Introduction
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The study of hypertension as a clinical entity began with the observation that high blood pressure was a major consequence of acute renal disease and led to strokes and other cardiovascular events that characterized such conditions as acute glomerulonephritis. Inevitably, hypertension at first became the province of the renal physician and interested the generalize only when severe.

Major population studies together with life insurance data subsequently showed that blood pressure and cardiovascular risk had a linear relationship. The clinical working definitions of hypertension thus became dependent on the ability to demonstrate benefits—chiefly reductions in the incidence of stroke and congestive heart failure by providing antihypertensive therapy.

Kaplan in 1983 proposed that conceptual definition of Hypertension be "that level of BP at which the benefits (minus the risk and costs) of action exceeded the risks and costs (minus the benefits) of inaction".

An elevated arterial pressure is probably the important public health problem in world. It is common, usually asymptomatic, readily detectable, easily treatable and often leads to lethal complications if left untreated. Clinical trials confirming the benefits of treating relatively mild forms of hypertension ushered in what could be called the epidemiologic era of hypertension.
Recently, attention has focused on the link between hypertension and coronary disease, and the fact that the more traditional forms of antihypertensive therapy have not been entirely successful in preventing coronary events.

Although, it is convenient to think of hypertension in its renal, epidemiologic and vascular eras, a new perspective is rapidly coming to the forefront. As we become more critical in evaluating the performance of our health care systems, it is obvious that the major problems in hypertension do not lie entirely with unsolved problems of physiology of therapeutics. Rather, we have come to realize that a large number of our hypertensive patients remain inadequately treated or, even more commonly, are receiving no treatment at all. Outcome research into strategies for enhancing patient compliance with treatment and research dealing with other issues associated with clinical effectiveness are emerging as leading priorities.

Most people will develop hypertension during their lifetime. As a consequence of the increased awareness of the frequency of hypertension and with the recognition that the progress of hypertension - induced cardiovascular disease can be slowed, if not stopped, by its treatment, the management of hypertension is now one of the leading indications for both visits to physicians and for the use of prescription drugs.

The percentage of people in the U.S. who are aware of their hypertension, who are receiving treatment, whose hypertension is controlled have risen progressively. Similar improvements in awareness and control have been reported in other industrialized countries such as Canada (Joffres et al, 1992) and Israel (Green and Peled, 1992).
As impressive as these data are, most hypertension remains poorly controlled, both in industrialized societies and even more so, in less developed countries. As a result, hypertension influenced diseases remain the most common cause of morbidity and mortality in developed countries. Moreover, the main burdens associated with hypertension occur not in the relatively few with severe disease but in the masses of patients with blood pressures that are only minimally elevated.

There is no evidence for a threshold level for development of complications. For reasons of determining prevalence and to establish a common usage, JNC VII has proposed a new classification as follows:

<table>
<thead>
<tr>
<th>Hypertension</th>
<th>Systolic &lt; 120 mm Hg and Diastolic &lt; 80 mm Hg</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normotensives</td>
<td></td>
</tr>
<tr>
<td>Stage I hypertension</td>
<td>Systolic ≥ 140 - 159 mm Hg or Diastolic ≥ 90 – 99 mm Hg</td>
</tr>
<tr>
<td>Stage II hypertension</td>
<td>Systolic ≥ 160 mm Hg or Diastolic ≥ 100 mm Hg</td>
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</tbody>
</table>

These criteria are practical for screening large population but neither the method nor the range has any intrinsic or inherent value in reaching a clinical decision on who should be treated and was never intended as such. For therapeutic purposes the practical approach of using cut off points based on demonstrated benefit has been widely adopted.
Risk factors for Hypertension include

* Gender
* Race: Blacks tends to have higher levels
* Smoking
* Dyslipidemia
* Diabetes Mellitus
* Age > 60 years
* Obesity
* Pulse pressure
* Family history

Clinical features

* Palpitation
* Chest pain
* Dyspnoea
* Cough
* Syncope
* Headache
* Dizziness
* Blurring of vision
* Photophobia

Target organ damage

1. Heart Disease: LVH Angina or MI Heart failure
2. Stroke or TIA
3. Nephropathy
4. Peripheral arterial disease
5. Retinopathy
CONCEPTUAL DEFINITION OF HYPERTENSION

Although it has been more than 100 years since Mahomed clearly differentiated Hypertension from Bright’s renal disease, authorities still debate the level of blood pressure considered abnormal. Sir George Pickering for many years challenged the wisdom of this debate and described the search for an arbitrary dividing line between normal and high blood pressure. In 1972, he started his argument, “There is no dividing line. The relationship between arterial pressure and mortality is quantitative; the higher the pressure, the worse the prognosis” . He viewed “arterial pressure as a quantity and the consequence numerically related to the size of that quantity” (Pickering, 1972).

However, as Pickering realized, physicians feel more secure when dealing with precise criteria, even if the criteria are basically arbitrary. To consider a blood pressure of 138/88 mm Hg normal and one of 140/90 high is obviously arbitrary, but medical practice requires that some criteria be used to determine the need for workup and therapy. The criteria should be established on some rational basis that includes the risks of disability and death associated with various levels of blood pressure, as well as the ability to reduce those risks by lowering the blood pressure. As stated by Rose (1980), “The operational definition of hypertension is the level at which the benefits .....of action exceed those of inaction”.

The risks of elevated blood pressure have been determined from large-scale epidemiologic surveys. Mac Mohan et al (1990) performed a meta-analysis of all available major prospective observational studies relating diastolic blood pressure (DBP) level
to the incidence of stroke and coronary heart disease (CHD) the nine studies analyzed almost 4,200,000 people were followed up for 6 to 25 years. A total of 599 fatal stroke and 4,260 deaths from CHD were recorded. These rates are higher than the rates for normal population. They also had statistically significance.

The overall results demonstrate "direct continuous, and apparently independent association" with "no evidence of any threshold" level of DBP below which lower levels of DBP were not associated with lower risks of stroke and CHD. In reaching this conclusion, Mac Mohan et al considered the common practice in all nine studies to measure DBP only once, which leads to a substantial underestimation of the true association of the usual or long term average DBP with disease. By applying a correction factor based on three sets of readings recorded over 4 years in the Framingham study to all nine sets of data. Mac Mohan et al came up with estimates of risk that are about 60% greater than those previously published using uncorrected data. They estimated that a DBP that is persistently higher by 5 mm Hg is associated with at least a 34% increase in stroke risk and at least a 21% increase in CHD risk.

It is with this background that the present study was attempted to study the clinical profile of hypertension with special reference to risk factors, laboratory investigations, complications and management in the patients attending Hypertension Clinic at M.L.B. Medical College, Jhansi.