

Hypertension in African Americans Aged 60 to 79 Years: Statement From the International Society of Hypertension in Blacks

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A 2014 hypertension guideline raised goal systolic blood pressure (SBP) from <140 mm Hg to <150 mm Hg for adults 60 years and older without diabetes mellitus (DM) or chronic kidney disease (CKD). The authors aimed to define the status of hypertension in black adults 60 to 79 years from the National Health and Nutrition Examination Survey 2005–2012 and provide practical guidance. Black patients were more often aware and treated ($P \leq .005$) for hypertension than whites and had higher rates of DM/CKD ($P < .001$), similar control to <140/<90 mm Hg with DM/CKD ($P = .59$), and lower control without DM/CKD (<140/<90 mm Hg and <150/<90 mm Hg, $P \leq .01$).

Limited awareness (<30%) and infrequent health care (>30% 0–1 health-care visits per year) occurred in untreated black and white hypertensive patients without DM/CKD and BP ≥ 140 / <90 mm Hg. The literature suggests benefits of treated SBP <140 mm Hg in adults 60 to 79 years without DM/CKD. The International Society of Hypertension in Blacks recommends: (1) continuing efforts to achieve BP <140/<90 mm Hg in those with DM/CK, and (2) identifying hypertensive patients without DM/CKD and BP ≥ 140 / <90 mm Hg and treat to an SBP <140 mm Hg in black adults 60–79 years. *J Clin Hypertens (Greenwich)*. 2015;17:252–259. © 2015 Wiley Periodicals, Inc.

For nearly 30 years, the International Society of Hypertension in Blacks (ISHIB) has provided leadership to mitigate the very high risk of hypertension-related morbidity and mortality in black people of African descent.¹ Specifically, ISHIB has promoted greater recognition, treatment, and control of hypertension and concomitant cardiovascular risk factors in blacks.^{2–4}

Hypertension is a growing global problem.⁵ Yet, the greatest adverse consequences of hypertension, particularly stroke, heart failure, and end-stage renal disease, occur in black individuals of African descent.^{1–4} In the United States, black-white stroke disparities extend to prehypertension.⁶ Several factors likely contribute to greater population attributable risk of hypertension in blacks including: (1) higher prevalence of hypertension,^{1–4} partially reflecting accelerated transition from prehypertension to hypertension⁷; (2) greater prevalence of stage 2 hypertension blood pressure (BP) ≥ 160 / ≥ 100 mm Hg^{1–4,8}; (3) lower rates of hypertension control^{1–4}; and (4) higher prevalence of comorbid conditions, which amplify cardiovascular and renal risk such as obesity, diabetes mellitus (DM), and albuminuria.³

Greater attention to hypertension treatment and control in the Hypertension Detection and Follow-Up

Program (HDFP) reduced black-white disparities in stroke and total mortality.^{9,10} Secular trends with improving treatment and control of hypertension and hypercholesterolemia have likely contributed to absolute reductions in black-white cardiovascular disparities, although relative disparities persist.^{1,11,12} Progress in reducing incident stroke is linked to better hypertension control and reductions in population BP.^{11,13}

Many ISHIB members expressed major concerns with the 2014 self-authorized hypertension guidelines from the 2014 Hypertension Guideline strongly recommending that antihypertensive pharmacotherapy among adults 60 years and older in the general population (without diabetes or chronic kidney disease [CKD]) commence at SBP ≥ 150 mm Hg with a treatment goal <150 mm Hg (strong recommendation—Grade A).¹⁴ The corollary recommendation for the general population 60 years and older without diabetes or CKD stated that if pharmacotherapy lowers SBP to <140 mm Hg and is well tolerated, further treatment adjustments are not required (expert opinion—Grade E).

ISHIB trustees were unanimous in their concerns with the 2014 guidelines for three reasons. First, each trustee had observed that recommendations to initiate treatment among adults 60 years and older with diabetes or CKD with SBP ≥ 140 mm Hg and to treat to <140 mm Hg were being overlooked with errant focus on goal BP <150/<90 mm Hg for all adults 60 years and older. Second, the expert opinion statement to continue current treatment in adults 60 years and older who were doing well with SBP <140 mm Hg

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was being ignored and antihypertensive therapy was being reduced for some older patients with well-controlled BP. Third, expert opinion recommendations for treating adults younger than 60 years with SBP ≥ 140 mm Hg to a goal of < 140 mm Hg should have extended to adults 60 years and older. Studies supporting the expert opinion recommendation to treat adults younger than 60 years with SBP ≥ 140 mm Hg to a target < 140 mm Hg also included adults 60 years and older.¹⁴

ISHIB trustees agreed it was important to provide clear guidance for primary care clinicians who manage most older non-Hispanic black adults with hypertension. Since clinical trial data on adults ≥ 80 years outside Hypertension in the Very Elderly Trial (HYVET) are limited, our comments focus on black adults 60 to 79 years old.

ISHIB trustees relied on three sources of information: (1) characteristics of non-Hispanic black and white hypertensive adults aged 60 to 79 years without diabetes or CKD and BP $\geq 140/ < 90$ mm Hg in NHANES 2005–2012, ie, the group most affected by strong recommendations to begin antihypertensive therapy at an SBP of ≥ 150 mm Hg and treat to < 150 mm Hg; (2) achieved SBP and outcomes in completed trials that included adults aged 60 to 79 years; and (3) various hypertension guideline statements on BP goals in adults at various ages.

DEFINING THE STATUS OF HYPERTENSION IN AFRICAN AMERICANS AGED 60 TO 79 YEARS

Data on self-identified non-Hispanic black and white adults aged 60 to 79 years in the National Health and Nutrition Examination Survey (NHANES) 2005–2012 were examined as described.^{15,16} *Traditional hypertension* was defined by SBP ≥ 140 mm Hg and/or diastolic BP (DBP) ≥ 90 mm Hg and/or positive response to “Are you currently taking medication to lower your BP?” *Untreated, twice-told hypertension* was defined by untreated individuals with a BP $< 140/ < 90$ mm Hg who reported a physician told them twice that they had hypertension.^{17,18}

Hypertension control was defined as a BP $< 140/ < 90$ mm Hg for adults with diabetes and/or CKD. Hypertension control was assessed at both $< 140/ < 90$ mm Hg and $< 150/ < 90$ mm Hg for adults 60 to 79 years without diabetes and/or CKD.^{14,16} *Diabetes mellitus* was defined by individuals reportedly being informed by a physician that they had diabetes, according to fasting glucose ≥ 126 mg/dL or glycosylated hemoglobin $\geq 6.5\%$.¹⁹ *Cardiovascular disease* was defined as a composite of coronary heart disease (CHD), stroke, and congestive heart failure.^{20,21} CKD was defined by an estimated glomerular filtration rate (eGFR) < 60 mL/1.73 m²/min and/or a urine albumin creatinine ratio ≥ 300 mg/g,²² ie, values previously used to define a systolic blood pressure goal < 130 mm Hg. Serum creatinine values were adjusted to facilitate comparisons of eGFR across surveys.²³

Medical visits were defined by responses to “How many times did you receive health care over the last year?” Responses were classified into < 2 vs ≥ 2 visits per year. *Uninsured status* was defined by a negative answer to “Are you covered by health insurance or some other kind of health-care plan?” *Cigarette smoker* was defined if a patient answered “every day” or “some days” to “Do you now smoke cigarettes?” *Atherosclerotic (AS) CVD 10-year risk scores* were calculated for black and white adults 60 to 79 years who were free of clinical CVD.²⁴

Data Analysis

SAS survey procedures (SAS Institute Inc, Cary, NC) were used to account for NHANES complex survey design. PROC SURVEYMEANS was used to generate means and standard errors. PROC SURVEYFREQ was used to calculate proportions and standard errors. PROC SURVEYLOGISTIC was used to assess relationships between clinical variables and untreated and uncontrolled hypertension. Taylor linearization was used for variance estimation and domain analysis was used for subpopulation analysis, since selection of subpopulations may be unrelated to sample design. For within-survey between-group comparisons, Rao-Scott chi-square test was used to test for differences in categorical variables. The Wald *F* test was used to assess differences in continuous variables. *P* values $\leq .05$ were considered statistically significant.

SURVEY OF THE RELEVANT LITERATURE

Several hypertension trials relevant to SBP targets in older adults were reviewed.^{13,14,25–35} Several guideline statements referenced in the 2014 Hypertension Guidelines and the American Heart Association/American College of Cardiology and the American Society of Hypertension/International Society of Hypertension statements were reviewed.^{3,14,36–40}

KEY OBSERVATIONS IN OLDER BLACK AND WHITE ADULTS WITH HYPERTENSION

Among adults 60 to 79 years with hypertension, blacks had a smaller proportion of men, fewer lean and more obese patients, and were more likely to be uninsured than whites (Table I). Blacks had higher SBP values, were more likely to be aware of and treated for hypertension, were more likely to have diabetes and smoke cigarettes, and had higher 10-year atherosclerotic cardiovascular disease risk than whites. The two groups did not differ by age, frequency of health-care visits, DBP, BP control to $< 140/ < 90$ mm Hg (all hypertensives), treatment for hypercholesterolemia, CKD, or cardiovascular disease.

When BP control was defined as $< 140/ < 90$ mm Hg for patients with diabetes and/or CKD and $< 150/ < 90$ mm Hg in adults without diabetes and/or CKD, whites were more likely than blacks to meet target values. Black and white adults had similar proportions with hypertension when traditionally defined as on treatment and/or SBP

≥140 mm Hg and/or DBP ≥90 mm Hg and when defined as twice told of hypertension but untreated with nonhypertensive BP on examination. SBP was higher in blacks than whites treated for hypertension, and DBP was not different. In adults with controlled BP, SBP and DBP were similar in the two race groups.

Table I provides comparisons of black and white adults 60 to 79 years without diabetes or CKD who had BP ≥140/<90 mm Hg. Among all black adults 60 to 79 years with hypertension, 16.0% were in this group vs 21.6% of white adults. In those on treatment, blacks had higher SBP than whites. In the untreated group, blacks were more likely to be aware of hypertension than whites, although the majority of both groups was unaware.

Figure 1 shows hypertension control in four groups of black and white adults 60 to 79 years. Hypertension control did not differ between blacks and whites when all hypertensive adults (53.5% vs 56.5%, *P*=.15) or only those with diabetes and/or CKD were examined (56.6% vs 58.3%, *P*=.59). Black adults without diabetes and/or CKD were less likely than their white counterparts to have hypertension controlled to <140/<90 mm Hg (48.9% vs 55.6%, *P*=.01) and to <150/<90 mm Hg (66.9% vs 75.3%, *P*=.002).

Figure 2 depicts multivariable odds ratios (ORs) and 95% confidence intervals (CIs) for various clinical predictors of uncontrolled hypertension. Data are provided for all adults 60 to 79 years with hypertension, only those with diabetes and/or CKD and only those

Group	Black	White	<i>P</i> Value
NHANES, No.	1038	1719	
US population, No.	3,115,288	20,574,110	
er, % ^a	11.6±1.1	76.4±1.7	
Age, y	68.0±0.2	68.4±0.1	.07
Male sex, %	40.0±1.6	46.5±1.1	.001
BMI, kg/m ²	31.3±0.2	30.1±0.2	<.001
BMI, kg/m ²			
<25, %	18.3±1.2	19.7±1.3	<.001
≥30, %	53.3±1.8	44.8±1.3	
Visits per y, % <2	12.0±1.3	14.4±1.1	.14
≥2	88.0±1.3	85.6±1.1	
Uninsured, %	7.3±1.0	3.7±0.5	<.001
Hypertension variables			
tHT, %	97.3±0.5	97.0±0.6	.65
ntHT, %	2.7±0.5	3.0±0.6	.65
SBP, mm Hg (all)	138.4±0.8	135.1±0.6	.001
DBP, mm Hg (all)	70.1±0.7	69.1±0.5	.16
Aware, %	90.2±1.0	84.7±1.0	<.001
Taking BP medication, %	83.0±1.2	78.2±1.1	.005
SBP, mm Hg (on Rx)	136.0±0.8	131.5±0.5	<.001
DBP, mm Hg (on Rx)	69.0±0.7	67.5±0.5	.07
Controlled <140/90, %	53.5±1.8	56.5±1.3	.15
SBP, mm Hg (controlled)	122.9±0.5	121.9±0.4	.10
DBP, mm Hg (controlled)	65.8±0.6	65.0±0.5	.27
Controlled <150/<90, % ^b	61.1±1.7	68.5±1.3	<.001
Other CVD risk factor data			
Non-HDL, mg/dL, %	135.5±1.5	141.8±1.1	.002
Cholesterol medication, %	41.3±1.5	44.4±1.3	.13
Smoker, %	18.5±1.6	11.1±0.9	<.001
DM, %	47.0±1.7	27.7±1.4	<.001
CKD, %	22.1±1.5	20.7±1.0	.42
DM and/or CKD, %	56.4±1.9	40.0±1.2	<.001
CVD, %	29.2±1.5	26.0±1.5	.08
ASCVD _{10 y} , %	23.9±0.7	21.1±0.4	<.001

Abbreviations: ASCVD_{10 y}, estimated 10-year risk for atherosclerotic cardiovascular disease; BMI, body mass index; CKD, chronic kidney disease; CVD, cardiovascular disease; DBP, diastolic blood pressure; HDL, high-density lipoprotein; NHANES, National Health and Nutrition Examination Survey; Rx, medication; SBP, systolic blood pressure. Data are presented as mean and standard error. ^aPercentage of all adults 60 to 79 years by race group with hypertension defined as taking treatment and blood pressure (BP) ≥140/≥90 mm Hg (tHT) or twice-told untreated adults with BP on examination <140/<90 mm Hg (nHT). ^bPercentage of all adults 60 to 79 years by race group with BP controlled to <140/<90 mm Hg if diabetes mellitus (DM) and/or chronic kidney disease (CKD) and to <150/<90 mm Hg if no DM or CKD.

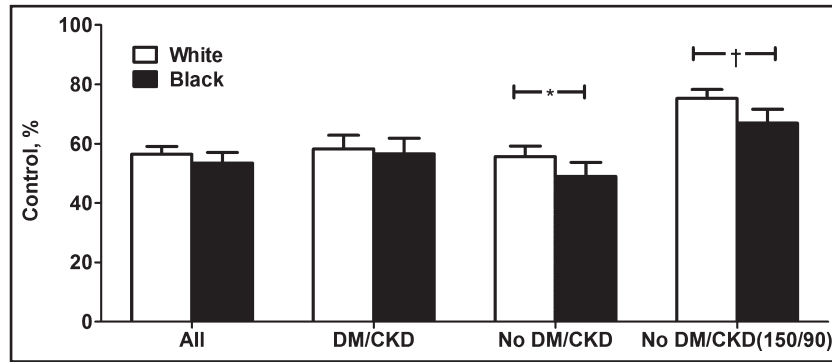


FIGURE 1. Means and standard errors depict blood pressure (BP) control (<140/<90 mm Hg unless designated) in various groupings of black and white adults aged 60 to 79 years, including: all patients, only adults with diabetes mellitus (DM) and/or chronic kidney disease (CKD), only adults without DM and/or CKD, and only adults without DM and/or CKD with goal <150/<90 mm Hg. **P*=.01, †*P*=.002. BMI indicates body mass index; CVD, cardiovascular disease.

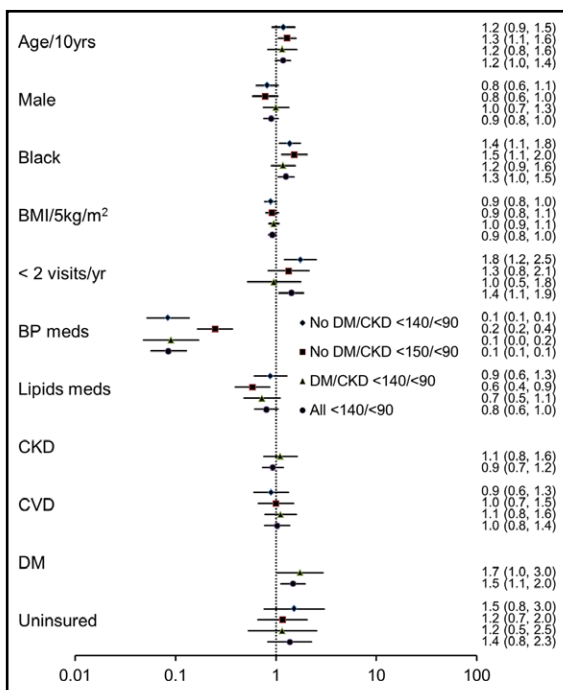


FIGURE 2. Multivariable odds ratios (ORs) and 95% confidence intervals (CI) depicting the relationship of various modifiable and nonmodifiable factors on uncontrolled hypertension in black and white adults aged 60 to 79 years. These relationships are provided for all patients combined (<140/<90 mm Hg), for patients with and without diabetes mellitus (DM) and/or chronic kidney disease (CKD) (<140/<90 mm Hg), and for adults without DM or CKD (<150/<90). Relationships between clinical variables and uncontrolled hypertension are considered significant when 95% confidence limits do not cross the line of identity (1.0).

without DM and/or CKD, and for the latter group not achieving <150/<90 mm Hg. Black race was associated with uncontrolled hypertension except among adults with diabetes and/or CKD. Health-care visit frequency ≥ 2 times per year was associated with reduced likeli-

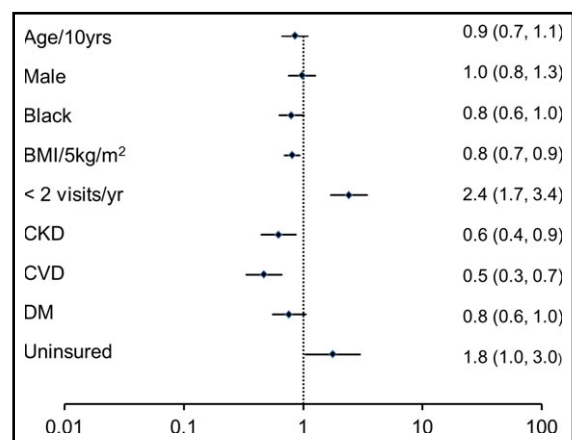


FIGURE 3. Multivariable odds ratios (ORs) and 95% confidence intervals (CIs) depicting the relationship of various modifiable and nonmodifiable clinical variables to untreated hypertension in black and white adults aged 60 to 79 years. Relationships between clinical variables and untreated hypertension are considered statistically significant when 95% CIs do not cross the line of identity (1.0). DM indicates diabetes mellitus; CKD, chronic kidney disease.

hood of uncontrolled hypertension among all hypertensive adults 60 to 79 years and those without diabetes or CKD when the target of <140/<90 mm Hg was assessed. Insurance status was not associated with uncontrolled hypertension.

Figure 3 provides multivariable ORs and 95% CIs for factors associated with untreated hypertension. Black race, increasing BMI, CKD, and CVD were associated with lower probability of untreated hypertension. Infrequent health care (<2 visits per year) and uninsured status were associated with greater probability of untreated hypertension.

SUMMARY OF THE RELEVANT LITERATURE

Six randomized controlled trials on stage 2 isolated systolic hypertension (BP $\geq 160/<90$ –95 mm Hg) are

summarized in Table S1. All four placebo-controlled trials demonstrated benefit of active treatment on composite cardiovascular events.^{25–29} Neither of two studies comparing target SBP <140 mm Hg with higher values showed benefit on composite cardiovascular events,^{30,31} although these studies were powered to detect relatively large differences of $\geq 25\%$.

Two randomized clinical trials of systolic/diastolic hypertension that included adults 60 to 79 years are summarized in Table S2. The Felodipine Event Reduction (FEVER) study³² documented a 27% reduction in the primary outcome of stroke (-27%) with a 4/2-mm Hg lower BP vs the comparison group. The Usual vs Tight Control of Systolic Blood Pressure in Nondiabetic Patients With Hypertension (Cardio-SIS)³³ trial showed a 37% decrease in electrocardiographic left ventricular hypertrophy with a 4/2-mm Hg lower BP vs the comparison group. The secondary composite cardiovascular event outcome was also reduced 50%. A statistically significant 19% reduction in recurrent stroke was seen in the Secondary Prevention of Small Subcortical Strokes (SPS3) with an 11-mm Hg lower SBP among patients assigned to <130 mm Hg vs 130 mm Hg to 149 mm Hg target.³⁴ In the Perindopril Protection Against Recurrent Stroke Study (PROGRESS), recurrent stroke was reduced with perindopril and indapamide combined, which lowered BP 12/5 mm Hg vs placebo but not with perindopril alone, which reduced BP 5/3 mm Hg.³⁵

BP goals are summarized for adults younger than 60 years, 60 to 79 years, and 80 years and older and for adults with diabetes and CKD from various guideline statements (Table S3).^{14,36–40} Because adults with diabetes and/or CKD were not the focus of this report, the American Diabetes Association and Kidney Disease Improving Global Outcomes (KDIGO) guidelines were not included.^{41,42}

COMMENTARY AND RECOMMENDATIONS ON THE MANAGEMENT OF HYPERTENSION IN AFRICAN AMERICANS AGED 60 TO 79 YEARS

ISHIB trustees have concerns related to misinterpretation of the 2014 Hypertension Guideline and the recommendation to begin treatment at an SBP ≥ 150 mm Hg rather than ≥ 140 mm Hg in adults 60 years and older without diabetes or CKD.¹⁴ Our comments and recommendation focus predominantly on African American adults 60 to 79 years with hypertension. Discussion of complex issues in adults 80 years and older exceeds the scope of this report.^{29,43,44}

Five comments are provided based on key observations derived from the NHANES analysis of hypertension in black and white adults 60 to 79 years with hypertension. Three recommendations are provided from the literature and guidelines review in response to the 2014 Hypertension Guideline. All comments and recommendations focus mainly on black adults of African descent aged 60 to 79 years with hypertension.

Discussion of complex issues in adults 80 years and older exceeds the scope of this report.^{29,43,44}

Observation 1: *Hypertension control to <140/<90 mm Hg is similar in black and white adults aged 60 to 79 years with DM and/or CKD* (Figure 1).

Comment 1: Adults with diabetes and CKD and those of African descent are more likely to have uncontrolled treatment-resistant hypertension than adults without these factors.⁴⁵ Thus, it is commendable that clinicians are achieving BP control in more than 50% of all black adults aged 60 to 79 years with hypertension and DM/CKD to <140/<90 mm Hg and achieving comparable control among black and white adults in this group. To improve hypertension control further, clinicians are referred to the outline for antihypertensive pharmacotherapy in the 2010 consensus report on management of hypertension in blacks.³

Observation 2: *The disparity in hypertension control to <140/<90 mm Hg between black and white adults 60 to 79 years is evident in the group without diabetes or CKD.*

Comment 2: The same pharmacotherapy guidance in comment 1 for patients with DM/CKD applies to patients with uncontrolled hypertension but without DM/CKD except that a calcium antagonist or diuretic is recommended as initial therapy, either alone or together with a renin-angiotensin system blocker.³

Of importance, in the untreated group with BP $\geq 140/<90$ mm Hg without DM/CKD, approximately 70% of black adults are unaware of their hypertension, and nearly half are seen less than twice annually (Table I). Infrequent health care and lack of awareness, while disproportionately a concern for younger adults,¹⁶ is also seen in a substantial subset of older adults with untreated isolated systolic hypertension. For older adults with infrequent health care, it is important to enlist this group in regular care, identify hypertension, and engage them in effective management with pharmacotherapy when needed.

Observation 3: *DM alone and with CKD are much more prevalent in non-Hispanic black than white adults 60 to 79 years with hypertension.*

Comments 3: Equity in cardiovascular and renal health equity is impossible when large disparities in major vascular risk factors persist, since treatment typically does not fully eliminate excess risk. The good news is that lifestyle changes including a weight loss of approximately 4 kg and walking 30 minutes daily most days of the week were at least as effective for preventing diabetes in black as white adults and in adults 60 years and older as in younger adults in the Diabetes Prevention Program.⁴⁶ Clinicians are encouraged to recommend and support these lifestyle changes in African Americans at risk for diabetes across the adult age span.

Observation 4: *Mean BP values achieved in all black adults 60 to 79 years with hypertension are lower than BP achieved in major trials on isolated systolic hypertension.^{25–28} Moreover, mean BP values achieved in*

TABLE II. Selected Variable for Black and White Adults Aged 60 to 79 Years With Treated or Untreated Hypertension But Without DM or CKD: NHANES 2005–2012

BP Group	Black, Treated	White, Treated	Black, Untreated	White, Untreated
	≥140/<90 mm Hg No DM/CKD	≥140/<90 mm Hg No DM/CKD	≥140/<90 mm Hg No DM/CKD	≥140/<90 mm Hg No DM/CKD
NHANES, No. (%) ^a	95 (9.4%)	174 (11.0%)	73 (6.6%)	184 (10.6%)
US population, No.	293,107	2,273,139	205,799	2,174,586
Age, y	67.8±0.6	68.6±0.5	66.2±0.7	67.6±0.4
Male, %	38.6±5.6	40.4±3.5	46.2±7.8	46.6±4.4
BMI, kg/m ²	29.2±0.6	28.8±0.6	28.0±0.9	28.0±0.6
<25, %	24.8±5.0	23.3±4.0	39.4±7.3	33.0±4.0
≥30, %	38.3±4.9	35.2±4.8	34.2±5.8	31.8±5.3
Visits per y, %				
<2	12.7±3.7	14.8±2.8	44.9±6.3	31.5±3.8
≥2	87.3±3.7	85.2±2.8	55.1±6.3	68.5±3.8
Uninsured, %	11.0±3.6	4.7±1.9	17.1±5.0	5.9±1.9
SBP, mm Hg	156.9±1.6	151.9±0.8 ^b	152.9±1.1	151.8±1.1
DBP, mm Hg	72.4±1.2	72.2±0.8	72.3±1.4	73.7±0.8
Aware, %	100.0±0	100.0±0	28.6±5.6	15.1±3.3 ^c
BP control <150/<90 mm Hg, %	44.0±4.4	54.0±3.8	49.4±6.3	52.6±4.7
Non-HDL, mg/dL, %	145.3±4.1	147.9±3.8	148.5±5.0	159.7±2.9
Cholesterol medication, %	36.5±5.6	45.2±3.4	15.6±4.3	19.9±3.4
Smoker, %	13.1±3.1	8.2±2.2	23.7±6.1	16.0±3.3
CVD, %	18.6±3.5	20.9±3.8	8.6±3.4	9.7±2.3
ASCVD _{10 y} , %	22.0±0.9	21.3±0.9	16.4±1.0	17.8±0.7

Abbreviations: ASCVD_{10 y}, estimated 10-year risk for atherosclerotic cardiovascular disease; BMI, body mass index; BP, blood pressure; CVD, cardiovascular disease; DBP, diastolic blood pressure; DM, diabetes mellitus; HDL, high-density lipoprotein; SBP, systolic blood pressure. Data in italics indicate relative standard errors >30%, which exceed National Health and Nutrition Examination Survey (NHANES) reporting guideline limits. These results are provided for information only and not statistical comparisons. ^aPercentage of hypertensive adults in race group (denominator from Table II). ^b*P*<.05. ^c*P*<.01 blacks vs whites within treated or untreated group.

black adults 60 to 79 years who are controlled to <140/<90 mm Hg are below the values achieved in the majority of clinical trials including groups that were more aggressively treated.^{29–35}

Comment 4: Among black and white adults 60 to 79 years who are controlled to <140/<90 mm Hg, mean BP values of 123/66 mm Hg in blacks and 122/65 mm Hg in whites are not significantly different. Moreover, the mean BP values, while well below the <140/<90 mm Hg goal, are in the range associated with greater stroke protection.^{34,47,48}

Observation 5: Black adults 60 to 79 years with hypertension are more likely to smoke cigarettes than their white counterparts (Table II).

Comment 5: Smoking is a major risk factor for stroke, ischemic heart disease, and peripheral vascular occlusive disease. Clinicians providing care for older African Americans are encouraged to identify those who smoke cigarettes and support smoking cessation efforts. Special attention to smoking cessation is especially important for African Americans with diabetes as they have more lower-extremity amputations than Caucasians with diabetes.⁴⁹ Smoking cessation interventions for African Americans should: (1) challenge misconceptions about the safety of

smoking menthol cigarettes that “taste good” and mask smoking irritation, (2) prepare high-nicotine smokers for quitting with nicotine-fading and band-switching techniques, and (3) emphasize relapse prevention, active stress reduction, and cultural meanings of smoking.⁵⁰

Recommendation 1: *When diabetes and/or CKD are present, initiate treatment for patients with an SBP ≥140 mm Hg and treat to a goal of <140 mm Hg including in adults aged 60 to 79 years.*

We are concerned that some adults in this group and their clinicians have overlooked the fourth and fifth recommendations in the 2014 Hypertension Guideline and are initiating treatment at a systolic blood pressure ≥150 mm Hg and treating to a goal of <150 mm Hg in older adults with diabetes or CKD. For older adults, a systolic blood pressure target <140 mm Hg remains reasonable and is associated with greater protection against stroke and other cardiovascular outcomes than higher targets.^{11,13,48,51} In a representative US civilian sample of non-Hispanic black adults 60 to 79 years with hypertension who attained BP <140/<90 mm Hg, their mean BP was 123/66 mm Hg (Table II), ie, lower BP is achievable and relatively well tolerated.^{34,52}

Recommendation 2: *Continue antihypertensive therapy in black adults of African descent aged 60 to 79 years without DM/CKD when treatment results in an SBP <140 mm Hg and is well tolerated.*

We are concerned the corollary to the first recommendation in the 2014 Hypertension Guideline is being overlooked and that treatment is being reduced for patients in this group. In the 2010 ISHIB consensus statement, the recommended goal clinic BP for black adults of African descent without DM/CKD was <135/<85 mm Hg.³ Given BP variability,⁵² average clinic BP will be <135/<85 mm Hg in the majority of adults 60 to 79 years who have controlled BP to <140/<90 mm Hg on most visits.

Recommendation 3: *Initiate treatment for SBP \geq 140 mm Hg and treat to a goal of <140 mm Hg in black adults 60 to 79 years of African descent who do not have DM/CKD.*

This recommendation is based on expert opinion informed by studies included in Table S2,^{32–35} several guideline statements (Table S3),^{36–40} and other trials and reports.^{9–11,47,51,53–55}

Another potentially important point to consider is that clinical trials in isolated systolic hypertension did not enroll a representative sample of older adults. Nearly a quarter million adults were screened in Systolic Hypertension in the Elderly Program (SHEP) to enroll approximately 4700.²⁵ Adults in SHEP, including the placebo and active intervention groups, had significantly greater longevity than an age-matched control population.⁵⁶ Moreover, adults in the Hypertension in the Very Elderly Trial (HYVET) did not have dementia, requirement for nursing care, heart failure requiring treatment with antihypertensive medication drug classes, recent cardiovascular events, or major renal impairment.²⁹ Thus, guidance provided by ISHIB and other groups are recommendations based on data in relatively healthy elderly populations and not mandates. Clinicians are encouraged to use their judgment in deciding when to implement guideline recommendations for an individual patient.

PERSPECTIVE

ISHIB trustees commend health-care professionals across the United States who provide care for African American adults aged 60 to 79 years with hypertension. Mean SBP for this high-risk group is <140 mm Hg, which has contributed to the decline in cardiovascular disease. More than half of all African American adults aged 60 to 79 years with hypertension also have diabetes and/or CKD compared with two in five white adults. Hypertension control to <140/<90 mm Hg in this group was documented in well over half and similar to their Caucasian counterparts. However, among black adults with hypertension in this age group who did not have diabetes or CKD, BP control to <140/<90 mm Hg was observed in fewer than half and was lower than in white adults. Of particular concern, in both black and white adults with hypertension in the absence of

diabetes or CKD and BP \geq 140/<90 mm Hg, fewer than 30% were aware of their hypertension and more than 30% reported only 0 to 1 health-care visits in the previous year. Based on expert opinion, ISHIB recommends a treatment goal of <140/<90 mm Hg to improve cardiovascular outcomes for black adults aged 60 to 79 years, including those without diabetes or CKD. Broad-based efforts are required in older adults without diabetes or CKD to raise awareness of isolated systolic hypertension and engage them in the treatment and control of their hypertension.

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Supporting Information

Additional Supporting Information may be found in the online version of this article:

Table S1. Results of randomized controlled trials in stage 2 isolated systolic hypertension.^{25–31}

Table S2. Outcomes in selected trials with antihypertensive medications that included adults aged 60 to 79 years.^{32–35}

Table S3. Goal blood pressure by age and comorbid conditions in contemporary guideline statements.^{3,14,36–40}