Antihypertensive Efficacy of Hydrochlorothiazide as Evaluated by Ambulatory Blood Pressure Monitoring

A Meta-Analysis of Randomized Trials

Franz H. Messerli, MD,* Harikrishna Makani, MD,* Alexandre Benjo, MD,* Jorge Romero, MD,* Carlos Alviar, MD,* Sripal Bangalore, MD, MHA†

New York, New York

Objectives
The purpose of this study was to evaluate the antihypertensive efficacy of hydrochlorothiazide (HCTZ) by ambulatory blood pressure (BP) monitoring.

Background
HCTZ is the most commonly prescribed antihypertensive drug worldwide. More than 97% of all HCTZ prescriptions are for 12.5 to 25 mg per day. The antihypertensive efficacy of HCTZ by ambulatory BP monitoring is less well defined.

Methods
A systematic review was made using Medline, Cochrane, and Embase for all the randomized trials that assessed 24-h BP with HCTZ in comparison with other antihypertensive drugs.

Results
Fourteen studies of HCTZ dose 12.5 to 25 mg with 1,234 patients and 5 studies of HCTZ dose 50 mg with 229 patients fulfilled the inclusion criteria. The decrease in 24-h BP with HCTZ dose 12.5 to 25 mg was systolic 6.5 mm Hg (95% confidence interval: 5.3 to 7.7 mm Hg) and diastolic 4.5 mm Hg (95% confidence interval: 3.1 to 6.0 mm Hg) and was inferior compared with the 24-h BP reduction of angiotensin-converting enzyme inhibitors (mean BP reduction 12.9/7.7 mm Hg; p < 0.003), angiotensin-receptor blockers (mean BP reduction 13.3/7.8 mm Hg; p < 0.001), beta-blockers (mean BP reduction 11.2/8.5 mm Hg; p < 0.00001), and calcium antagonists (mean BP reduction 11.0/8.1 mm Hg; p < 0.05). There was no significant difference in both systolic (p = 0.30) and diastolic (p = 0.15) 24-h BP reduction between HCTZ 12.5 mg (5.7/3.3 mm Hg) and HCTZ 25 mg (7.6/5.4 mm Hg). However, with HCTZ 50 mg, the reduction in 24-h BP was significantly higher (12.0/5.4 mm Hg) and was comparable to that of other agents.

Conclusions
The antihypertensive efficacy of HCTZ in its daily dose of 12.5 to 25 mg as measured in head-to-head studies by ambulatory BP measurement is consistently inferior to that of all other drug classes. Because outcome data at this dose are lacking, HCTZ is an inappropriate first-line drug for the treatment of hypertension. (J Am Coll Cardiol 2011;57:590–600) © 2011 by the American College of Cardiology Foundation

Hydrochlorothiazide (HCTZ) has been available for half a century and remains the most commonly prescribed antihypertensive drug worldwide. In the U.S. alone, >134.1 million prescriptions of HCTZ were written in the year 2008 (1). For comparison, the second most commonly prescribed drug was atenolol, with 44 million prescriptions (1). More than a third of the HCTZ prescriptions (47.5 million) were written for monotherapy and the remainder in fixed combination, mostly with blockers of the renin-angiotensin system. The dose of HCTZ prescribed was almost exclusively (>97%) 12.5 to 25 mg/day, and hypertension remains, by far, the most common indication. Over the past 30 years, this persistent prescription pattern of HCTZ has been heavily influenced by reports of the Joint National Committee for Prevention, Detection, Evaluation, and Treatment of High Blood Pressure, all 7 of which recommended “thiazides” or “thiazide-like drugs” or “thiazide-type diuretics” as first-line or as preferred therapy for hypertension. In an attempt to promote the use of thiazide-type diuretics, the National Heart, Lung, and Blood Institute sponsored the ALLHAT/JNC7 (Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial/Joint National Committee Seventh Report) dissemination project, which reached

From the *Division of Cardiology, St. Luke’s Roosevelt Hospital, Columbia University College of Physicians and Surgeons, New York, New York; and the †Division of Cardiology, New York University School of Medicine, New York, New York. Dr. Messerli reports that he has served as an ad hoc consultant for Novartis, Boehringer Ingelheim, Daiichi Sankyo, Sanofi, and Takeda; and has received research funding and grants from Novartis, Boehringer Ingelheim, and Forest. All other authors have reported that they have no relationships to disclose. None of the authors received any compensation for their work on this manuscript.

Manuscript received April 7, 2010; revised manuscript received June 29, 2010, accepted July 5, 2010.
18,524 physicians in 1,698 venues through 147 physician educators (2). This effort resulted in a small increase in thiazide-type diuretics use that almost exclusively consisted of HCTZ. However, despite the extensive use, little evidence is available regarding the efficacy and safety of HCTZ for the treatment of essential hypertension, particularly at the dose of 12.5 to 25 mg. In the following paper, we scrutinize antihypertensive efficacy of HCTZ as assessed by 24-h ambulatory blood pressure (ABP) monitoring and the evidence for morbidity and mortality reduction available in the extensive literature on this drug.

Methods

Search strategy. We searched PubMed, Embase, and Cochrane Central Register of Clinical Trials (Cochrane Library, Issue 2, 2009) using the terms "HCTZ," "hydrochlorothiazide," "ABP," "ambulatory blood pressure," and "hypertension." We limited our search to randomized trials in human subjects and in peer-reviewed journals from 1966 to March 2010. No language restriction was applied. The reference lists of identified articles and bibliographies of original articles were also reviewed. Trials in the abstract form without a manuscript published were excluded for this analysis.

Selection criteria. To be included in the analysis, a trial had to fulfill the following criteria: 1) randomized trials involving patients with hypertension that assessed the antihypertensive efficacy by 24-h ABP monitoring comparing HCTZ with other antihypertensive drug classes; 2) use of HCTZ as a monotherapy in the trial; and 3) trial duration of at least 4 weeks.

Data extraction. Two reviewers (J.R. and C.A.) extracted the data independently and in duplicate. Data were extracted using standardized protocol and reporting form. Disagreements were resolved by arbitration (H.M. or A.B.), and consensus was reached after discussion. We extracted characteristics of each trial, duration of intervention and methods, baseline demographics, and 24-h ABP and office BP at baseline and after the intervention for our analysis. Authors of the papers were individually contacted in case the data were unclear.

Outcomes assessed. The main outcome of the present analysis was BP (systolic/diastolic) reduction from baseline to follow-up.

Quality assessment. The criteria used for quality assessment were sequence generation of allocation, allocation concealment, blinding of participants, personnel, and outcome assessors, incomplete outcome data, selective outcome reporting, and other sources of bias (3). We classified studies with high or unclear risk for bias for any of the first 3 components as low quality.

Statistical analysis. The statistical analysis was done in line with recommendations from the Cochrane Collaboration and the Quality of Reporting of Meta-analyses (QUORUM) guidelines (4) using Review Manager (RevMan) version 5.0.23 (Copenhagen, Nordic Cochrane Centre, The Cochrane Collaboration, 2008).

Heterogeneity was assessed using the I^2 statistics. The I^2 statistic is the proportion of total variation observed between the trials attributable to differences between trials rather than sampling error (chance), and we considered I^2 <25% as low and I^2 >75% as high. The random-effects model of DerSimonian and Laird (5) was used to calculate the effect sizes if I^2 >25% and/or p < 0.05. Analysis was performed on an intention-to-treat basis. Data from changes in baseline BP were combined using the weighted mean difference method. Publication bias was estimated visually by funnel plots, and/or using Begg’s test and the weighted regression test of Egger (6). For trials that did not provide complete information about variance for net change in BP, the information was obtained from confidence intervals (CIs), p value, or r statistics. Variance was estimated from pre-test–post-test (parallel group and factorial design) and crossover designs, as suggested by Pollmann et al. (7)

Sensitivity analysis. Sensitivity analysis was performed for BP reduction in HCTZ dose 12.5 to 25 mg based on the quality of study, study design, and type of blinding in the study. We estimated difference between subgroups according to the tests of interaction (8).

Results

Study selection. We identified 2,440 articles, out of which 86 abstracts were retrieved and reviewed for possible inclusion (Fig. 1). Nineteen studies (Table 1) enrolling 1,463 patients (mean age 58 years; 54% men) fulfilled the inclusion criteria and were included in the analysis.

Baseline characteristics. Of the 19 studies, 14 studies (9–22) enrolling 1,234 patients evaluated HCTZ dose 12.5 to 25 mg, and 5 studies (23–27) with 229 patients evaluated HCTZ dose 50 mg. Of the 14 studies of HCTZ dose of 12.5 to 25 mg, 4 studies evaluated HCTZ 12.5 mg dose, 1 evaluated HCTZ 12.5 to 25 mg dose, and the majority (9 studies) evaluated HCTZ 25 mg dose. Fifteen studies (28–42) were excluded because they did not meet the inclusion criteria: 5 had inadequate data, 3 were nonrandomized studies, 2 had HCTZ combined with other drugs in case of inadequate response, 2 were duplicate studies, 1 had HCTZ compared with placebo, and 1 had HCTZ compared with exercise.

Quality assessment. Of the 14 studies with HCTZ dose 12.5 to 25 mg, 4 studies reported adequate generation of allocation sequence and adequate allocation concealment, and 10 reported adequate masking of participants, personnel, and outcome assessors. On the basis of quality assess-
ment, 4 were deemed as low bias risk trials and the rest as high bias risk.

**Antihypertensive efficacy.** The antihypertensive efficacy of HCTZ in the dose of 12.5 to 25 mg was assessed from 14 randomized controlled trials. The mean baseline BP in these studies was 148/110 mm Hg. After treatment with HCTZ for a mean duration of 17 weeks, systolic ABP decreased by 6.5 mm Hg (95% CI: 5.3 to 7.7 mm Hg) and diastolic ABP by 4.5 mm Hg (95% CI: 3.1 to 6.0 mm Hg) (Figs. 2 and 3). Other antihypertensive agents such as angiotensin-converting enzyme (ACE) inhibitors, angiotensin-receptor blockers (ARBs), beta-blockers, and calcium antagonists were significantly more efficacious than HCTZ in the dose of 12.5 to 25 mg as shown in Figure 2.

**Figure 1 Selection of Studies**

HCTZ = hydrochlorothiazide.

**Head-to-head comparisons.** In head-to-head comparisons with other antihypertensive drug classes, HCTZ in the usual dose of 12.5 to 25 mg lowered systolic ABP less well than ACE inhibitors by 4.5 mm Hg (p = 0.001), ARBs by 5.1 mm Hg (p = 0.003), beta-blockers by 6.2 mm Hg (p < 0.00001), and calcium antagonists by 4.5 mm Hg (p = 0.02). HCTZ lowered diastolic ABP less well than ACE inhibitors by 4.0 mm Hg (p < 0.0001), ARBs by 2.9 mm Hg (p = 0.002), beta-blockers by 6.7 mm Hg (p < 0.00001), and calcium antagonists by 4.2 mm Hg (p = 0.0001) (Figs. 4 and 5).

**Office versus ambulatory pressure.** Both office BP and ABP readings were available in 8 studies with HCTZ in the commonly used dose of 12.5 to 25 mg evaluating 488
### Table 1 Baseline Characteristics of Studies Included in the Meta-Analysis

<table>
<thead>
<tr>
<th>First Author (Ref #)</th>
<th>Study Design</th>
<th>Inclusion Criteria</th>
<th>n</th>
<th>Follow-Up (Weeks)</th>
<th>Age (yrs)</th>
<th>Men (%)</th>
<th>HCTZ Dose (mg)</th>
<th>Comparison Drug (mg)</th>
<th>Baseline ABP (mm Hg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Falconnet et al. (10) 2004</td>
<td>P, SB, RC, CO</td>
<td>Hypertensive patients of East African descent</td>
<td>61</td>
<td>4 49 56</td>
<td>25</td>
<td>Lisinopril 20</td>
<td>139/92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Galzerano et al. (11) 2004</td>
<td>P, DB, RC</td>
<td>Mild to moderate essential hypertension</td>
<td>69</td>
<td>52 54 55</td>
<td>25</td>
<td>Telmisartan 80</td>
<td>154/95</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kraiczi et al. (12) 2000</td>
<td>P, DB, CO, RC</td>
<td>Hypertensive patients with obstructive sleep apnea</td>
<td>40</td>
<td>12 57 100</td>
<td>25</td>
<td>Amlodipine 5, atenolol 50, enalapril 20, losartan 50</td>
<td>145/92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacourcière et al. (14) 1995</td>
<td>P, DB, R, PC</td>
<td>Mild to moderate primary hypertension</td>
<td>42</td>
<td>32 69 60</td>
<td>12.5-25</td>
<td>Amlodipine 5-10</td>
<td>154/89</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacourcière et al. (13) 2003</td>
<td>P, OL, PG, RC</td>
<td>Uncomplicated systolic hypertension</td>
<td>120</td>
<td>6 61 55</td>
<td>12.5</td>
<td>Losartan 50</td>
<td>150/86</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelttari et al. (15) 1998</td>
<td>P, DB, CO, RC</td>
<td>Hypertensive patients with obstructive sleep apnea</td>
<td>18</td>
<td>8 52 NR</td>
<td>25</td>
<td>Atenolol 50, lisinopril 50</td>
<td>152/105</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suonsyjälä et al. (16) 2008</td>
<td>P, DB, CO, R, PC</td>
<td>Finnish men with moderate hypertension</td>
<td>233</td>
<td>4 51 100</td>
<td>25</td>
<td>Amlodipine 5, bisoprolol 1, losartan 50</td>
<td>135/93</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tedesco et al. (17) 1998</td>
<td>P, DB, RC</td>
<td>Mild to moderate hypertension</td>
<td>77</td>
<td>95 54 53</td>
<td>25</td>
<td>Losartan 50</td>
<td>156/96</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ubaid-Giroli et al. (18) 2007</td>
<td>P, OL, PG, RC</td>
<td>Mild to moderate hypertension</td>
<td>63</td>
<td>12 49 46</td>
<td>25</td>
<td>Irbesartan 150, quinapril 20</td>
<td>136/88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>White et al. (19) 2008</td>
<td>P, MC, DB, RC</td>
<td>Stage II hypertension</td>
<td>354</td>
<td>8 51 55</td>
<td>25</td>
<td>Ramipril 20</td>
<td>148/92</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wing et al. (20) 2003</td>
<td>P, DB, CO, R, PC</td>
<td>Elderly with hypertension</td>
<td>19</td>
<td>6 68 58</td>
<td>12.5</td>
<td>Candesartan 8-16</td>
<td>161/85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abate et al. (21) 1998</td>
<td>P, MC, DM, DB, RC</td>
<td>Mild to moderate hypertension</td>
<td>84</td>
<td>8 78 46</td>
<td>12.5</td>
<td>Pinacidil 25</td>
<td>148/85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radevski et al. (22) 2002</td>
<td>P, OL, R, PC</td>
<td>Black patients with mild to moderate hypertension</td>
<td>42</td>
<td>12 57 33</td>
<td>12.5</td>
<td>Indapamide 2.5</td>
<td>147/94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lacourcière et al. (23) 1989</td>
<td>P, DB, PG, RC</td>
<td>Mild to moderate hypertension</td>
<td>38</td>
<td>12 57 42</td>
<td>25-50</td>
<td>Zofenopril 30-60</td>
<td>150/94</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morgan et al. (24) 2003</td>
<td>P, DB, CO, R, PC</td>
<td>Elderly hypertensive patients</td>
<td>24</td>
<td>8 77 75</td>
<td>50</td>
<td>Atenolol 50, felodipine 10, perindopril 8</td>
<td>157/85</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Silagy et al. (25) 1992</td>
<td>P, DB, RC</td>
<td>Elderly patients with isolated systolic hypertension</td>
<td>24</td>
<td>6 72 38</td>
<td>25-50</td>
<td>Atenolol 50-100, enalapril 10-20, isradipine 2.5-5</td>
<td>156/76</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wing et al. (27) 1997</td>
<td>P, DB, CO, RC</td>
<td>Elderly patients with isolated systolic hypertension</td>
<td>19</td>
<td>4 71 26</td>
<td>25-50</td>
<td>Lisinopril 2-4</td>
<td>160/84</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**ABP** = ambulatory blood pressure; **BP** = blood pressure; **CO** = crossover; **DB** = double blind; **DBP** = diastolic blood pressure; **DM** = double masked; **FT** = forced-titrated; **HCTZ** = hydrochlorothiazide; **HTN** = hypertension; **MC** = multicenter; **NR** = not reported; **OL** = open label; **P** = prospective; **PG** = parallel group; **R** = randomized; **RC** = randomized controlled; **SB** = single blind; **SBP** = systolic blood pressure.
patients followed up for a mean of 8 weeks. The mean baseline office BP was 163 ± 7.5/98 ± 6.5 mm Hg and the mean ABP was 149 ± 7.4/89 ± 3.6 mm Hg. In these 8 studies, office BP reduction by HCTZ was systolic 12.4 mm Hg (95% CI: 8.1 to 16.6 mm Hg) and diastolic 6.5 mm Hg (95% CI: 3.9 to 9.2 mm Hg). HCTZ lowered mean office systolic BP by 4.9 mm Hg (95% CI: 0.8 to 9.0 mm Hg) better than by ABP monitoring (p = 0.02). Average office diastolic BP was lowered by 2.5 mm Hg (95% CI: 0.9 to 4.1 mm Hg) better than by ABP monitoring (p = 0.002) (Fig. 6).

The mean office systolic and diastolic BP reduction with HCTZ 12.5 to 25 mg of 12.4/6.5 mm Hg was not significantly different from the mean office BP reduction with ACE inhibitors of 11.8/7.4 mm Hg (p = 0.65), with ARBs of 13.3/6.7 mm Hg (p = 0.66), with beta-blockers of 12.9/9.9 mm Hg (p = 0.71), and with calcium antagonists of 12.0/9.7 mm Hg (p = 0.36).

**Dose response.** The ABP was not significantly different when compared between the HCTZ 12.5 dose and the HCTZ 25 mg dose. However, with the HCTZ dose of 50 mg, the reduction in systolic ABP was 12.0 (95% CI: 8.2 to 15.9), and the reduction in diastolic ABP was 5.4 (95% CI: 3.2 to 7.7). Thus, there was a significant difference in the systolic ABP (p = 0.04), but not diastolic ABP (p = 0.97) (Fig. 7), when compared with the 25 mg dose.

Significant heterogeneity was found to be present in the ABP reduction with HCTZ (Fig. 3), head-to-head comparison of HCTZ with ACE inhibitors, ARBs, and calcium antagonists (Figs. 4 and 5), comparison of office BP with ABP monitoring of HCTZ (Fig. 6), office BP reduction with HCTZ, and BP reduction with different doses of HCTZ (Fig. 7). There was no evidence of publication bias for any of our analyses. Sensitivity analyses for various subgroups based on the study design, blinding, and the risk of bias did not make any noticeable difference to these outcomes (data not shown).

**Discussion**

The principal findings of our study are that the most commonly prescribed HCTZ dose of 12.5 to 25 mg has clinically significant inferior antihypertensive efficacy compared with other drug classes used to treat hypertension. Our analysis was based on 24-h ABP monitoring, which is the most thorough and objective way to assess antihypertensive efficacy. In contrast, the reduction of office BP by HCTZ (12.4/6.5 mm Hg) was similar to the reduction of office BP by ACE inhibitors, ARBs, beta-blockers, and calcium-channel blockers.

The office BP reduction with ACE inhibitors (11.4/6.4 mm Hg) and ARBs (11.6/6.5 mm Hg) obtained from Cochrane meta-analysis (43,44) was similar to that obtained from our analysis. Thus, when HCTZ is assessed by outpatient BP measurement, the antihypertensive efficacy seems comparable to that of other antihypertensive drug classes. This finding would indicate that HCTZ lowers BP well during daytime when patients are seen in the physician’s office but has less effect during the night and early morning hours. Indeed, Finkielman et al. (28) documented that the antihypertensive response to HCTZ is overestimated by using office BP measures. In their patient population of 228 subjects treated with HCTZ 25 mg daily, the difference between office BP and 24-h ABP was 4.8/2.1 mm Hg (p < 0.01). This difference is very similar to that found in our present analysis (4.9/2.5 mm Hg). Thus, assessing the antihypertensive efficacy of HCTZ by office BP measurements only is deceptive and is prone to provide to physicians and patients a false sense of security.

Not surprisingly, at a daily dose of 50 mg and above, HCTZ’s antihypertensive efficacy seems to be similar to most other drug classes. However, all biochemical adverse effects such as hypokalemia, hypernatremia, hyperuricemia, insulin resistance, and visceral fat accumulation are dose dependent and become clinically more significant with daily doses exceeding 25 mg (45). Thus, biochemical adverse effects of HCTZ may prohibit the prescription of higher doses in many patients. An additional concern is the risk of sudden cardiac death that has been shown to increase in a dose dependant fashion with HCTZ doses exceeding 25 mg daily (46). A recent meta-analysis also showed that the chlorthalidone reduces systolic BP significantly better than the HCTZ at equivalent doses of both drugs without increase in the risk of hypokalemia (47).

What then is the evidence that HCTZ reduces morbidity and mortality in hypertension? A thorough scrutiny of the literature reveals that outcome evidence for low-dose HCTZ is lacking. All outcome studies were done with higher doses than the currently used 12.5 to 25 mg or with other thiazides such as chlorthalidone or indapamide.
HCTZ was compared with and found to be inferior to enalapril in the large Australian National Blood Pressure 2 study (48), although the exact dose was not specified. In the MRFIT (Multiple Risk Factor Intervention Trial) study (49), both HCTZ and chlorthalidone were used, and the highest mortality rates were found in a subset of hypertensive patients treated with HCTZ, with death most likely from lethal arrhythmias due to hypokalemia. In 9 clinics whose staff prescribed HCTZ, the trend of mortality was unfavorable whereas it was favorable in the 6 clinics whose staff primarily used chlorthalidone (50). The investigators decided to switch everybody to chlorthalidone, and concluded that the more favorable mortality trend was due to “a change in the diuretic treatment protocol about 5 years after randomization which involved replacement of HCTZ with chlorthalidone” (50). On the basis of these data, we have to conclude that, for the most prescribed antihypertensive drug in the U.S., outcome evidence is lacking. In its commonly used dose of 12.5 to 25 mg once a day, there has been no evidence that HCTZ reduces myocardial infarction, stroke, or death. This lack of outcome data together with the poor antihypertensive efficacy should strongly motivate physicians to refrain from prescribing HCTZ as initial therapy in hypertension.
The fact that our data indicate that HCTZ in its commonly used dose is a suboptimal antihypertensive drug should not prevent it from being useful in combination with a blocker of the renin-angiotensin system such as an ACE inhibitor, an ARB, or even a direct renin inhibitor. Numerous, mostly factorial design studies have shown that when combined with these drug classes, HCTZ, even at low doses, elicits a distinct incremental fall in BP. That would

Figure 4  Systolic 24-h ABP Reduction by HCTZ at 12.5 to 25 mg Compared With Other Antihypertensive Drugs

Head-to-head comparison of systolic 24-h ambulatory blood pressure (ABP) reduction with hydrochlorothiazide (HCTZ) at the dose of 12.5 to 25 mg with other classes of antihypertensive drugs. Trial references as in Table 1; abbreviations as in Figure 3.
indicate that HCTZ is more useful as an “enhancer” or “sensitizer” for the antihypertensive effect of renin-angiotensin system blockers than as a monotherapeutic agent. However, even when combined with a renin-angiotensin system blocker, outcome data suggest that HCTZ is inferior to amlodipine, as was reported in the recent ACCOMPLISH (Avoiding Cardiovascular Events in Combination Therapy in Patients Living With Systolic Hypertension) study (51).

Figure 5  Diastolic 24-h ABP Reduction by HCTZ at 12.5 to 25 mg Compared With Other Antihypertensive Drugs

Head-to-head comparison of diastolic 24-h ambulatory blood pressure (ABP) reduction with hydrochlorothiazide (HCTZ) at the dose of 12.5 to 25 mg with other classes of antihypertensive drugs. Trial references as in Table 1; abbreviations as in Figure 3.
Clinical implications. HCTZ still remains the most commonly prescribed antihypertensive drug in the U.S. and worldwide. The National Heart, Lung and Blood Institute continues to advocate (2) the use of “thiazide-type diuretics,” which, for practicing physicians, simply means HCTZ in a daily dose of 12.5 to 25 mg. However, because the BP-lowering effect of HCTZ is inferior to that of every other drug class and outcome data at commonly used doses are nonexistent, its use as a first-line antihypertensive agent is ill advised. On a milligram-per-milligram basis using pooled data, chlorthalidone, for which solid outcome data are available, produced greater reductions in systolic BP than HCTZ did, while mean changes in potassium were found to be equivalent (47). Thus, if a clinical indication calls for a thiazide-type diuretic, chlorthalidone or indapamide remain the drugs of choice.

Study limitations. As in other meta-analyses, given the lack of data in each trial, we did not adjust our analyses for compliance to assigned therapy. Also, the results are subject to limitations inherent to any meta-analysis based on pooling of data from different trials with different designs, different duration, and different patient groups. The trials
did not report cardiovascular outcomes, and hence, the superiority of ABP monitoring over office BP measurement for prevention of cardiovascular outcomes cannot be derived from our study. However, there are solid data establishing ABP monitoring as a better surrogate end point than office BP measurement (52). There is also evidence that thiazides are primarily or only effective for patients with low renin, salt-volume hypertension, so monotherapy limited to this group might have shown different results; however, the design of the meta-analysis precluded examining such a possibility (53). Although no clear dose range was established for other antihypertensive drugs when used for comparison with HCTZ in this meta-analysis, most of these drugs were used in one-half the maximal dose.

Conclusions

HCTZ in its commonly used dose of 12.5 to 25 mg daily lowers BP significantly less well than do all other drug classes as measured in head-to-head studies by ABP monitoring. Because of such paltry antihypertensive efficacy and the lack of outcome data at these doses, physicians should refrain from prescribing HCTZ as initial antihypertensive therapy.

Reprint requests and correspondence: Dr. Franz H. Messerli, Hypertension Program, Division of Cardiology, St. Luke’s-Roosevelt Hospital, Columbia University College of Physicians and Surgeons, 1000 10th Avenue, Suite 3B-30, New York, New York 10019. E-mail: fmesserl@chpnet.org.

REFERENCES


Key Words: ambulatory blood pressure • hydrochlorothiazide • hypertension • meta-analysis.