

Who Owns Hypertension?

Tina Turner's Death Turns Spotlight on Nephrologists' Role in Treating High Blood Pressure

By Eric Seaborg

When rock icon Tina Turner died on May 24, 2023, at age 83, many obituaries highlighted her status as a patient with kidney disease. Her death brought new attention to her widely read blog post on a website for patients with kidney diseases, titled “My kidneys are victims of my elevated blood pressure” (1). Turner was diagnosed with hypertension in 1978 at approximately age 40, but said she “didn’t care much about it. I can’t remember ever getting an explanation about what high blood pressure means or how it affects the body.”

In a plea for other patients to take the condition seriously, Turner wrote that had she known more about the deleterious effects of hypertension on her kidneys, she would have taken it more seriously, noting, “My kidneys are victims of me denying the fact that my hypertension needed therapy with conventional medicine.”

Taking ownership

Turner’s story invigorated an ongoing debate in the kidney community about nephrologists’ role in treating hypertension. “[W]e need to continue to take ownership of hypertension as nephrologists,” Kenar D. Jhaveri, MD, FASN, professor of medicine at the Donald and Barbara Zucker School of Medicine at Hofstra/Northwell in Hempstead, NY, and editor-in-chief of *Kidney News*, wrote in these pages last year (2).

Jhaveri says that in recent years, “There has been more interest in the nephrology community to be in charge of treating hypertension. A lot of the divisions of kidney disease[s] include hypertension in their name. Cardiologists, internists, and nephrologists can take on these patients, but out of experience and interest, I think nephrologists can do a better job. When the patient’s regular doctor can’t handle it, instead of going through other specialists, maybe the first referral should be to a nephrologist.”

“Nephrology already owns hypertension,” according to Aldo Peixoto, MD, professor of medicine in nephrology at Yale School of Medicine, New Haven, CT. He says that hypertension was formerly “a sort of subspecialty” of cardiology, but over the past 20–30 years, more cardiologists have focused their attention on interventional cardiology and other procedure-based approaches and paid less attention to preventive cardiology. His sense from his involvement with the former American Society of Hypertension (ASH) and with the American Heart Association’s (AHA’s) Hypertension Council is that nephrologists outnumber cardiologists in these groups.

Peixoto says that hypertension is so common among the general population that it needs to be handled “in general internal medicine,” and most cases can be handled with a simple drug regimen. But for the 15%–20% of patients who need to see a subspecialist for resistant hypertension, nephrologists “are very good at treating” these complicated, more difficult cases.

“It’s important not to have turf wars about who should do what,” says Swapnil Hiremath, MD, MPH, associate professor at the University of Ottawa and staff nephrologist at The Ottawa Hospital in Ontario, Canada. “Whoever does it the best should do it. I have seen all sorts of people doing hypertension work: a family doctor, internist, nephrologist, cardiologist, clinical pharmacologist, and endocrinologist. But they need to know what they are doing.”

Hypertension certification

Hiremath worries that some nephrologists think hypertension is simple—as he did when he began practicing—and

do not take an adequate interest in learning about it. When a colleague recruited Hiremath to help with research projects, he found that his nephrology fellowship had not prepared him adequately for the level of hypertension knowledge he needed. Hiremath studied and pursued specialist certification from the former ASH.

The former ASH established that certification program in 1998, but the society dissolved 6 years ago. However, a group of physicians carried on the American Hypertension Specialist Certification Program (AHSCP) (3), which is currently governed by a board of directors of nine physicians, of whom three of its five officers are nephrologists. The certification exam is administered by the Professional Testing Corporation, a company headquartered in New York City.

The AHA absorbed another project of the former ASH: certification of hypertension centers. One requirement for certification as a center is that the director must be certified by the AHSCP. The AHA website lists fewer than 20 centers that have been certified nationwide. (The AHA certifies hypertension centers, not people.) The AHA also established the Hypertension Council among its many scientific councils. The Hypertension Council holds annual hypertension scientific sessions in conjunction with the AHA’s Council on the Kidney in Cardiovascular Disease.

In another area reflecting its influence, the AHA and the American College of Cardiology published the influential, general “2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults” (4), explains Peixoto, who contributed to the guideline as a reviewer representing the former ASH. (ASN was not among the 11 organizations listed as official collaborators.)

Consequences of hypertension

AHA’s interest in hypertension reflects that stroke and heart failure top the list of the condition’s most serious risks. “Most patients die of cardiovascular disease or stroke before they reach end stage kidney disease,” says Matthew Sparks, MD, FASN, associate professor of medicine in the Division of Nephrology at Duke University, Durham, NC, noting it is relatively rare to see a patient with end stage kidney disease compared with cardiovascular problems. “It is an independent risk factor for cardiovascular disease. When you have kidney disease, you have cardiovascular disease. The kidney plays a really important role in the long-term management of blood pressure. Perturbations in the kidney cause high blood pressure, and high blood pressure causes perturbations in the kidney. It is kind of a chicken and the egg.”

This interplay illustrates how hypertension cuts across disciplines—and a sampling of the leadership of a few hypertension centers around the country reveals the diversity of specialties involved in treatment. The University of Chicago’s AHA-certified center is led by a nephrologist, as is the center at Hiremath’s institution. The Center for Resistant Hypertension at Johns Hopkins Medicine in Baltimore, MD, is led by a cardiologist. The clinical director of the AHA-certified center at Beth Israel Deaconess Medical Center in Boston, MA, is an internist. All six of the physicians at the Brigham and Women’s Hospital Hypertension Clinic in Boston are endocrinologists. This diversity can lead to a lack of clarity about which discipline should take charge in cases of hypertension, but nephrologists are perfectly positioned to do so, Hiremath says.

“If you look at what causes hypertension, in most cases, the kidney is involved in one way or the other, so who else but us [nephrologists] should know about it?” Hiremath asks. “We need to know how to treat blood pressure well

because our patients very commonly have high [blood] pressure.” Hiremath believes that nephrologists who did not get enough exposure to treating hypertension during their fellowship should pursue training, which can be done in a variety of ways. “If you have people on your faculty who have expertise, and you do a rotation in that clinic or work with them, you will get good training. On the other hand, if you are [at] a center where hypertension is not a part of any nephrologist’s interest, and the cardiologists or endocrinologists are managing hypertension, then you are not going to get enough exposure. You have to work with patients, even [if it means working with] someone outside of nephrology who is working in hypertension.”

Sparks suggests that nephrologists should play a leadership role in hypertension in at least two ways: “One role is to disseminate best practices to be involved in clinical guidelines and research. And the other role is, because a lot of our patients have hypertension, we have to be good at treating it. If you see a patient with uncontrolled hypertension, it is not something that you punt back to primary care. One of our biggest roles is to try to uncover the reason why an individual has hypertension.”

Jhaveri points out that another reason for ownership of hypertension is the opportunity it offers for finding additional cases of kidney diseases. “We do get consulted for resistant hypertension, and we often diagnose patients with kidney disease [who] might have actually triggered the hypertension,” he explains.

In Tina Turner’s case, it’s not possible to make a diagnosis or draw definitive conclusions without access to her medical records, but in her memoirs and the blog post, she detailed a long and complicated medical history that included strokes, dialysis, and a kidney transplant. Her belief that her kidneys were the victim of her elevated blood pressure might be debatable. “It is kind of old school science that hypertension causes kidney disease,” Jhaveri says. “There is actually more and more data that [it] is the other way around, that kidney disease might be the cause of hypertension.” Sparks notes that getting hypertension at the age of 40 is unusual. The knowledge was not available at the time of her diagnosis so many years ago, but nephrologists have since learned about polymorphisms in the apolipoprotein L1 gene that can raise the risk for chronic kidney disease. But that might be all the more reason for nephrologists to be engaged in hypertension treatment. As Turner noted in her blog post: “The struggle for healing is always also a struggle for accurate information!” ■

References

1. Turner T; European Kidney Health Alliance. My kidneys are victims of my elevated blood pressure. 2023. <https://www.showyourkidneyslove.com/articles/my-kidney-are-victims-of-my-elevated-blood-pressure-tina-turner/>
2. Jhaveri K. Hypertension 2022: Nephrologists in charge. *Kidney News*, January 2022; 14(1):17–19. https://www.kidneynews.org/view/journals/kidney-news/14/1/article-p17_10.xml
3. American Hypertension Specialist Certification Program (AHSCP). <https://www.ahscp.org/>
4. American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. 2017 Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults. September 2017. https://www.acc.org/-/media/Non-Clinical/Files-PDFs-Excel-MS-Word-etc/Guidelines/2017/Guidelines_Made_Simple_2017_HBP.pdf?utm_version=158324753