When 32nd American President died of hypertension

Dear Editor,

Puneeta Gupta *et al.* underscore one of the drawbacks of modern medical science, or of the way it’s now practised: unnecessary, costly, avoidable and potentially harmful care.[1] They correctly state that at the beginning, medical science used to deal with only diseased patients by diagnosing and treating them. But in due course of time with its expansion, we started to label apparently healthy persons unhealthy by changing definitions of abnormality, lowering thresholds of tests, hence overriding normal with abnormal. Nonetheless here we’d like to cite the longest and the largest prospective cohort study of our times – the Framingham heart study – initiated in 1948 after the death of the then US President, Franklin D Roosevelt in 1945 by stroke.[2]

To further investigate the then expanding epidemic there of cardiovascular disease, which rapidly became the number one killer, federal agencies pumped in large sums of money and efforts; as a result today we know certain risk factors associated with the illness; which if properly controlled, significantly reduce the risk of premature death.[3] Under a header, ‘The overdiagnosis in many common chronic conditions (non neoplastic)’, the authors state that labelling a diagnosis and then treating them with drugs has not proved to decrease mortality and morbidity due to hypertension. However, we treat such people not only for some fancy number but based on their overall risk to future CV events – based on Framingham Risk Score. & Such calculation has been shown to decrease overall morbidity and mortality.[4] For example, we treat a person for even a mild rise in blood pressure if he is a diabetic too. The larger is the risk factor profile in an individual, the greater is the risk reduction in him. And as all the actuarial analysis applies for the population, their value for an individual may lie anywhere on a normal curve.

Similarly, in a carefully selected patient population, various devices including biventricular pacing, Implantable Cardiovverter Defibrillator and Cardiac Resynchronization Therapy are shown to improve survival – even when the individual is largely asymptomatic and his selection is based purely/mainly on electro/echocardiographic parameters.[5] When certain ECG/Cartographic/ Holter/Echo findings are there in an individual, & they are at an increased risk of future potentially life-threatening events, implantation of certain devices are known to improve survival, hence further giving value to screening this cohort.

Under the same header, the authors also write that following the same logic gestational diabetes can also be overdiagnosed. However, current evidence indicate that meticulously controlling blood sugar profile of an expectant mother around childbirth significantly improves short- and long-term prognosis, reduces the incidence of various perinatal complications that otherwise occur at a higher frequency and still is not available to a large part of masses. Moreover, now evidence is emerging that those women found to be having gestational diabetes, run an increased risk of development of diabetes or prediabetes in the future.[6] Therefore, there is a need to evolve guidelines to advise that where screening gives value to care and where not.

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