



INTERNATIONAL SOCIETY OF  
HYPERTENSION

A Member of the Scientific Advisory Board  
of the **World Heart Federation**

# Hypertension News

Opus 9; March 2006



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***ISH2006***

***Global Challenge for Overcoming High Blood Pressure***



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**Abstract submission deadline: April 15, 2006**

Meeting Secretariat ISH2006  
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3-6-13 Awajimachi, Chuo-ku, Osaka  
541-0047, Japan  
E-mail: [ish2006@congre.co.jp](mailto:ish2006@congre.co.jp)

**Dear ISH Member,**

Welcome to the 9th issue of the ISH Hypertension News which has a focus on the 21st Biennial Scientific Meeting of the Society, which will be held in Fukuoka, Japan, from 15 to 19 October 2006. The International Society of Hypertension, with the collaboration and generous support of corporate sponsors, is pleased to announce the availability of a certain number of awards and hereby calls for nominations for these awards (pp. 19–20). This issue of ISH News also comprises reports on our activities in low and middle income countries, this time with a focus on Africa, and we are happy to publish a report from a young investigator from South Africa, Dr. Alta Schutte. The next issue, Opus 10, which will come out at the end of May, will be the last one I edit.

As before, you will find instructions about how to recruit a new member at the end of the newsletter. Please do so! Finally, I have been asked several times by members to provide a list of past ISH Presidents. The list was put together with the help of Alberto Zanchetti, Milan (who else.....?).

Lars H Lindholm

**ISH's Past Presidents**

- |                       |           |
|-----------------------|-----------|
| 1. Irvine Page        | 1966-1970 |
| 2. Franz Gross        | 1970-1976 |
| 3. Ian Robertson      | 1976-1978 |
| 4. Alberto Zanchetti  | 1978-1980 |
| 5. James O. Davis     | 1980-1982 |
| 6. Austin Doyle       | 1982-1984 |
| 7. Lennart Hansson    | 1984-1986 |
| 8. John H Laragh      | 1986-1988 |
| 9. Giuseppe Mancia    | 1988-1990 |
| 10. Peter van Zwieten | 1990-1992 |
| 11. John Chalmers     | 1992-1994 |
| 12. Kikuo Arakawa     | 1994-1996 |
| 13. Jay Cohn          | 1996-1998 |
| 14. Karl-Heinz Rahn   | 1998-2000 |
| 15. Albert Mimran     | 2000-2002 |
| 16. Lawry Beilin      | 2002-2004 |
| 17. Michael Alderman  | 2004-2006 |

***President elect***

- |                     |           |
|---------------------|-----------|
| 18. Lars H Lindholm | 2006-2008 |
|---------------------|-----------|

## **ISH PRESIDENT'S ADDRESS**

**MH Alderman**

**New York, U.S.A.**

There is a great deal that we do not know about hypertension, but there is also a great deal we do know. We know that, worldwide, blood pressure associated disease accounts for more than half of all mortality, and that blood pressure above the “normal” range is the leading risk factor for all morbidity and mortality - in the developed as well as the developing world. Indeed, most cardiovascular deaths already occur in low and middle income countries, and the anticipated explosion of cardiovascular mortality in the coming decades will be largely borne by these countries.

While none of this comes as new knowledge, a recent WHO publication (Preventing CHRONIC DISEASES: a vital investment, WHO, 2005, [http://www.who.int/chp/chronic\\_disease\\_report/en/](http://www.who.int/chp/chronic_disease_report/en/)) has put the facts, and some of the myths and misconceptions about it, in stark perspective. In a sense, the most disturbing aspect of this story is that the capacity to prevent so much of the burden of blood pressure related disease is both available and feasible, but not used. Moreover, this gap between potential and application is not only a phenomenon of the resource-strapped world, but is a reality of affluent countries as well. A more detailed World Bank sponsored publication also dealing with the worldwide Chronic Disease Burden is due this spring.

What is new, however, is a growing recognition that too little attention is being paid, worldwide, to the present and impending health impact of cardiovascular and other chronic diseases. Indeed, WHO commits only 3.5% of its budget to Chronic Diseases – which, together, account for more than 80% of the world's burden of disease. WHO and other institutions respond to the “squeaky wheel”. Neither surprisingly nor inappropriately, the rapidly unfolding tragedy of HIV/AIDS, and its complicating infectious companions, has, at last, caught the attention of resource providers. Now, many countries, the World Bank, the Gates, and other Foundations, and the United Nations have begun to assemble the resources necessary to mount a meaningful response to what has already become a disaster in some countries, and an impending disaster in others.

The WHO Report on Chronic Diseases, by casting a bright light on CVD in particular (which accounts for more than half of all chronic disease mortality – and thus more than cancer, chronic respiratory disease, and diabetes together) is not meant, nor should it be taken as a call to reallocate existing funds according to disease burden. Instead, it provides the basis for arguing not only that additional and new resources are needed, but more attention must be mobilized to develop strategies to prevent cardiovascular and renal diseases as well. The point is that while financial resources are critical, of at least equal importance is the need for planning, coordination of effort, and the means to effectively deliver, everywhere, what the available resources can buy. In many areas of the world the planning, either for program or manpower, is not in place to appropriately exploit resources as they become available.

In part a response to this challenge, major international societies met in December at the Rockefeller Study Center in Bellagio, Italy. In a meeting initiated by the ISN and the ISH, and sponsored by the Rockefeller Foundation, representatives of the Societies, as well as other international health authorities, spent 4 days dedicated to forging a common strategy to mobilize a worldwide effort to avert the anticipated CVD pandemic. More will be heard about the specifics agreed upon at Bellagio, but already ISH and others are planning specific efforts. We at ISH have made a particular commitment to facilitating the development of an appropriate science base in low and middle income countries. Specific educational outreach efforts in Africa and Asia are already underway and will be sharply increased in the coming years.

ISH has long been a leader in the science of blood pressure and its relation to cardiovascular disease. Our particular target in what must become a multifaceted enterprise is to facilitate the science base in low and middle income countries that will be essential to develop a health and medical care program to meet local needs. I hope it will become possible for more ISH members to participate in this initiative. The Committee of the Scientific Council directing ISH efforts is headed by Robert Fagard ([robert.fagard@uz.kuleuven.ac.be](mailto:robert.fagard@uz.kuleuven.ac.be)). I know that he (or I) would be happy to hear from any of you with thoughts about how the Low and Middle Income Countries' initiative can be advanced.

**Patrick J. Mulrow, M.D.**  
**Ohio**

The World Hypertension League (WHL) has designated Saturday, May 13, 2006 as World Hypertension Day (WHD 2006). Further emphasis this year is "Treat to Goal." Most patients with hypertension are inadequately treated. Our aim is to increase worldwide awareness of the serious medical complications of hypertension, and to encourage all people to have their blood pressure measured. The WHL urges groups around the world to organize WHD activities and programs and offer free information on prevention, detection and treatment of hypertension in your region. For more information on WHD 2006, please click on [www.worldhypertensionleague.org](http://www.worldhypertensionleague.org).

## ISH2006 FUKUOKA PROGRESS REPORT

Toshio Ogihara  
Osaka, Japan

**Abstract Submission Online** is available till **April 15, 2006**  
**Registration Online** is available till **August 31, 2006**

**<http://www.congre.co.jp/ish2006>**

We are pleased to announce that our preparations for ISH2006 Fukuoka are in the final phase of the whole planning. Thanks to the cooperation and support of ISH2006 Organizing Committee, Executive Program Committee and Advisory Members, we believe that the meeting has been designed to approach worldwide researchers and to seize a chance leading to scientific evolution. We are pretty satisfied with the scientifically interesting topics collected and the speakers nominated from various fields.

The framework has required particular development; it has taken a few years to select the speakers. In the beginning, according to the 45 science topics, the speakers had been suggested through the questionnaires among the Committee, and more names had been nominated and the list had been repeatedly reviewed. In conclusion, at ESH 2005 Milan, we held the special program committee in order to narrow down the speakers' list. The list was further scrutinized with more inputs. Upon the speakers' accepting our invitation, we confirm the following speakers.

**ISH Presidential Lecture:** Michael Alderman

### Plenary Lectures – preliminary (alphabetical order)

Speaker	Science Topic	Title
A. Dominiczak	Genetics of Experimental Hypertension	Oxidative Stress and Cardiovascular Disease: Genes, Genomes and Pathways
V. J. Dzau	Renin-angiotensin System	TBA
J. Hall	Obesity, Adipocytokines, Lipid Metabolism	Obesity, Adipokines and Hypertension
T. Kurtz	Gene Targeting and Gene Regulation	TBA
R. Lifton	Ion Transport and Cell Calcium Handling	TBA
L. H. Lindholm	Epidemiology of Hypertension	TBA
G. Mancia	Guidelines for Management of Hypertension	Assessment of Total Cardiovascular Risk. Methodology, Problems and Implications for Treatment
S. Nagata	Cell Growth and Apoptosis	Apoptosis and Engulfment
E. L. Schiffrin	Endothelial Dysfunction	TBA

**State-of-the-Arts – preliminary (alphabetical order)**

Speaker	Science Topic	Title
A. W. Cowley Jr.	Kidney and Hypertension	TBA
D. Evans	Lifestyle Modification	TBA
C. M. Ferrario	Stroke	TBA
T. Fujita	Oxidative Stress and Antioxidants	TBA
S. Harrap	Genetics of Human Hypertension	The Genetics of Blood Pressure in Humans – A Difficult Business
R. Jackson	Lifestyle Modification	There is No Such Things as Hypertension
L. Landsberg	Sympathetic Nervous System and Autonomic Dysfunction	Feast or Famine: The Sympathoadrenal System and the Metabolic Syndrome
L. Liu	Ethnicity and Hypertension	TBA
G. M. London	Arterial Stiffness	Arterial Stiffness in Physiology and Pathology
S. Mendis	Hypertension in Developing Countries – Special Session with WHO	TBA
S. Reddy		Challenges for Hypertension Control in Developing Countries
F. Pipkin	Hypertension in Women, Pregnancy, Preeclampsia	Studies of Pre-Eclampsia Today and Its Impact Tomorrow
Y. Seedat	Ethnicity and Hypertension	Hypertension in the Blacks in Sub-Saharan Africa: Medicine in an Unjust World
K. Shimada	Hypertension in the Elderly	TBA
S. Stabouli	Pediatrics	TBA
P. Stewart	Endocrine Hypertension	TBA
M. Tuck	Metabolic Syndrome, Insulin Resistance	The Treatment of Hypertension in the Patient with Insulin Resistance
T. Unger	Atherosclerosis and Inflammation	TBA
K. Walsh	Membrane Receptors, Signal Transduction (Vascular Biology)	Adiponectin Actions on Cardiovascular Tissues
J. Whitworth	Aldosterone and Other Mineralocorticoids	Glucocorticoids, Hypertension and Cardiovascular Risk

Along with the above selection of the topics and the speakers, we also chose the 18 science topics for Breakfast Topical Workshop in the special program meeting at ESH2005 Milan. We considered coordinating the overall program and managed to choose the topics other than the above. One 75-minute session will consist of 2 moderators and 3 speakers, so an interactive session will be expected rather than a lecture-type session. Every morning during the main meeting 4–5 sessions with the following topics will be held:

**Breakfast Topical Workshop (Moderators)**

1. Functional Genomics and Pharmacogenomics of Hypertension (P. Hamet & G.H. Williams)
2. Gene Therapy and Regenerative Medicine in Hypertension (D. Heistad & R. Morishita)
3. Vasoactive Peptides (D.J. Webb & T. Eto)
4. Metabolic Syndrome and Hypertension (Molecular and Cellular Biology) (A. Mark & K. Nakao)
5. Metabolic Syndrome and Hypertension (Epidemiology and Clinical) (K. Shimamoto)
6. New Paradigms in Renin-Angiotensin System (T. Inagami & M. Horiuchi)
7. New Paradigms of Aldosterone Research (N. Kaplan & T. Saruta)
8. Significance of Sympathetic Nervous System in Hypertension (M. Esler & G. Grassi)
9. Hypertension Control by Subclinical Assessment of Potential Atherosclerosis (M. Safar & A. Takeshita)
10. Hypertension and Kidney (A. Morganti & A. Mimran)
11. Hypertension and Stroke (J. Reid & S. Takishita)

12. Hypertension in the Elderly (H. Matsuoka)
13. Blood Pressure Variability and Morning Hypertension (T. Morgan & Y. Imai)
14. Polypill vs. Traditional Treatment (A. Rodgers & P.A. van Zwieten)
15. Non-Pharmacological Treatments for Hypertension (L.J. Beilin & H. Ueshima)
16. How to Address Hypertension in the Developing World (to be organized by WHO)  
(D. Maclean & W. Pasini)
17. Ischemic Heart Disease (N. Poulter & T. Imaizumi)
18. Ethnicity and Hypertension (K. Yusoff & S. Erdine)

The other accompanying scientific programs to liven up the main meeting are Late-Breaking Session, Sponsored Symposia, Investigator-Initiated Symposia and Public Forum.

### **Late-Breaking Session**

Several large-scale clinical trials have been nominated including CASE-J (Candesartan Antihypertensive Survival Evaluation in Japan) and JATOS (Japanese Trial to Assess Optimal Systolic Blood Pressure in Elderly Hypertensive Patients). We welcome more nominations for this session to make it more interesting.

### **Sponsored Symposia in the major program**

Following the number of the ISH2006 official sponsors, many symposia are to be held throughout the 5 days: 4 Satellite Symposia, 15 Luncheon Seminars and 3 Evening Seminars. We negotiated with the sponsors over and over during the process of their selecting the speakers and the chairs. Because of such time-consuming correspondence, the sponsored symposia will be well coordinated with the main meeting.

### **Investigator-Initiated Symposia**

In China, the 2 symposia have been planned in Beijing and Shanghai before the main meeting. In Japan, the 2 symposia have been newly programmed, so totally the 14 symposia are to be held before and after the main meeting. All of them have been well planned by the organizers and focus on the relevant topics to the official theme, "Global Challenge for Overcoming High Blood Pressure". For the information on each symposium, please visit our website.

### **Public Forum**

In conjunction with the Japanese Society of Hypertension, we will hold 3 public forums in Fukuoka, Osaka and Tokyo. Each forum has been designed to attract the public and raise awareness about the prevention of hypertension and lifestyle modification; for example, the forums will be scheduled on Saturday afternoon as many people are likely to have spare time. At the forum in Osaka, scheduled on Saturday afternoon of Oct. 21, Dr. Alderman will lecture to the public.

**Social Events**

Event	Date & Time	Content	Location
Opening Ceremony & Welcome Reception	Sun., Oct. 15 18:00–21:30	Opening Address Attraction: <i>Noh</i> play (Japanese traditional play with performers wearing masks, delivering the elements of drama, music & poem.)	Fukuoka Sun Palace
Concert	Tue., Oct. 17 18:45–21:20	Classic Performance & Authentic Japanese Music	ACROS Fukuoka Symphony Hall
Gala Evening	Wed., Oct. 18 18:30–21:30	Buffet Dinner Japanese Festivals with fair stalls and dancing	JAL Resort Sea Hawk Hotel Fukuoka
Closing Ceremony	Thu., Oct. 19 16:30–17:30	Closing Remarks Presentation of Upcoming Meetings (JSH2007, APSH2007, ISH2008)	Fukuoka Sun Palace

We are confident that we will produce a great success at ISH2006 Fukuoka!

**ISH LOWER AND MIDDLE INCOME COUNTRIES STRATEGIC INITIATIVES  
WORKING GROUP**

**WESTERN EUROPE – AFRICA REGIONAL SUBCOMMITTEE**

**Robert H. Fagard,  
B-3000 Leuven, Belgium**

The objectives of the “International Society of Hypertension Lower and Middle Income Countries Strategic Initiatives Working Group”, which was founded in 2004, have been published in the ISH Electronic Newsletter: Hypertension News, Opus 5, October 14, 2004. One of the goals of the committee is to support hypertension meetings in those countries. Because the problems of lower and middle income countries differ from region to region, and because the expertise of individual members of the committee is likely to be restricted to particular parts of the world, four regional subcommittees have been created, one of which links Western Europe and Africa (see: [www.ish-world.com](http://www.ish-world.com)).

The “Western Europe – Africa Regional Subcommittee” has, among other things, contributed with three speakers to the First PanAfrican Congress on Hypertension held in Yaoundé, Cameroon, December 2–5, 2005, on which you can read a report in this Newsletter. The committee is now planning an “ISH Teaching Seminar”, to be held in Maputo, Mozambique, on September 21–22, 2006. Dr. A. Damasceno will be the local host of the seminar. The current program of the seminar is as follows:

**International Society of Hypertension Teaching Seminar  
Maputo, Mozambique, September 21–22, 2006  
Seminar directors: A. Damasceno & R. Fagard**

**Day 1.**

**Session 1.**

Epidemiology of hypertension and contributing factors in Africa.	A. Damasceno
Measurement of blood pressure in low resource settings.	E. O’Brien
Evaluation, diagnosis and risk stratification of the hypertensive patient.	Y. Seedat

**Session 2.**

Ambulatory blood pressure, blood pressure variability, target organ damage and prognosis.	E. O’Brien
Pathogenesis of hypertension in blacks.	J. Polonia
Complications of hypertension in Africa.	B. Onwubere

**Day 2.**

**Session 3.**

When and whom to treat?	B. Onwubere
Non-pharmacological treatment of hypertension in blacks.	R. Fagard
Drug treatment of hypertension in blacks.	Y. Seedat
How to organize the management of hypertension in a low resource setting	J.R. M’Buyamba

**Session 4.**

Hypertensive emergencies.	J. Polonia
How to set up an epidemiological study.	A. Damasceno
How to set up an intervention trial.	R. Fagard
Abstracts on research in Africa.	Selected speakers

The aim is to attract 25–30 participants from Mozambique and other African countries, interested in the management of hypertension and/or in research in hypertension and related fields. Collaboration with the International Forum for Hypertension Control and Prevention in Africa (IFHA) is currently being explored, as well as the opportunity for local researchers to present and discuss their work.

The Maputo experience will be discussed at the next ISH Council meeting on the occasion of the 21st Scientific Meeting of ISH in Fukuoka, Japan, in October 2006 and it is hoped for that this first “ISH Teaching Seminar” will be followed by a yearly initiative in different parts of Africa, in collaboration with other bodies and organizations involved in hypertension and related fields in the continent.

## A Young Investigator's Research on Hypertension in South Africa

**Alta Schutte,  
Potchefstroom, South Africa**

I am pleased to accept the invitation to write a short paper on our group's hypertension research in SA. So much extensive research on black South Africans is intensely needed, and a number of SA researchers have dedicated their careers to hypertension research, even though their efforts have not yet been enough. This is demonstrated by the stroke rate in black South Africans being twice as high as that of Caucasians<sup>1</sup>. Exact data on hypertension prevalence rates are still quite difficult to obtain, possibly because of the many obstacles (such as funding) researchers have to overcome when performing research in Africa.

Nevertheless, a number of SA researchers have managed to perform cutting-edge research and two of the most well-known SA hypertension researchers (Prof. L Opie and YK Seedat) have recently discussed these findings in an excellent paper on hypertension in Sub-Saharan populations in *Circulation*<sup>1</sup>. Various aspects surrounding cardiovascular disease in Africans are stipulated here, and I will now attempt to address those aspects that we have studied in our Cardiovascular Research Group at the North-West University (Potchefstroom Campus, Potchefstroom, South Africa).

- As in most African countries, mass migration from rural to urban areas might be the most important underlying factor contributing to the high incidence of hypertension in urban black Africans<sup>1</sup>. In 2002 I entered the research arena with my PhD entitled: *Various dietary risk markers of hypertension in black South Africans: The THUSA and THUSA BANA Study*. The THUSA study (Transition and Health during Urbanisation in South Africa) was designed to assess the relationships between the level of urbanisation and measures of health status, such as blood pressure in the black adult population (aged 16-70 years) of the North West Province (NWP) in SA<sup>2,3</sup>. Some of the objectives were to assess the rate of hypertension in apparently healthy black subjects in the NWP and to assess the relationship between dietary and anthropometric risks of cardiovascular disease and blood pressure. Two years after finishing this project, a similar study in children (aged 10–15 years), namely the THUSA BANA (Transition and Health during Urbanisation in South Africa in children, Bana = children in Setswana), was carried out in the same province. The study was designed to assess the relation between the level of urbanisation and health status of children of the NWP. These were both multidisciplinary studies involving 1850 and 1250 participants respectively. The results of my PhD<sup>4-7</sup> clearly showed that conditions associated with an urban lifestyle, such as malnutrition, the metabolic syndrome and obesity, are amongst the most pressing challenges that need to be addressed. To further address the transitional changes associated with urbanisation, our research group has recently embarked on a new research project in collaboration with 17 other developing countries. The PURE study (Prospective Urban and Rural Epidemiology) orchestrated by Dr Salim Yusuf (who also coordinated the InterHEART-study) aims to be one of the first multinational longitudinal studies investigating the changes taking place during urbanisation. During 2005 our Cardiovascular Research Group have already performed blood pressure and pulse wave velocity measurements on 1000 rural and 1000 urban participants.

We aim to obtain funding for biochemical analyses of blood samples and to follow these participants for the next 12 years.

- In their publication in *Circulation* Opie and Seedat also suggested that one of the most important lifestyle changes that should help to stem the epidemic of hypertension is decreased obesity – especially in women<sup>1</sup>. Our analyses of the THUSA and THUSA BANA data also underlined the detrimental effects of abdominal obesity<sup>7,8</sup> mainly observed in African women and girls. This led the way to the POWIRS study (Profiles of Obese Women with the Insulin Resistance Syndrome) of which I acted as project leader<sup>9</sup>. This study involved 102 African and 115 Caucasian women with varying levels of obesity. Our results indicated that the obese African women had the worst exposures, namely the poorest living conditions, smallest income, lowest levels of education, least sense of spiritual well-being and highest self-reported alcohol intake. They also presented the most adverse health outcomes, such as significantly higher blood pressure, gamma-glutamyl transferase, leptin, triglycerides, fasting blood glucose, fibrinogen and PAI-1 levels than their lean counterparts. The intertwined relationship between obesity and hypertension has become more evident upon further analyses of these data<sup>10,11</sup>. Based on a full 5-point oral glucose tolerance test (for glucose, insulin, pro-insulin, C-peptide and free fatty acids) we are currently investigating the role of obesity in the development of prediabetes and how this would affect their development of cardiovascular diseases.
- Due to the increased levels of obesity, stroke and hypertension in especially the urban African people, we are currently directing our focus to the role of inflammatory factors such as hs-CRP, IL-6 and TNF- $\alpha$  in the development of atherosclerosis. By comparing African and Caucasian populations from urban environments we will attempt to understand why (and if!) these population groups differ regarding cardiovascular risk factors and how various metabolic syndrome associated factors (including arterial stiffness and adipokines such as leptin and adiponectin) are involved in this process. We have already found an interesting age-related change in the association between blood pressure and fasting insulin levels (after adjustments for obesity) in various population groups<sup>12-14</sup>, and hope to clarify these results with current ongoing studies.

In conclusion, it is extremely challenging to study hypertension in South African population groups where a vast range of possibilities for this condition needs to be taken into account. I am nevertheless pleased and honored to be one of a handful of South African researchers tackling this problem hands-on – hoping to provide better conditions for many (who are in most instances not even aware of their hypertensive condition yet).

## References

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## **Beilin Symposium**

**Judith Whitworth  
Canberra, Australia**

A Symposium to celebrate the outstanding contributions of Lawrie Beilin to international hypertension research and hypertension management was held in Melbourne in December 2005.

The Symposium preceded the annual meeting of the High Blood Pressure Research Council of Australia, where Anna Dominiczak was the distinguished RD Wright lecturer. Lawrie is a past-president of HBPRC, as he is of ISH.

The organising committee, led in this as in so many things by another ISH past-president, John Chalmers, hosted a bevy of Lawrie's friends and colleagues from all around the world, with an especially strong contingent from his home town of Perth.

The highlight of the meeting was the big debate in which, inter alia, Chris Bulpitt established that alcohol is good for you, Garry Jennings that exercise is a waste of effort, and Caryl Nowson that more salt is better.

The social programme, in keeping with the spirit of the main event, comprised compulsory pre-breakfast callisthenics and a gala dinner (tee-total and vegan).

We salute Lawrie for his achievements and look forward to his continuing contributions to the world of hypertension.

## **Report on the First Convention for Hypertension in Central Africa**

**Talma Rosenthal, MD**  
**Tel Aviv, Israel**

Developing countries are witnessing a decline in the incidence of infectious diseases and a rise in the toll of cardiovascular diseases, including stroke and myocardial infarction. Indeed, according to physicians in certain areas, cardiovascular disease is rising. Hypertension appears to be a special case in point, being widespread, with enormous economic cost due to the severity of its complications, and frequently non- or under-diagnosed. While some statistics exist, actual figures on hypertension in Africa are scant and there is a crying need for large population studies and randomised controlled trials. Limited resources of many African countries is one of the major obstacles to providing better detection and treatment. The available resources are simply not sufficient to handle the high number of hypertensives. Inadequate funds, inexperience, and lack of infrastructure further burden the delivery of whatever medical care there is to the population.

The first Convention for Hypertension in Central Africa, organized by the International Forum for Hypertension Prevention and Control in Africa (IFHA), met against this background. We are familiar with these facts from the literature, but when we stand face to face with the doctors and hear about the problems of such a large population in which basic medical services are missing, we not only understand, we feel overwhelmed, helpless.

In one of the discussions a suggestion was made to teach lay people how to measure blood pressure, how to explain about hypertension and advise people, to give them primary treatment, even drugs. This approach would be downright unacceptable - in fact wouldn't even occur - to more advanced countries. The local doctors in Africa are eager to have contact with Europe, Canada and the United States, and their strong motivation to improve health care may just have an impact on exploiting resources and possibilities for more and better health care. But, many regions are disconnected from the big cities and some regions don't have doctors. The convention was a combination of lectures by invited speakers and communications from various local centers in Central Africa, who spoke on the subjects described below. Top people from the ISH and the WHL attended. Lars H Lindholm, President elect of the International Society of Hypertension, represented the ISH. Claude Lenfant, a former chief of NIH, represented the WLH, of which he is President, and spoke on the global epidemic of hypertension. Helen Alderson came from the World Heart Federation.

### **HEART FAILURE**

Physicians from the Department of Cardiology in Yaoundé, Cameroon pointed out that heart failure is a frequent and severe condition in Africa, but there is little data that include modern diagnostic advances like echocardiography. The main etiologies among 167 patients who did undergo echocardiography in their service were hypertension (54.49%), cardiomyopathies (26.34%) and valvular heart diseases (24.55%). Ischemic heart disease was the fifth etiology (2.39%). This was a descriptive study carried out from October 1998 to November 2001.

A group from Senegal described the clinical characteristics of patients with coronary heart disease, comparing them with Caucasians. Their population had much more severe coronary lesions, mainly among diabetics, many of whom could not pay to have appropriate treatment. A study from another center in Yaoundé described using EKG to assess left ventricular hypertrophy (LVH) in a black population.

We know that in Africa this tool was used by default instead of the more expensive echocardiography. It is worth noting that EKG was also used in the LIFE study as the main tool for making the diagnosis of LVH, but in LIFE it was not because they had no other choice, as happens in Africa. Generally one does not rely solely on EKG when treating a patient - echocardiography is also used.

A hopeful message came from Sudan where, despite poverty in this country of 1 million square miles and a population of 30 million with an average monthly income of \$40, three cardiology and cardiac surgery centers opened in the capital city of Khartoum in the late 1990s. From early 2000 to late 2005, it has seen nearly 45,000 patients, performed about 3,000 cardiology procedures (including interventions), and more than 1,400 operations (with more than 1100 open heart). This is proof that such advanced practices can be successfully sustained in an underdeveloped country with local initiatives and a great deal of outside help.

### **BRAIN**

Lemogum Daniel gave a lecture on stroke prevention, treatment and rehabilitation in Sub-Saharan Africa. According to him, stroke is a major public health problem, with higher mortality than in developed countries, and occurrence at a younger age. A group from Lagos, Nigeria, pointed out that a major cause of acute hypertensive death is cerebrovascular accident. Most patients continue to die young, at less than 50 years of age, one-third of them within an hour of arriving at the emergency room. The most common type of cerebrovascular accident seen was intracerebral hemorrhage, affecting more than half the subjects. There seems to be a trend in their Center towards reduction of hypertension reflected in acute deaths in the post-calcium channel blocker era. However, CVA continued to be a major cause of acute hypertensive death.

### **KIDNEY**

The problem of chronic kidney disease (CKD) is enormous. Worldwide over 50 million individuals have progressive CKD and only well over a million of them are on renal replacement therapy (RRT). The causes of renal disease in Enugh, Nigeria, were hypertension, diabetes mellitus, chronic glomerulonephritis and other toxic nephropathy, HIV-associated nephropathy, sickle cell disease etc. However, the main cause of renal disease could not be ascertained in more than half the population. In Nigeria and elsewhere in Africa, diabetic nephropathy with hypertension is coming to the fore as a cause due to the lack of resources. The mean number of sessions of dialysis was very low, being  $6.01 \pm 14.69$  (range 1–398 sessions). Maintenance hemodialysis was available to only 94 patients (10.52% of dialysed patients), and only 4 patients (0.26%) had kidney transplantation.

The prohibitive cost of managing end stage renal disease was stressed again in relation to the few who have renal replacement therapy. No system of social security or health insurance exists in Nigeria, as in most other developing countries. With the financial burden resting solely on the patient and relatives, the prognosis for patients with chronic kidney disease is truly abysmal. Dialysis and renal transplantation are simply not available for end stage renal disease in the majority of places.

### **SCREENING**

A group from Eugu, Nigeria screened women in their area in two communities: 27 women from Nnewi and 40 from Enugwu-Agid, mean age of the groups  $50.19 \pm 11.25$  years (range 25–75 years); 56.9% reported buying drugs without prescriptions; of which 32.8% prescribed drugs for themselves.

The use of skin lightening/toning creams, herbal supplements, native concoctions, and medicated/mercury-containing soaps was found in 25.4%, 28.4%, 29.9%, and 25.4%, respectively. Such a study is hoped to serve as a springboard for a more thorough community screening program. Only such programs can drive home the need for medical check-ups and the caution that must be exercised when using non-medical products and services. It was emphasized that such studies require the participation of all interested parties, in particular the governmental and non-governmental agencies and multinational pharmaceutical companies.

### **SPEAKERS FROM ABROAD**

Investigators Van Borte and Sebastian Vermeerch, both from Ghent University, Belgium, Nawar from Canada, Fournier from France, Seedat from South Africa, and Rosenthal from Israel attended and spoke. Sebastian Vermeerch delivered a comprehensive lecture about the methods for measuring arterial stiffness, while Van Bortel spoke about arterial stiffness and cardiovascular risk. Fournier from Amiens, France presented a few of his experimental studies, and reviewed 34 large primary and secondary stroke prevention trials, a work that involved investigators like Wang from Shanghai and Messerli from New York.

Lindholm from Sweden spoke on beta blockers and thiazide diuretics as being diabetogenic and should not be combined. Nilsson from Sweden felt that the main intervention and treatment approaches to dealing with the rising rates of diabetes and hypertension in Africa, and the health and financial problems associated with the sequelae of these diseases, are lifestyle support. But this he means projects and public awareness programs to reduce smoking and alcohol abuse - the two risk factors for many health problems including type 2 diabetes when accompanied by poor diet and adverse social circumstances.

According to Seedat from Durban, South Africa, better blood pressure control, dealing with associated morbidities and a concerted national policy like that proposed in Nigeria, can help meet this enormous lack of services. He considered decreasing salt intake and a change in attitude to obesity in women the keys to stemming the epidemic of hypertension in Africa. Not only are they effective, they are also feasible in this population. He also noted that since the majority of the patients have low plasma renin activity, the black patients should respond best to diuretic combined with other antihypertensive agents. He also mentioned the guidelines he formulated for this region of the world. Doctors from the Diabetic/Endocrine Clinic in Ibadan, Nigeria, cautioned about the risk of development of nephropathy posed by the high prevalence and poor control of high blood pressure among Nigerian diabetics. He called for drawing physicians' attention to the insufficient use of renoprotective ACEI drugs in diabetics as a preventive measure against this trend.

Nawar from Canada spoke about chronic kidney disease, noting that, because it is often asymptomatic and patients with normal serum creatinine may still have markedly diminished GFR, it is more prevalent than thought, affecting over 10% of the adult population. The disease is a major risk factor for cardiovascular disease, and more patients die from the latter than progress to ESRD.

Immigration studies from Israel conducted in Yemenites and Ethiopians who came to Israel from poor agricultural countries were presented by Rosenthal. These studies teach a great deal about the influence of environment on blood pressure. All these immigrants arrived in Israel with very low blood pressure, and the longer they lived

there the more they developed hypertension and even diabetes. More such studies are underway.

Helen Alderson from the World Heart Federation spoke about a public/private partnership that was first launched in the late 1980s, which involved the World Health Organization, the United Nations Children's Fund, the World Bank, the United Nations Development Programme and the Rockefeller Foundation. Today the Task Force for Child Survival and Development, an independent body, manages it. The program's success stems from the fact that, beyond donating medicines, it also closely oversees their distribution. As Dr. Alderson said:

While public interaction with the private sector is essential and desirable for many reasons, formal partnerships should be reserved for carefully considered issues where joint action is planned and aligned policies exist, and where there is not likely to be any conflict of interest, real or perceived, or any distortion of public health messages.

### **COST**

Researchers from University Hospital in Butarc, Rwanda, together with colleagues from Ghent University in Belgium, addressed the cost of drugs in Sub-Saharan Africa. Little is known about the prices of medicines in this region of the world, but what is known is that in most of sub-Saharan Africa, the cost is borne by the patient and not subsidized by social insurance. Antihypertensive drugs, within the same class and between classes, have large differences in price. Those listed in the WHO International Drug Indicator Guide were always cheaper. Their conclusion: adding advocated drugs to countries' National List of Essential Medicines should reduce prices.

The Minister of Health explained the importance of this convention in raising awareness of the problems of hypertension and other risk factors. It was clear he was not talking to impress the foreigners, but was truly involved in his country's problems. In a very moving and impressive ceremony, Professor OO Akinkugbe and Professor YK Seedat were given the Life Achievement Award for their work on hypertension in Africa. All in all, the atmosphere was pleasant and informal and the hospitality warm and gracious. Everybody went away having learned about the status of hypertension diagnosis and treatment on the continent of Africa, where resources are limited and enthusiasm for change is great.

## Announcement - International Society of Hypertension Awards 2006

On the occasion of its 21st Biennial Scientific Meeting, which will be held in Fukuoka, Japan, from 15–19 October 2006, the International Society of Hypertension, with the collaboration and generous support of corporate sponsors, is pleased to announce the availability of a certain number of awards. The ISH would like to call for nominations for the following awards:

**Franz Volhard Award and Lectureship** To be presented to a person who has initiated a concept which remains of current interest in the field of hypertension or in a related discipline. The recipient shall be invited to deliver to the International Society of Hypertension a lecture on the topic for which the award is bestowed.

**Merck Sharp and Dohme International Award** To be presented to a person, persons or institution responsible for distinguished work relating to the aetiology, epidemiology, pathology or treatment of high blood pressure.

**AstraZeneca Award** To be presented to a distinguished investigator responsible for outstanding work related to the clinical pharmacology and therapy of arterial hypertension.

**The Stevo Julius Award** Funded by NOVARTIS, will be given to a person or persons demonstrating exceptional and continuous commitment to the dissemination of information, knowledge and skills in the field of hypertension to: (a) general public; (b) medical community; (c) specialists in the hypertension field; and (d) to investigators involved in hypertension research.

**Boehringer Ingelheim Developing World Award** This award is for a researcher in the developing world who has done outstanding work in the region. The nomination should include full curriculum vitae, a short résumé of his/her research, no more than 5 publications, which the applicant considers as important publications and a letter of support from the applicant's mentor. The awardee will be expected to submit an abstract of his/her research for the ISH Scientific Meeting.

**ISH Membership Awards** The spirit of these awards is to provide access to membership of the Society and to a regular subscription for the Journal of Hypertension, free of charge for colleagues who fulfil all the usual criteria for regular membership of the ISH. Determination of these membership awards will require:

Acceptance by the ISH that the country in which the nominee is working is one suffering economic hardship.\* Acceptance of nominations will be limited to those who have accomplished meritorious original investigation in the field of hypertension or related topics.

(\*BASED ON THE WORLD BANK LIST OF ECONOMIES AT JANUARY 2006)

A primary and secondary sponsor who is a member of the International Society of Hypertension must propose nominees. Their letters of support must detail the scientific accomplishments and ongoing research of the candidate in relation to the description of the award applied for. The curriculum vitae and list of publications of the nominee should also accompany letters of submission.

*The Awards Committee of the International Society of Hypertension will make the selection of the awardees. The awards will be presented to the recipients at the 21st Biennial Scientific Meeting which will be held in Fukuoka, Japan, 15–19 October 2006.*

**NOMINATIONS FOR THE ABOVE ISH AWARDS SHOULD BE RECEIVED BEFORE 31 MARCH 2006**

**Please send your nominations to:**

**ISH Secretariat  
c/o Hampton Medical Conferences Ltd  
113-119 High Street, Hampton Hill  
Middlesex TW12 1NJ, United Kingdom**

**FOR INFORMATION ON THE FOLLOWING AWARDS SEE THE ISH 2006 BROCHURE OR VISIT THE WEBSITE AT [WWW.CONGRE.CO.JP/ISH2006](http://WWW.CONGRE.CO.JP/ISH2006)**

**Austin Doyle Award** This award is supported by Servier Australia. This award was established to mark the contribution of Austin Doyle, Past-President of the ISH and Founding Chairman of the High Blood Pressure Research Council of Australia. It will be awarded to a graduate who is within 5 years of postgraduate qualification. The recipient will be judged to have given the best original presentation relevant to clinical medicine at the ISH Biennial Scientific Meeting.

**Pfizer Award** To be given to each of two investigators presenting a superior research project on calcium and membrane transport mechanisms.

**Jiří Widminský Sr Award** funded by Hypertension Prague 2002 Organising Committee. This award will be given over a period of ten years. Every two years it will be awarded to three distinguished young investigators from an Eastern European country

**Japanese Society of Hypertension Award** The JSH Award is a once-only award being presented by the Japanese Society of Hypertension as an incentive to a young investigator (under the age of 40) who has performed promising research in the field of clinical or experimental hypertension.

**Young Investigator Travel Grants** A limited number of travel grants are available for young investigators whose abstracts have been accepted for presentation. These grants are limited to investigators who will be 40 years of age or younger and in full-time training at the time of the Meeting.

**Travel Grants for delegates from Countries experiencing Economic Hardship** Funds have been allocated to subsidize some of the costs for delegates from countries experiencing economic hardship. Preference will be given to applicants whose abstracts have been accepted.

## Membership

If you have not yet renewed your ISH membership for 2006 now is the time to do so to ensure you continue to receive copies of the Journal of Hypertension and subsequent copies of the Newsletter.

Payment can be made **on-line by visiting [www.ish-world.com](http://www.ish-world.com)** Note: **You will be required to quote your membership number** (if you do not know this, it can be obtained by emailing [secretariat@ish-world.com](mailto:secretariat@ish-world.com)).

Go to the Membership page and click on Membership Fees. A confirmation email will be sent to you.

## Newsletter

Within the next month or so there will also be a members' only area on the new ISH website ([www.ish-world.com](http://www.ish-world.com)) where members will be able to read past copies of the ISH Newsletter.

In addition, HMC maintain the electronic ISH membership database and keep it updated with address changes, etc. If you have not already done so, please complete and fax back the form below.

## Recruit New Members

We would welcome your assistance to help us recruit new members to the Society. The Society welcomes applications for membership from individuals working in the field of hypertension and cardiovascular disease.

If you have a colleague who would like to become a member of the International Society of Hypertension, please ask them to complete the downloadable Application Form that can be found on the Society's new website: **[www.ish-world.com](http://www.ish-world.com)**.

Applications must also be accompanied by:

1. A written statement by two members of the Society (names of regional/national members can be provided by the Secretariat) as to the qualifications of the nominee;
2. A list of the nominee's academic degrees, professional positions, and a list of five best and five most recent publications relating to hypertension or allied fields.

Nominations are initially considered by the Membership Committee and ultimately approved by the Society at its biennial scientific meetings.

If you have any questions regarding your membership, please do not hesitate to contact us.

International Society of Hypertension Secretariat  
Hampton Medical Conferences Ltd  
113-119 High Street  
Hampton Hill  
Middlesex, TW12 1NJ, UK  
Fax: +44 (0)20 8979 6700  
Email: [secretariat@ish-world.com](mailto:secretariat@ish-world.com)  
Website: [www.ish-world.com](http://www.ish-world.com)

**PLEASE FILL IN AND RETURN TO THE ISH SECRETARIAT AT THE ADDRESS BELOW**

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<b>First Name</b>	
<b>Family Name</b>	
<b>Address</b>	
<b>Area Code</b>	
<b>Telephone No.</b>	
<b>Fax No.</b>	
<b>Mobile No.</b>	
<b>Email address</b>	

<b>Any additional details</b>	