

16:30 >> **17:00**

Salon/Room Adenauer

CONTROVERSE

CONTROVERSI

Modérateurs / Chairpersons

Hélène LELONG, Paris

Grégoire WUERZNER, Lausanne (Suisse/Switzerland)

16:30 **Faut-il mesurer la pression artérielle au cabinet ?**

Do we still need to measure office BP?

Pour

Pro

Jacques BLACHER, Paris

Contre

Contra

Philippe Van De BORNE, Bruxelles/Brussels (Belgique/Belgium)

16h30
17h00

Controverse

Faut-il mesurer

la pression artérielle au cabinet ?

Pour : J. Blacher / Contre : P. Van de Borne

Modérateurs : H. Lelong - G. Wuerzner **p.32**

Besoin croissant de mesures alternatives car

Du point de vue des patients:

- perte de temps
- exposition et contribution à la pollution
- manque de disponibilité

Du point de vue des médecins:

- manque de temps
- il existe des solutions alternatives validées

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14,4 millions d'hypertendus devraient se rendre au cabinet médical tous les 3 à 6 mois

En France, plus de 10 millions de personnes souffrent d'hypertension...

D'après des données validées par le Comité français de lutte contre l'hypertension artérielle établies à partir des enquêtes FLASH 2004, en France, 7,6 millions de personnes se traitent contre l'HTA, soit 25 % de la population des plus de 35 ans.

Si l'on utilise l'auto-mesure pour évaluer la tension :

- 14,4 millions de sujets sont hypertendus ;
- 6,8 millions sont hypertendus mais non traités ;
- seulement 2,3 millions sont traités et contrôlés.

Le contrôle de l'hypertension est deux fois moins fréquent chez les hommes traités que chez les femmes sous traitement. Près de 42 % des 35-55 ans "ne connaissent pas leurs chiffres de tension".

http://www.frhta.org/tout_sur_l_hypertension.php

2013 ESH/ESC Guidelines for the management of arterial hypertension

8 Follow-up

8.1 Follow-up of hypertensive patients

After the initiation of antihypertensive drug therapy, it is important to see the patient at 2- to 4-week intervals to evaluate the effects on BP and to assess possible side-effects. Some medications will have an effect within days or weeks but a continued delayed response may occur during the first 2 months. Once the target is reached, a visit interval of a few months is reasonable, and evidence has been obtained that no difference exists in BP control between 3- and 6-month intervals.⁶⁷³ Depending on the local organization of health resources, many of the later visits may be performed by non-physician health workers, such as nurses.⁶⁷⁴ For stable patients, HBPM and electronic communication with the physician (SMS, e-mail, social media, or automated telecommunication of home BP readings) may also provide an acceptable alternative.^{675–677} It is nevertheless advisable to assess risk factors and asymptomatic OD at least every 2 years.

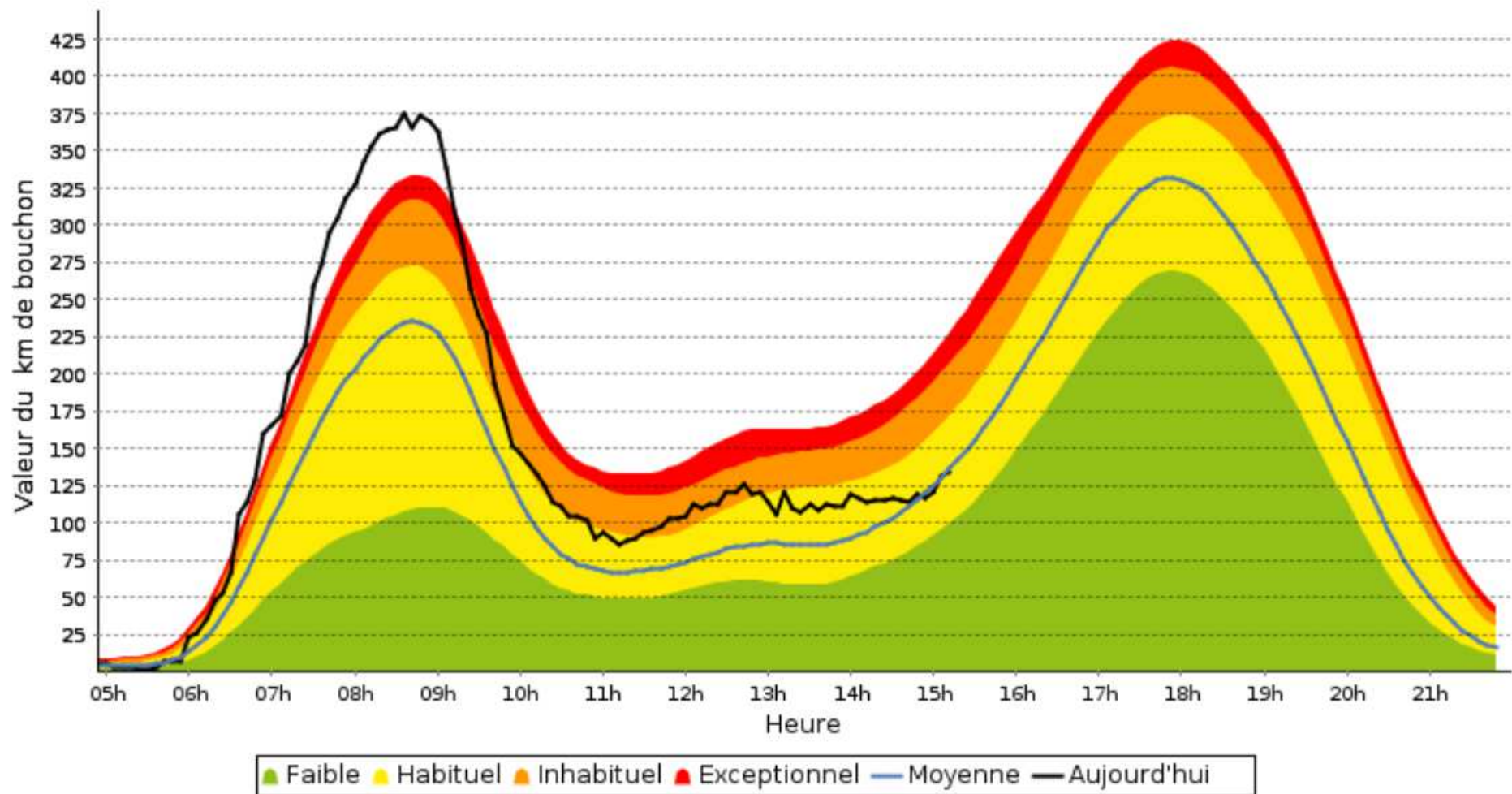
Kilomètres d'embouteillages en Ile de France - Décembre 2017

Actuellement, le cumul de bouchon (km bouchon) est à la valeur **135 km**

Etat du trafic : Habituel pour cette heure-ci

Tendance: ➔

*Km de bouchon - Ile de France
le 01/12/17 à 15h16*



Courbe générée toutes les 6 mn

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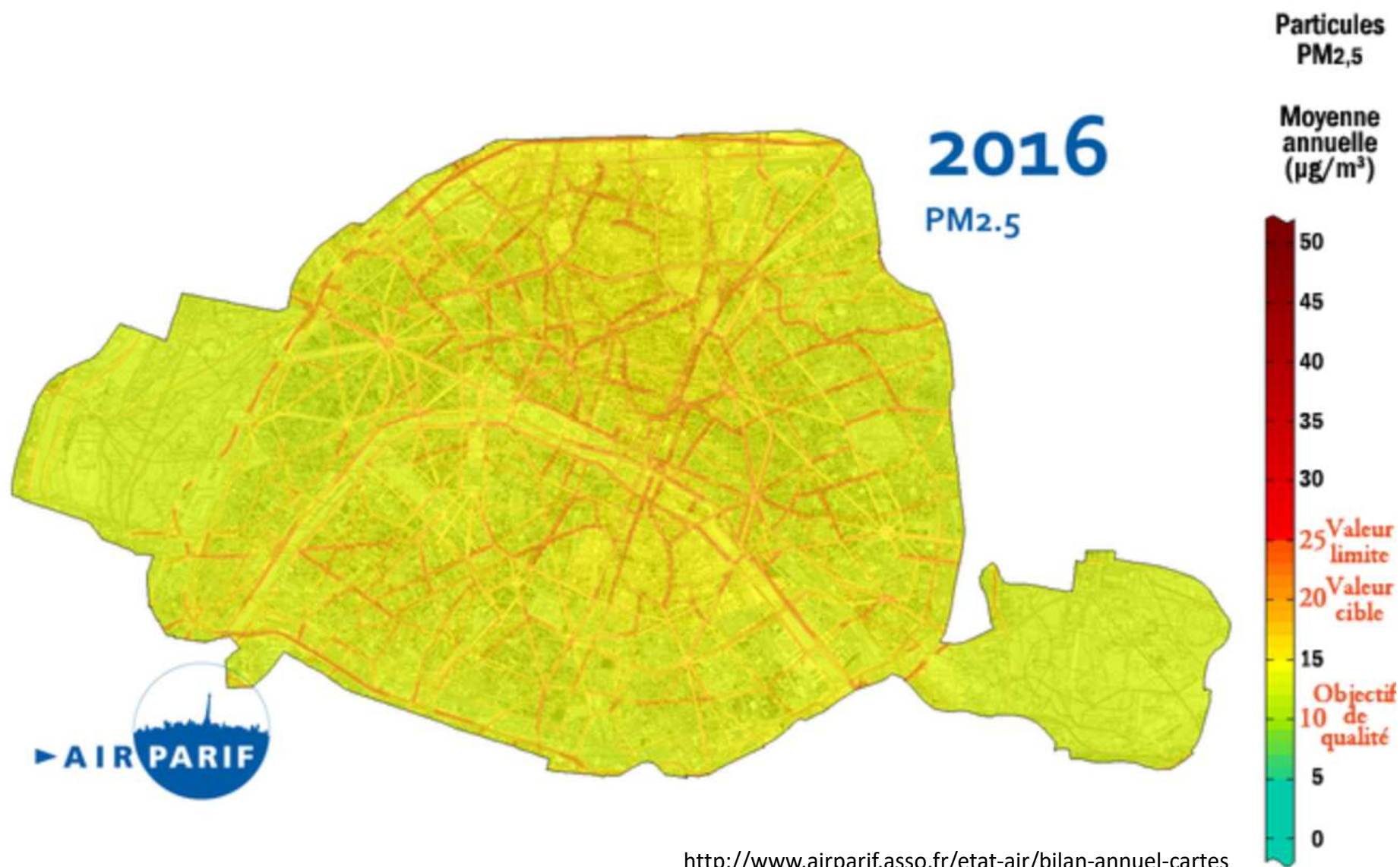
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Se rendre au cabinet médical: perte de temps , stress, exposition à la pollution atmosphérique



Association between long-term exposure to air pollution and mortality in France: A 25-year follow-up study

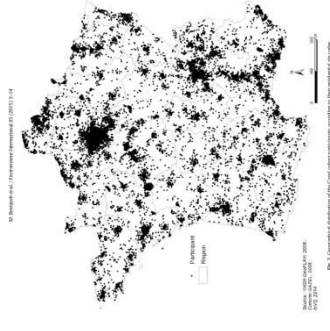
Malek Bentayeb ^{a,*}, Verene Wagner ^a, Morgane Stempfelet ^a, Marie Zins ^{b,c}, Marcel Goldberg ^{b,c}, Mathilde Pascal ^a, Sophie Larrieu ^a, Pascal Beaudou ^a, Sylvie Cassadou ^a, Daniel Eilstein ^a, Laurent Filleul ^a, Alain Le Tertre ^a, Sylvia Medina ^a, Laurence Pascal ^a, Helene Prouvost ^a, Philippe Quénel ^{a,d}, Abdelkrim Zeghnoun ^a, Agnes Lefranc ^a

^a French Institute for Public Health Surveillance (InVS), Saint-Maurice, France

^b Inserm, Population-based Epidemiologic Cohorts Unit, UMS 011, Villejuif, France

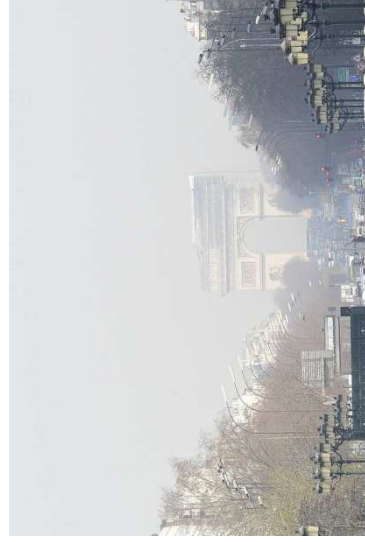
^c Versailles St-Quentin University, UMS 011, F-94807 Villejuif, France

^d School of Public Health (EHESP/SPC) – IRSET Inserm UMR 1085, Rennes, France



Results: The cohort recorded 1967 non-accidental deaths. Long-term exposures to baseline PM_{2.5}, PM₁₀₋₂₅, NO₂ and benzene were associated with an increase in non-accidental mortality (Hazard Ratio, HR = 1.09; 95% CI: 0.99, 1.20 per 5.9 µg/m³, PM₁₀₋₂₅; HR = 1.09;

95% CI: 1.04, 1.15 per 2.2 µg/m³, NO₂; HR = 1.14; 95% CI: 0.99, 1.31 per 19.3 µg/m³ and benzene: HR = 1.10; 95% CI: 1.00, 1.22 per 1.7 µg/m³). The strongest association was found for PM₁₀: HR = 1.14; 95% CI: 1.05, 1.25 per 7.8 µg/m³. PM₁₀, PM₁₀₋₂₅ and SO₂ were associated with non-accidental mortality when using time varying exposure. No significant associations were observed between air pollution and cardiovascular and respiratory



Bilan 2016

- 3 477 personnes ont perdu la vie sur les routes de France métropolitaine.

23% âgés de moins de 24 ans

25,5% âgés de plus de 65 ans

559 piétons / 162 à vélos / 121 à cyclos / 613 à motos

1 760 voitures de tourisme / 130 véhicules utilitaires

55 poids lourds / 12 transports collectifs / 85 autres

270 autoroutes (155 millions de km / an)

2 188 hors agglomération

1 019 en agglomération

30 à 45 % Vitesse pour les moins de 35 ans

25 % Alcool "

15 % Stupéfiant "

8 % Priorité "

6 % Téléphone "

- 57 522 accidents corporels

- 72 645 blessés (dont hospitalisés: 27 187)



La mortalité des personnes âgées de 65 ans ou plus poursuit en forte progression depuis 2013 (+28%). Cette augmentation s'observe même si l'on rapporte à la population de cette classe d'âge (+17% d'augmentation du ratio depuis 2013, et +3% depuis 2015). La mortalité des personnes âgées 65 ans ou plus pourrait approcher les 880 personnes tuées sur 2016. Parmi ces derniers, l'augmentation de la mortalité des personnes âgées 75 ans ou plus est plutôt avérée chez les piétons, alors que l'augmentation chez les 65-74 ans concerne plutôt les cyclistes et les automobilistes.

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AIM OF THE STUDY

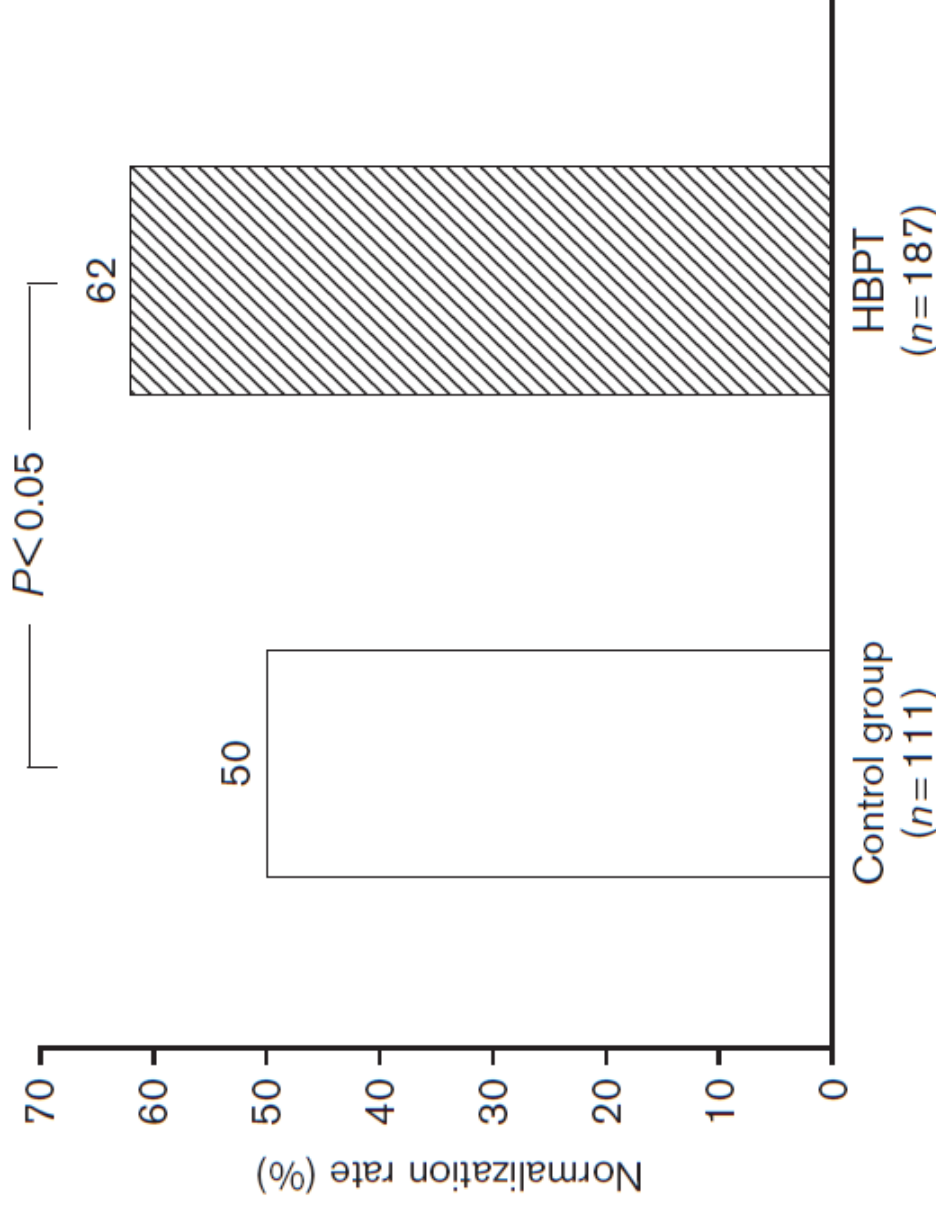


RESULTS (2): Nr of medications reported in n:7961 patients (0 vs. 1 vs. 2 or more drugs)

Parameters	≥ 2 medications	1 medication	0 medication
Systolic BP (mmHg)	139±19	139±18	143±21*
Diastolic BP (mmHg)	80±11	81±11	83±13*
Age (years)	68±12	62±13	55±15*
Heart rate (bpm)	72±10	73±9	75±10*
Body mass index (kg/m ²)	29.0±5.8	27.2±5.0	26.7±5.2*

S: systolic; D: diastolic; BP: Blood pressure; bpm: beat per minute; * p<0.0001

Éducation thérapeutique du patient



Percentage of patients with daytime ambulatory blood pressure normalization (systolic blood pressure < 130 mmHg and diastolic blood pressure < 80 mmHg) among those randomized to conventional management with office blood pressure measurement only (open bar) or to clinical management including the teletransmission of home blood pressure values [home blood pressure telemonitoring (HBPT), striped bar]. P refers to the statistical significance of the between-groups differences

Parati G, Omboni S, Albini F, Piantoni L, Giuliano A, Revera M, et al.; TeleBPCare Study Group. Home blood pressure telemonitoring improves hypertension control in general practice. The TeleBPCare study. *J Hypertens* 2009; **27**:198–203.

Role of home blood pressure telemonitoring in hypertension management: an update

Gianfranco Parati^{a,b,c} and Stefano Omboni^d

Table 2 Feasibility and acceptability of home blood pressure telemonitoring among patients and doctors

Author, year (ref.)	Type of HBPT	No. of patients	Type of condition	Compliance (%)	Acceptability by patients (%)	No. of doctors	Acceptability by doctors (%)
Friedman <i>et al.</i> [25]	Telephone (voice)	276	Hypertension	–	69	102	85
Denolle <i>et al.</i> [26]	Telephone	55	Pregnant hypertensive women	90	–	–	–
Bondmass <i>et al.</i> [27]	Telephone	33	Hypertension	88	–	–	–
Artinian <i>et al.</i> [28]	Telephone	26	Hypertension	67	–	–	–
Rogers <i>et al.</i> [29]	Telephone	121	Hypertension	–	96	–	–
Omboni [30]	Telephone	195	Hypertension	90	96	12	95
Omboni <i>et al.</i> [18]	Internet	789	Hypertension	–	–	226	95
Nakajima <i>et al.</i> [31]	Telephone	10	Normotension	84	80	–	–
Scherr <i>et al.</i> [32]	Mobile phone	20	Hypertension, heart failure	83	100	–	–
Bobrie <i>et al.</i> [33]	Mobile phone	33	Diabetes mellitus	149	85	–	–
Logan <i>et al.</i> [34]	Telephone	22	Hypertension, diabetes mellitus	–	73	–	–
Santamore <i>et al.</i> [35]	Internet	161	High-risk patients	–	92	–	–
Liddy <i>et al.</i> [36]	Telephone	22	Hypertension, diabetes mellitus, cardiovascular disease, chronic obstructive pulmonary disease	–	–	4 ^a	100

HBPT, home blood pressure telemonitoring.

^aThree nurses + one pharmacist.



FEASIBILITY AND ACCEPTABILITY



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Médecine générale : la durée des consultations et visites s'établit à seize minutes en moyenne

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Etudes et résultats, Drees, avril 2006, n° 481, 8 p. "La durée des séances des médecins généralistes"



22 consultations par jour de 17 minutes en moyenne : comment travaillent les généralistes

Sophie Martos | 02.05.2017

QS Le Quotidien Santé

Le Quotidien du Médecin | Le Quotidien du Pharmacien | Le Généraliste

**LE QUOTIDIEN
DU MEDECIN**.fr
Toute l'actualité médicale
et socio-professionnelle

2013 ESH/ESC Guidelines for the management of arterial hypertension

Table 5 Office blood pressure measurement

When measuring BP in the office, care should be taken:

- To allow the patients to sit for 3–5 minutes before beginning BP measurements.
 - To take at least two BP measurements, in the sitting position, spaced 1–2 min apart, and additional measurements if the first two are quite different. Consider the average BP if deemed appropriate.
-
- To measure at the first visit, BP 1 and 3 min after assumption of the standing position in elderly subjects, diabetic patients, and in other conditions in which orthostatic hypotension may be frequent or suspected.

**5 minutes
de repos
+
4 minutes
mesure
assi
+
3 minutes
mesure
debout
=
il reste
5 minutes
pour :
anamnèse
dés/habillage
explications
prescriptions**

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1.2 New aspects

Because of new evidence on several diagnostic and therapeutic aspects of hypertension, the present guidelines differ in many respects from the previous ones.² Some of the most important differences are listed below:

- (1) Epidemiological data on hypertension and BP control in Europe.
- (2) Strengthening of the prognostic value of home blood pressure monitoring (HBPM) and of its role for diagnosis and management of hypertension, next to ambulatory blood pressure monitoring (ABPM).
- (3) Update of the prognostic significance of night-time BP, white-coat hypertension and masked hypertension.
- (4) Re-emphasis on integration of BP, cardiovascular (CV) risk factors, asymptomatic organ damage (OD) and clinical complications for total CV risk assessment.

Table 17 Methods to improve adherence to physicians' recommendations

Patient level	Information combined with motivational strategies (see Section 5.1.6 on smoking cessation).
	Group sessions.
	Self-monitoring of blood pressure.
	Self-management with simple patient-guided systems.
	Complex interventions. ^a
Drug treatment level	Simplification of the drug regimen.
	Reminder packaging.
Health system level	Intensified care (monitoring, telephone follow-up, reminders, home visits, telemonitoring of home blood pressure, social support, computer-aided counselling and packaging).
	Interventions directly involving pharmacists.
	Reimbursement strategies to improve general practitioners' involvement in evaluation and treatment of hypertension.

Table 7 Clinical indications for out-of-office blood pressure measurement for diagnostic purposes

Clinical indications for HBPM or ABPM	
• Suspicion of white-coat hypertension	- Grade I hypertension in the office
	- High office BP in individuals without asymptomatic organ damage and at low total CV risk
• Suspicion of masked hypertension	- High normal BP in the office
	- Normal office BP in individuals with asymptomatic organ damage or at high total CV risk
• Identification of white-coat effect in hypertensive patients	
• Considerable variability of office BP over the same or different visits	
• Autonomic, postural, post-prandial, siesta- and drug-induced hypotension	
• Elevated office BP or suspected pre-eclampsia in pregnant women	
• Identification of true and false hypertension	

8.2 Follow-up of subjects with high blood pressure and white-coat hypertension

Individuals with high normal BP or white-coat hypertension have additional risk factors, including a higher chance of developing office hypertension, respectively 28, 35, 51, 67% (see Section 5.1.6 on smoking cessation). They should be scheduled for regular monitoring of blood pressure in office and out-of-office, according to their profile. Regular annual visits are recommended for appropriate treatment.

(7) What are the optimal out-of-office (home and ambulatory) BP targets to be reached with treatment and should targets be the same or higher in high risk hypertensives?

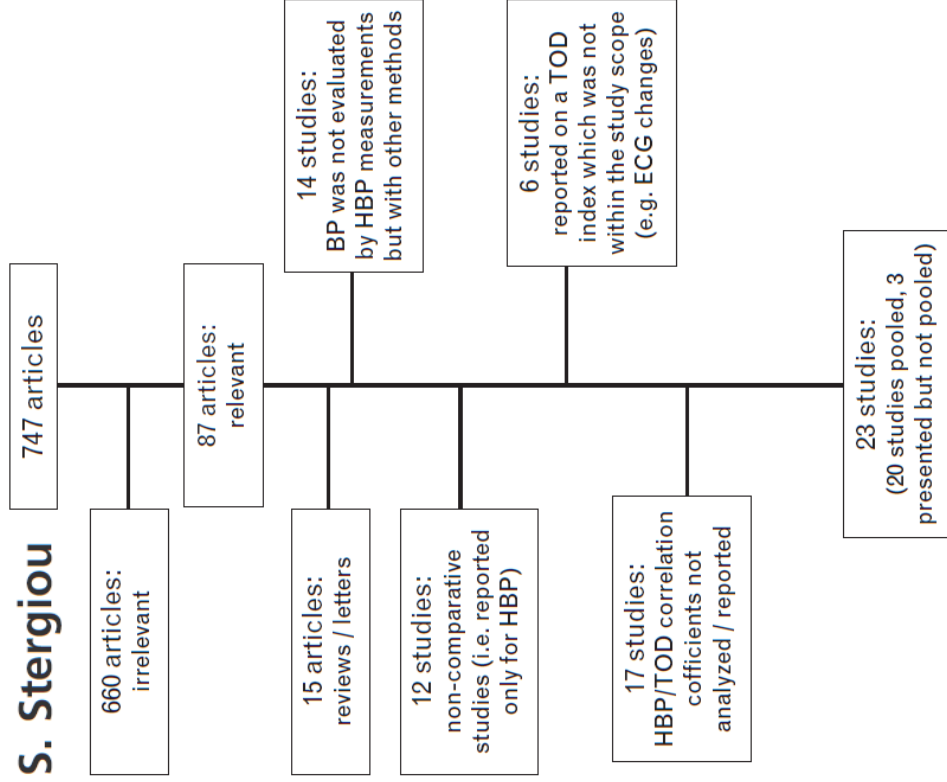
Values to be reached with treatment or absence of dipping, such as lower or higher in high risk hypertensives? (see Section 5.1.6 on smoking cessation). CV risk factors of reinforcement to present the appropriate treatment.

ambulatory blood pressure monitoring; BP = blood pressure; CKD = chronic kidney disease; CV = cardiovascular; HBPM = home blood pressure monitoring

Home versus ambulatory and office blood pressure in predicting target organ damage in hypertension: a systematic review and meta-analysis

Marker of organ damage	Sensitivity for changes	Time to change	Prognostic value of changes
LVH/echo	Moderate	Moderate (>6 months)	Yes

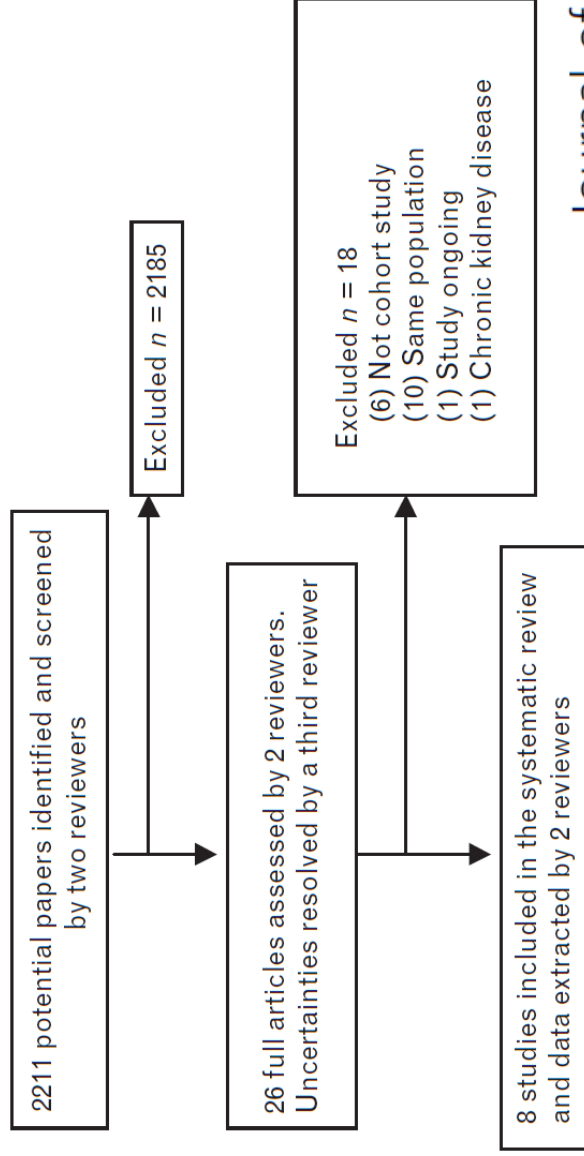
European Heart Journal (2013) 34, 2159–2219



Conclusion: These data suggest that home BP is as good as ambulatory monitoring and superior to office measurements in regard to their association with preclinical organ damage assessed by echocardiographic LVMI.

Home measurement of blood pressure and cardiovascular disease: systematic review and meta-analysis of prospective studies

Alison M. Ward^a, Osamu Takahashi^b, Richard Stevens^a, and Carl Heneghan^a



Journal of Hypertension 2012, 30:449–456

Conclusions: Home BP remained a significant predictor of cardiovascular mortality and cardiovascular events after adjusting for office BP suggesting it is an important prognostic variable over and above that of office BP.

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