

ANTI HYPERTENSIVE DRUGS

Definition of HTN

- Elevation of BP above the normal range, depending on the age and sex.



Initiation of anti HTN

(according to BHS)

- If sys BP > 200 or dias BP > 120 : start treatment immediately
- If sys BP > 160 or dias BP > 100 : should be confirmed over 1-2 wks, then start treatment.



Initiation of anti HTN

(according to BHS)

- If sys BP 140 – 159 or dias BP 90 -99, with CVS complications or target organ damage or DM: should be confirmed over 3-4 wks , then start treatment. If the above associations are absent , remeasure weekly over 4-12 wk, if still sustained start treatment.



Types of Anti HTN Drugs

- DIURETICS
- β BLOCKERS
- Ca Channel Blockers
- ACE inhibitors
- Ang II antagonists
- Vasodilators
- α Blockers
- Central acting agents



DIURETICS

- MOA:
- 1- ↑ renal excretion of Na & water →
↓ plasma volume → ↓ C.O.
- 2- ↓ peripheral resistance (desensitize
smooth muscles to action of
catecholamines)



1-Thiazide

- Sulfonamide molecule
- Prolonged action
- Flat curve response
- Potentiates action of other anti HTN
- Eg: Hydrochlorothiazide (Ezidrex) , Bendrofluazide
- SE: hypo K^+ , hypo Na^+ , hyperuricemia, hyperglycemia, lipid profile disturb.



Loop Diuretics -2

- Steep curve response
- Restricted to CCF & CRF
- Eg: Frusemide
- SE: \downarrow K^+ , \downarrow Na^+ , hypotension, ototoxic in v.high doses



K⁺ sparing diuretics -3

- Not effective alone, so used in combination
- Eg: Spironolactone, Amiloride ,
Uniretic (HCT + Amiloride)
- SE: ↑ K⁺, gynecomastia



Beta Blockers

- Cardioselective (Beta1): Atenolol
- Noncardioselective (Beta 1 & 2):
Propranolol



Beta Blockers

- **MOA:**

- Block beta receptors —————→ ↓ sympathetic drive —————→
- 1- ↓ H.R. & contractility, ↑ P.R. —————→ ↓ C.O.
- 2- ↓ Renin release & activity —————→ ↓ Ang II
—————→ ↓BP

Act as anti HTN within 3-7 days



Beta Blockers

- **Metabolism:**

Hydroxylated in liver to water soluble compounds excreted in kidneys

- Preferred in HTN with angina, SVT, HOCM, Thyrotoxicosis, Pheochromocytoma, Migraine and L.cirrhosis.



Beta Blockers

- **SE:** bradycardia, bronchospasm, cold extremities, hypoglycemia, insomnia, bad dreams
- **Overdose:** hypotension, bradycardia, bronchospasm, coma (**treated** with Atropine, Isoprenaline, glucagon)
- **C.I:** HF, Asthma, DM, H.Block, Periph.vascular diseases , Hyperlipidemia



Beta Blockers

- **Atenolol**: less lipid soluble → less CNS SE
- **Timolol**: lipid soluble → more CNS SE.



Ca Channel Blockers

- **MOA:**
- 1- ↓ Arteriolar tone
- 2- ↓ Pacemaker excitability & ↓ contractility →
↓ CO
- 3- ↓ conduction in C.S.



Ca Channel Blockers

TYPES:-

Dihydropyridine: Nefidipine, Amlodipine

- Mainly vasodilators (so combined with B.Blockers)
- Preferable in black old pts & Angina
- Effective in isolated sys HTN
- Used cautiously in HF



Ca Channel Blockers

- SE: Headache, sweating, palpitation, ankle swelling, flushing
(↓ by concomitant B.Blockers)



Ca Channel Blockers

:Nondihydropyridine •

(Diltiazem : (60mg •

on Heart, by inhibition of AVN 50% •
conduction

on Vessels 50% •

Prophylaxis and treatment of angina •

Mild & moderate HTN •



Ca Channel Blockers

- SE: sinus bradycardia, SAN block, L.L edema, skin rash, GIT upset (rare)
- C.I: Hypersensitivity , sys BP < 90, CCF, SAN syndrome, H.Block.
- Should not be combined with B.Blockers, Antiarrhythmic and digoxin.



Ca Channel Blockers

:Verapamil •

H.R. by ↓ SAN and AVN conduction ↓ •

Minimal vasodilator effect •

Used mainly as anti arrhythmic •

SE: bradycardia, H.Block, constipation, •

C.I. with B.Blockers and Digoxin



ACE Inhibitors

- Eg: Captopril, Lisinopril

MOA:

- ↓ ang II → ↓ vasoconstriction
- ↓ degradation of Bradykinin (vasodilator)



ACE Inhibitors

- Preferred in DM , LV dysfunction
- Less response in Black African (unless combined with diuretics)
- Less effective in elders & Predominant sys HTN



ACE Inhibitors

- SE: first dose hypotension, hyper K⁺, dry cough, angioedema (rare)
- C.I.: severe bilat. RA stenosis
- Relative C.I.: periph. Vascular disease
- **Monopril** has dual route of excretion (Liver & kidney) better in Renal insufficiency.



Angiotensin II receptor Antagonists

- Eg: Losartan, Valsartan
- MOA: block ang II receptors → vasodilation & block Aldosterone secretion
- Advantage: No cough



VASODILATORS

Eg: Hydralazine, Minoxidil •

- Used for pt resistant to other anti HTN
- Usually combined with B. BLOCKERS
- SE:
 - Hydralazine: Reflex tachycardia, SLE-like syn, fluid retention
 - Minoxidil: severe edema , Hirsitism



Central acting agents

- Eg: Methyldopa, Reserpine
- MOA:
- Stimulate α adrenergic receptors in CNS
→ ↓ vasomotor tone
- SE: Sedation, Dry Mouth, Postural hypotension, Impotence



General Principles

- In younger pt avoid B.Blockers alone (impotence, dyslipidemia)
- In elders : 1st diuretics, then B.Blockers, ACE inhibitors.
- In CCF: ACE inh, Nitrate
- Ischemic HD: B.Blockers, Ca blockers
- DM: ACE inh
- CRF: Diureics



(Refractory HTN (Treatment failure

- 1- Noncompliance
- 2- Inadequate treatment
- 3- 2° HTN (RA stenosis, Pheochromocytoma)
- 4- Using of anagonists (eg: steroids, NSAID)



Bibliography

- Text book of Medicine: KUMAR (5th edition)
- Short Textbook of Clinical Diagnosis and Management: M. I. Danish (5th edition)

