



Ambulatory Blood Pressure Monitoring: A Major Paradox amidst Newest Hypertension Guidelines

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Editorials

The American College of Cardiology and American Heart Association writing committee recently addressed the prevention, detection, evaluation, and management of high blood pressure in adults, with major updates to prior Joint National Commission (JNC) reports. The new guidelines, under a class I-A recommendation, place an increased emphasis on the use of out-of-office and self-monitoring of blood pressure, i.e., Home Blood Pressure Monitoring (HBPM) and Ambulatory Blood Pressure Monitoring (ABPM) to confirm the diagnosis of hypertension and for titration of blood pressure medication.

It's not an overstatement to say that ABPM alongside HBPM, were rightly given special emphasis in the management of both White Coat Hypertension and Masked Hypertension (a class IIA-B-NR recommendation is for screening white coat hypertension when the clinic blood pressure is in the hypertensive range but less than 160/100 mmHg, and for screening masked hypertension when the clinic blood pressure is elevated in the 120 mmHg to 129 mmHg SBP or 75 to 79 for DBP range). Furthermore, in adults with white coat hypertension, periodic monitoring with either ABPM or HBPM is recommended to detect transition to sustained hypertension, most often in the presence of elevated 10-year ASCVD risk and advanced age. With regards to masked hypertension, a class IIB-C-EO recommendation has it that, further screening for masked uncontrolled hypertension with ABPM may be reasonable especially in the presence of target organ damage or increased overall ASCVD risk (30 percent of diabetics have increased levels of masked hypertension and masked uncontrolled hypertension).

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In the United States, insurance may (and more importantly MAY NOT!) pay for an Ambulatory Blood Pressure Monitoring (ABPM) device in the management of white coat hypertension. To be eligible, you cannot have evidence of end-organ damage. In addition, we have rigorous requirements that you must have had blood pressure readings >140 mm Hg/90mm Hg on at least three doctor's office visits and at least two out-of-office instances that were documented. To make matters worse, ABPM, despite being a "gold standard" for detecting masked naïve and/or masked uncontrolled hypertension, is unavailable as a covered insurance benefit and is excessively costly.

Where as we struggle to get ABPM for our hypertensive patients in the United States, The National Institute for Health and Care Excellence (NICE) recommends ABPM for all patients suspected of hypertension. In fact, according to NICE quality standards, the use of ABPM for the diagnosis of hypertension need to be widened and encouraged (offering pharmacist-led ABPM services in community pharmacies and primary care).

While the United Kingdom, Europe and the rest of the world has been cultivating the evidence-based best practices when it comes to the appropriate utilization of ABPM in the management of hypertension, at best or at last, we have come up with at least the right guidelines. It remains to be seen how the recommendations can be adhered to by the physicians, when barriers to coverage of ABPM are here to stay.