CORRESPONDENCE

Treatment Resistant Hypertension—Investigation and Conservative Management
by Prof. Dr. med. Franz Weber, Prof. Dr. med. Manfred Anlauf
in issue 25/2014

Better Risk Assessment for Individual Substances
The colleagues Weber and Anlauf list substances with blood pressure-increasing effects to be considered in differential diagnosis (Box, p. 427).

However, for psychiatric medications it is not correct to link entire drug classes, such as antipsychotics, monoamine oxidase (MAO) inhibitors and tricyclic antidepressants, with arterial hypertension in the way presented in the article.

In contrast to the statements in the article, antipsychotics (or neuroleptics) are rather associated with orthostatic dysregulation and hypotension (e.g. quetiapine, risperidone, clozapine) than with hypertension, especially when patients are newly started on the medication; here, alpha1-antagonistic effects play a major role. Likewise, MAO inhibitors have mostly blood pressure-lowering effects. Only if dietary restrictions (low-tyramine diet) are not followed, patients are at risk for hypertensive crisis, with the risk of blood pressure increases being much higher for tranylcypromine, an irreversible, unselective MAO inhibitor, than for moclobemide or rasagiline. The same applies to tricyclic antidepressants where patients on the medication rather develop arterial hypotension and only in exceptional cases hypertension (e.g. under desipramine).

Not listed are some psychiatric medications frequently associated with marked increases in blood pressure. These include antipsychotics with noradrenergic effects, such as venlafaxine (1), duloxetine (2), bupropion (3), reboxetine (4), tranylcypromine, duloxetine and placebo: an 8-month, double-blind trial in patients with major depressive disorder. Current medical research and opinion 2007; 23: 1303–18.

Overall, we would prefer if the risk assessment for blood pressure-elevating effects was performed for individual compounds instead of drug classes.

REFERENCES

Conflict of interest statement
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In Reply:
We like to thank our colleagues Freudemann et al. for their constructive and differentiated criticism. However, we like to point out that in the summaries of product characteristics (SmPCs), especially of those antipsychotics named by you, hypertension, apart from orthostatic dysregulation and hypotension, is listed as very common adverse event (quetiapine), common adverse event (clozapine) or after the use of an injectable formulation (risperidone). This also applies to amitryptiline as a tricyclic antidepressant. Our article’s perspective is that of a physician investigating possible causes of treatment-resistant hypertension. Here, the patient’s medication history should also take rare adverse reactions to psychiatric medications into consideration.

The new antidepressants highlighted by you represent an important addition to the substances we listed in our table in a very summarizing fashion due to lack of space.

REFERENCES

Conflict of interest statement
The authors declare that no conflict of interest exists.