA guidelines later summarize “All patients with diabetes and hypertension should be treated with a regimen that includes either an ACE inhibitor or ARB”; however, this is appropriately given a Level E class of evidence (ie, expert opinion). The results of the ALLHAT study, which demonstrated equivalent macrovascular protection and prevention of end stage renal disease in diabetic patients in the thiazide, ACEI and CCB subgroups support the use of any of these classes in the hypertensive diabetic patient.5,6 In fact, the “renal protective” effects of ACEIs and ARBs independent of their blood pressure-lowering activities have been called into question in a recent meta-analysis.7 When considering that thiazides cost pennies a day, and ACEIs/ARBs considerably more, it is unclear why clinical practice guidelines continue to use consensus level recommendations to encourage ACEI/ARB use first-line. A more appropriate emphasis would be on ensuring target blood pressures are met.

Finally, it is imperative that guidelines produced by national bodies such as the American Stroke Association remain unbiased toward any manufacturer of any drug, therapeutic or diagnostic product. Despite the fact that several versions of the drug warfarin are available on both the American and Canadian markets, we identified the word “Coumadin” several times within the text of the document. Considering the much more cumbersome “extended-release dipyridamole” was consistently used over the branded name of this product (we cannot however commend you on using the term “aspirin”, which is also a brand name), we can only assume that the use of the brand name version of warfarin was an unintentional editing error. We trust that it will be corrected for future updates or revisions to these guidelines.

Disclosures

None.

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