May we at least have a civilised discussion about primary aldosteronsim in New Zealand?

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Primary aldosteronism (PA) is the commonest and most important remediable secondary cause of hypertension reportedly affecting at least 2% of the general hypertensive population and up to 22% of patients referred to specialist clinics for hypertension.\(^1,2\) The diagnostic rate of PA in New Zealand (or greater Auckland anyway) however, appears to be extremely low, and it is a matter of intense frustration to me that I have, to date, been unable to generate any meaningful discussion or debate about this. I attribute this, in part, to The New Zealand Medical Journal (based on reviewer reports) declining to publish two PA series from the Waitemata DHB Hypertension Clinic. In the first paper, in 2012, we reported 8 cases of PA among 635 patients referred to the clinic—an incidence of 1.25%. (We eventually published these results in an open-access hypertension journal which is available for perusal free on-line\(^3\)). This seemed a very low number given the international experience, so we revised our screening and workup criteria and following implementation of these, then did a further prospective audit of PA diagnosis. In the calendar year 2013, we reported 33 cases among 631 consecutive hypertension clinic patients—an incidence of 5.2%, which represents a quadrupling of the earlier diagnostic rate. The majority of these patients were Waitemata DHB (population 550,000). For comparison, I did a straw poll of endocrinologists in greater Auckland, including (population 1,500,000) and could only find an additional 5 or 6 confirmed PA diagnoses for that year.

We wrote up this second study, and again submitted it to The New Zealand Medical Journal, who again declined it, on the basis of the report of one of two reviewers. The reviewer who did not like the paper took issue with our interpretation of data and suggested that widespread screening for PA was too expensive, and that missing the diagnosis of PA may not matter too much because patients with resistant hypertension are likely to eventually end up on spironolactone anyway. The reviewer also questioned why our PA diagnostic rate was less than some reported series. All of these points may have some validity, but this subject is too important just to be swept under the carpet. This (by New Zealand standards) is a big series, and (reviewer’s comments notwithstanding) we are diagnosing the vast majority of PA in greater Auckland (containing 1/3 of the national population). This in turn implies that either the problem is widely undiagnosed (at least in greater Auckland, outside the Waitemata DHB area), or we are egregiously diagnosing PA where it does not exist (which we would vigorously contest).

PA is an important and common secondary cause of hypertension, which is difficult to diagnose. I don’t pretend to have all the answers, but I passionately believe that its profile needs to be raised among New Zealand medical professionals—particularly GPs who are the sole medical contact for most patients with hypertension. I urge you to read the full text of my (unpublished) paper ‘Amplified Screening and Workup Protocol for Primary Aldosteronism: A Strategy to Improve New Zealand’s Woefully Low Diagnostic Rates?’ A PDF version of this is available on my educational website www.hypertensionclinic.co.nz. At the bottom of the first page click on the link to...
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‘Primary Aldosteronism Paper’. There is also a link to a second (unpublished) paper on fludrocortisone suppression testing, which we believe is an essential component of PA work-up.

We would welcome contact from anyone who has an interest in this area.

Competing interests: Nil

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