the prevention of clinical events is based primarily on nonrandomized evidence with substantial inherent limitations, and the small randomized studies published to date have only demonstrated improved graft patency (5). Nonetheless, some clinical practice guidelines recommend 1 year of DAPT for ACS after CABG, thus we felt it was imperative to report results stratified by ACS and stable coronary artery disease.

Given the substantial clinical efficacy and safety uncertainty of DAPT for on-pump CABG, we believe a large randomized controlled trial adequately powered for mortality, graft patency, and safety outcomes should be a research priority for the cardiovascular community.

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http://dx.doi.org/10.1016/j.jacc.2017.04.063

Please note: The authors have reported that they have no relationships relevant to the contents of this paper to disclose. Deepak L. Bhatt, MD, MPH, served as Guest Editor-in-Chief for this paper; and Faisal Bakaeen, MD, served as Guest Editor for this paper.

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Hypertension Treatment in the Elderly

Individualized Target or Intensive Blood Pressure Lowering?

The meta-analysis by Bavishi et al. (1) showed that in older hypertensive patients, intensive blood pressure (BP) control decreased major adverse cardiovascular events, whereas the risk of renal failure maybe increased. We wish to discuss some of our views.

First, meta-analysis is considered as the highest level of evidence for guiding clinical practice by professional societies. However, in Bavishi’s analysis, only 4 studies were included, and these studies were with significant heterogeneity, such as differences in trial design, inclusion criteria, and baseline characteristics (2). If clinical heterogeneity cannot be well settled in a meta-analysis, the results should be interpreted with caution.

Second, in the recent clinical practice guideline from the American College of Physicians (3), data from 6 studies showed that lower systolic BP targets (<140 mm Hg) showed no statistically significant reduction in all-cause mortality or cardiac events. In patients with a history of stroke or transient ischemic attack, treating to a systolic BP of 130 to 140 mm Hg reduced stroke recurrence. The different conclusions in the 2 studies may be caused by a difference in the studies included for analysis.

Third, older people are with multiple chronic conditions, such as coronary heart disease, diabetes, chronic kidney disease, and frailty. However, there are little data for determining the optimal BP target (4). Furthermore, to achieve the target BP in elderly patients with chronic conditions, it should be achieved by careful titration of medications and monitoring for side effects.

In conclusion, considering the great clinical heterogeneity among the trials included in Bavishi et al.’s analysis, the results should be interpreted with caution. Emphasizing an individualized target BP weighing side effects and treatment effort may be much more proper than advocating intensive BP lowering.

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http://dx.doi.org/10.1016/j.jacc.2017.04.062

Please note: This work is supported by the Key Specialist Department Training Project of Foshan City, Guangdong, China (No:FSPY3-2015034). The authors have reported that they have no relationships relevant to the contents of this paper to disclose. P.K. Shah, MD, served as Guest Editor-in-Chief for this paper; and Stanley Franklin, MD, served as Guest Editor for this paper.
Huang and colleagues point out the difference in results of our study (1) and the recent systematic review and meta-analysis conducted as a part of the guideline from the American College of Physicians and the American Academy of Family Physicians on pharmacological treatment of hypertension in adults ages 60 years or older (2,3). Apart from other substantial flaws (4), the guideline (2) and the accompanied meta-analysis (3), although supposedly dealing with adults ages 60 years or older, included randomized trials of adults with a diagnosis of hypertension and mean age of at least 60 years. This means that the meta-analysis (and the resulting guidelines) were based on numerous patients who were below that age limit. Our meta-analysis included 4 high-quality randomized controlled trials that exclusively randomized older hypertensive patients (≥65 years) to intensive versus standard blood pressure (BP) targets (1).

Huang and colleagues rightly contend that “individualized target BP weighing side effects and treatment effort may be much more proper than advocating intensive BP lowering.” In doing so, they basically reiterated the same point that we have emphasized in our conclusions: “When considering more intensive BP control in the elderly, clinicians should carefully balance benefits against potential risks” (1). Finally as clinicians, we should remember a simple, but inescapable, truth in medicine: patients are genetically, physiologically, metabolically, pathologically, psychologically, and culturally different. Accordingly, there never will be only 1 way to diagnose and treat.

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REPLY: Hypertension Treatment in the Elderly
Individualized Target or Intensive Blood Pressure Lowering?

The Importance of Invasive Hemodynamics for Pulmonary Hypertension Screening in TAVR Patients

The recent American College of Cardiology expert consensus for transcatheter aortic valve replacement (TAVR) decision pathway mentions pulmonary hypertension (PH) as a major cardiovascular comorbidity (1). The consensus does not specify the method of assessment, only suggesting that PH may be evaluated by echocardiography; however, right heart catheterization (RHC) is the gold standard for PH assessment. We retrospectively evaluated consecutive patients that had transthoracic echocardiogram (TTE) and RHC performed within 3 days of one another as part of their routine clinical care before TAVR at the University of Pittsburgh Medical Center. We sought to determine the agreement between pulmonary artery systolic pressure (PASP) measured by TTE and RHC in these patients.

According to the guidelines, PASP was calculated using the maximal tricuspid regurgitation jet