Assessing Cardiovascular Risk
Should We Discard Diastolic Blood Pressure?

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High blood pressure (BP), a major established predictor of cardiovascular disease, is the leading risk factor for mortality worldwide.\(^1\),\(^2\) Both systolic BP (SBP) and diastolic BP (DBP) have continuous, independent relations with the risk of cardiovascular disease;\(^3\) however, considerable uncertainty persists about the relative importance of SBP, DBP, and their combination in predicting cardiovascular risk.

Increased peripheral resistance, which is considered to be caused by arterial vasoconstriction, traditionally has been viewed as the key determinant of DBP.\(^4\) This has led to the long-standing conviction that the cardiovascular risks associated with hypertension derive principally from the diastolic component of BP. As a matter of fact, the early releases of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure defined hypertension on the basis of elevated DBP values only (Table).

This view has been challenged by a number of studies demonstrating that SBP outweighs DBP as a predictor of cardiovascular morbidity and mortality\(^5\),\(^6\) and is not just a natural and innocuous consequence of the stiffening of the large arteries caused by aging. It was only in 1988 that the prognostic role of isolated systolic hypertension was acknowledged in the Joint National Committee Report, and since the Fifth Report published in 1993, hypertension has been defined as an elevation of SBP and/or DBP.\(^6\)

**Significance of SBP and DBP**

Given the stronger prognostic value of SBP compared with DBP and the prominent role of aortic stiffness as a predictor of cardiovascular outcomes, a simplified definition of hypertension has been proposed.\(^7\) According to this view, the thresholds for diagnosing and treating hypertension should be based on SBP only, and DBP values should be discarded, at least in individuals 50 years of age or older. A number of other undisputed theoretical and practical reasons support this position. SBP tends to rise continuously throughout life, whereas DBP rises up to approximately 50 years of age, then levels off and tends to decrease after the age of 60.\(^8\) As a consequence thereof, elevated SBP is more prevalent than DBP in populations with increasing life expectancy.\(^9\) Moreover, poor SBP control is much more common than poor DBP control.\(^10\) Also, measurement of SBP is more accurate than that of DBP. Finally, a single number is simpler to communicate in public health initiatives and may be an easier target to focus on for physicians.

In the recent issue of *Circulation*, Franklin et al\(^1\) shed new light on the debated issue of which BP components best capture the BP-associated cardiovascular risk. The authors took advantage of the prospectively collected database of the Framingham Heart Study. In 9657 adults who were free from cardiovascular disease and without antihypertensive therapy, the authors confirmed that SBP is a stronger risk factor for cardiovascular disease than DBP. More importantly, they demonstrated that the combined evaluation of SBP and DBP improves cardiovascular risk prediction over the 2 individual components. The model that included both SBP and DBP was significantly better than the models that included a single BP component (SBP or DBP) in predicting cardiovascular risk, although the increase in the area under the receiver operating characteristic curve of the SBP-plus-DBP model compared with the SBP model was lower in the multivariate-adjusted than in the unadjusted model, which suggests that some of the incremental prognostic information provided by DBP may already be included in the other commonly accepted risk markers. These data are in agreement with an earlier analysis of the Multiple Risk Factor Intervention Trial that showed that the addition of DBP to SBP improved prediction of cardiovascular mortality in middle-aged men.\(^12\)

What added value can the evaluation of DBP convey beyond that of SBP in cardiovascular risk stratification? First, isolated diastolic hypertension was a cardiovascular risk factor in the study by Franklin et al.\(^1\) Subjects with isolated diastolic hypertension represented 14% of the hypertensive population, and their cardiovascular risk was found to be about twice that of the subjects with normal BP. It must be recognized that in the setting of the Framingham Heart Study, subjects with isolated diastolic hypertension also tend to have a cluster of markers of cardiovascular risk, including male sex, smoking, and higher body mass index,\(^13\) which may explain in part the risk associated with high DBP. However, the increased cardiovascular risk among subjects with isolated diastolic hypertension was confirmed in a multivariate-adjusted model. Moreover, a recently published analysis of a large, nationwide Chinese database also confirmed that isolated diastolic hypertension is an independent risk factor for cardiovascular disease.\(^14\) Overall, these data suggest that the view of isolated DBP elevation as a low-risk condition should be reconsidered. Second, DBP was...
Table. Evolving Definition of Hypertension in Adults According to the Joint National Committee Guidelines

<table>
<thead>
<tr>
<th>Guideline</th>
<th>Publication Year</th>
<th>BP Criterion</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>JNC 1</td>
<td>1976</td>
<td>DBP</td>
<td>$\geq 90$ mm Hg</td>
</tr>
<tr>
<td>JNC 2</td>
<td>1980</td>
<td>DBP</td>
<td>$\geq 90$ mm Hg</td>
</tr>
<tr>
<td>JNC 3</td>
<td>1984</td>
<td>DBP</td>
<td>$\geq 90$ mm Hg</td>
</tr>
<tr>
<td>JNC 4</td>
<td>1988</td>
<td>DBP + isolated systolic hypertension</td>
<td>$\geq 90$ mm Hg</td>
</tr>
<tr>
<td>JNC 5</td>
<td>1993</td>
<td>SBP and/or DBP</td>
<td>$\geq 140/90$ mm Hg</td>
</tr>
<tr>
<td>JNC 6</td>
<td>1997</td>
<td>SBP and/or DBP</td>
<td>$\geq 140/90$ mm Hg</td>
</tr>
<tr>
<td>JNC 7</td>
<td>2003</td>
<td>SBP and/or DBP</td>
<td>$\geq 140/90$ mm Hg</td>
</tr>
</tbody>
</table>

JNC indicates Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure.

found to have a nonlinear, quadratic relation with cardiovascular risk, and the highest multivariate-adjusted risk was recorded in those subjects with both high SBP and low DBP. Presumably because this combination of BP values is the typical hemodynamic consequence of increased large-artery stiffness, a well-known independent predictor of advanced vascular disease and mortality. For instance, subjects with SBP $\geq 180$ mm Hg and a DBP between 80 and 89 mm Hg had a 2.4-fold multivariate-adjusted risk compared with normotensive individuals, whereas the OR increased to 9 in the subjects with similar SBP but a DBP between 70 and 79 mm Hg and to 7.7 in the presence of a DBP $\geq 110$ mm Hg. These data extend to a large, general-population-based cohort the findings of a meta-analysis performed by Staessen et al., showing that arterial resistance-stiffness model based on mean and pulse pressures has relevant pathophysiological implications, however. In contrast to DBP, which displayed a quadratic relation with cardiovascular risk, both mean and pulse pressure had a linear, independent relation with risk. These data, in agreement with previous reports, show that arterial resistance (represented approximately by mean arterial pressure) and large-artery stiffness (witnessed by pulse pressure) have joint adverse effects on the subsequent risk of cardiovascular disease.

The present study should be considered within the context of its limitations. It has been suggested that stroke might preferentially be predicted by mean arterial pressure, whereas pulse pressure could have a stronger impact on coronary heart disease. Unfortunately, the analysis by Franklin et al. only considered overall cardiovascular end points (largely because of a power issue) and did not take into account coronary and cerebrovascular outcomes separately. Moreover, to maximize the number of person-observations and to utilize the information provided by multiple BP measurements obtained over the years in a given individual, the observation time was divided into serial 4-year intervals, each of which was treated as an independent observation (despite coming from the same individual), and the different BP components obtained at the beginning of each 4-year period and their combinations were related to the occurrence of cardiovascular events over the next 4 years. Thus, despite the 50-year-long duration of the Framingham Heart Study, the present analysis only considered short-term cardiovascular risks. This might explain in part why the authors could not replicate their previous findings based on long-term observations from the Framingham Heart Study. In that study, a progressive shift from DBP to SBP and then to pulse pressure was found with increasing age, whereas in the present short-term analysis, no significant effect of age was documented.

What are the clinical and public health implications of these findings? It is unquestionable that SBP is able to capture most of the prognostic significance of BP, especially in subjects above the age of 50 years; however, it is not yet time to discard DBP. The results of this large prospective study and other observations suggest that isolated diastolic hypertension should not be regarded as a benign entity. These findings support the recommendation of the Seventh Joint National Committee to consider both SBP and DBP in the definition and management of hypertension. Moreover, the combination of high SBP and low DBP represents a condition of particularly high cardiovascular risk, which has been emphasized appropriately in the 2007 European guidelines on high blood pressure management and deserves to be better highlighted in forthcoming releases of the Joint National Committee recommendations.

Disclosures

None.

References


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