



INTERNATIONAL SOCIETY OF HYPERTENSION

Hypertension News

October 2007 – Opus 14



SAVE THE DATE

ESH 18th Scientific Meeting
European Society
of Hypertension

ISH 22nd Scientific Meeting
International Society
of Hypertension

> June 14–19, 2008
Berlin, Germany

www.hypertension2008.com

The Scientific Meetings of



In co-operation with
Hochdruckliga



www.ish-world.com



NOTE FROM THE EDITOR

Dear ISH Member,

This issue of the newsletter signals the forthcoming Joint meeting of ISH and ESH in Berlin June 14-19 2008. This meeting should be excellent scientifically and socially. Registrations are already open and abstracts can be submitted now to the meeting website www.hypertension2008.com with a closing date for submission of January 15th 2008.

Trefor Morgan announces the forthcoming Asian Pacific meeting of Hypertension which includes an ISH workshop in Beijing this November 15-19.

The article by John Chalmers describes extensive international research links that have been established throughout South East Asia from the George International Institute in Sydney and provides an example of what others might aspire to do to help facilitate hypertension research worldwide.

You will also see a call for bids for the ISH Biennial Scientific Meeting in 2016. We look forward to receiving proposals to host this event by the deadline of February 29, 2008.

With best wishes,

Lawrie Beilin
Editor Hypertension News



PRESIDENT'S ADDRESS

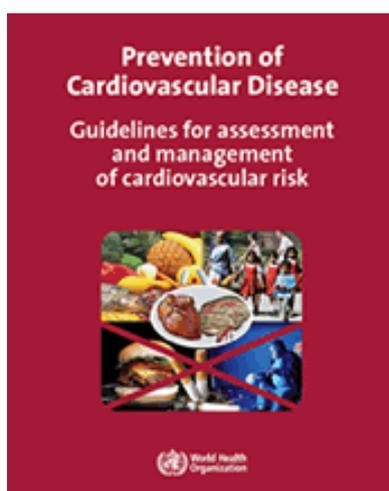
Lars H Lindholm, Sweden

Cardiovascular disease (CVD) contributes substantially to the escalating costs of health care in the world. It is a major public health challenge, particularly for low and middle income countries, where 80% of the cardiovascular deaths occur and where there are competing health priorities and limited resources for health care.

The World Health Organization (WHO) and the International Society of Hypertension (ISH) have recently released cardiovascular risk prediction charts for all WHO sub-regions of the world (28 charts from 14 sub-regions) that will help low and middle income countries to manage the CVD burden more effectively by targeting limited health care resources at people with high cardiovascular risk. To the best of my knowledge, there have been no globally applicable cardiovascular risk-prediction systems until now that are specifically applicable for different populations in lower income countries. Further work is in progress through the collaboration between WHO and ISH, to further validate this approach against other methods such as those that rely on the Framingham Heart Study risk prediction equations.

A shift from management of single risk factors to total cardiovascular risk-prediction and management will enable limited health-care resources to be targeted to those who are most in need and most likely to benefit. Hence, taking the absolute risk approach for prevention of cardiovascular disease through the new WHO/ISH cardiovascular risk prediction charts is an important step forward for managing the cardiovascular disease burden more cost effectively in low and middle income countries.

All the charts will shortly be available in colour as well as black and white on the ISH website [www.ish-world.com] where the full document can be found today. There will also be nine short versions of the recommendations, four in English and one each in Chinese, Russian, Arabic, Spanish, and French.





6th ASIAN PACIFIC CONGRESS OF HYPERTENSION BEIJING, 16-19 NOVEMBER, 2007



The 6th Asian Pacific Congress of Hypertension meeting will be held in Beijing from November 16-19, 2007. This meeting will be held in association with a number of other events including the Annual Chinese International Symposium on Hypertension and Related Diseases and a meeting of the World Hypertension League.

The Asian Pacific Society of Hypertension (APSH) is the representative body of the International Society of Hypertension (ISH) in this region and coordinates its meetings with those of the ISH. The first meeting under this name was held in Bali, Indonesia in 1999 after two meetings under the name of the Pacific Rim Society of Hypertension held in Tokyo and Manila. The meetings have gone from strength to strength despite obstacles such as the SARS epidemic which caused postponement of the Singapore meeting. The meetings in Thailand (2001) and Korea (2005) were very successful and brought together people from this region. The last meeting was a conjoint meeting with the ISH and The Japanese Society of Hypertension in Fukuoka, Japan in 2006. The attendance and scientific and clinical participation have increased at each event and the 2007 meeting promises to continue this pattern. The meeting consists of plenary (state of the art) lectures, symposia on issues of topical interest, free communications and posters to present original work from the region. To facilitate young people to attend there are a number of young Investigator fellowships and young investigator prizes to recognise their achievements.

The Society is a confederation of regional societies and at present the following countries are members - Australia, China, Hong Kong, India, Indonesia, Japan, Korea, Malaysia, Nepal, New Zealand, Philippines, Singapore, Taiwan and Thailand. The Hypertension Society of the different countries is the affiliated body or if none is present the Cardiac Society is the representative body. We welcome new members particularly from those countries in Western Asia which are poorly represented at present. The Society exists to promote the field of hypertension in all its aspects: To make the community aware of hypertension, to institute procedures to reduce hypertension in the community, to identify people with hypertension, to treat people with hypertension and to support research and collaboration among our member societies. To this end, a workshop is being held prior to the main Congress on the problem of hypertension in the Asian Pacific region sponsored by APSH and ISH. From this workshop it is hoped that a position paper will be developed that will lead to programs of prevention and better clinical management.

Further information on the APSH can be viewed at www.apsh.org or by emailing secretary@apsh.org.

For more details on the meeting in BEIJING please view www.apsh2007.com or email info@apsh2007.org.

We hope that you can attend this and subsequent meetings. The following event is in Kuala Lumpur, Malaysia in February 2009.

Trefor Morgan
Secretary General
Asian Pacific Society of Hypertension



AUSTRALIAN COLLABORATIVE INTERNATIONAL RESEARCH

In the era of globalisation, much research involves worldwide collaboration. This is certainly so with blood pressure research. In the fields of epidemiology and clinical trials, Australian researchers have been active in many collaborative projects with overseas colleagues. There has quite naturally been a strong focus on the Asia-Pacific region, our own part of the world, but also very far-flung collaboration across all continents. We bring together here a sample of projects reaching out to the massive populations in the developing world, showing some work in progress in India, China and South Africa.

Professor John Chalmers

Cardiovascular mortality and morbidity in rural Andhra Pradesh, India

R Joshi, C Chow, B Neal from The George Institute for International Health, University of Sydney, Sydney, Australia

India is undergoing rapid epidemiological transition as a consequence of economic and social change, and cardiovascular disease is becoming an increasingly important cause of death. While some information is available for urban areas, data about cardiovascular disease in rural areas, where 70% of the Indian population resides, is scant.

The George Institute for International Health, together with the Byrraju Foundation, Hyderabad, CARE Foundation, Hyderabad and Centre for Chronic Disease Control, New Delhi established a research collaboration (The Andhra Pradesh Rural Health Initiative). The overall goal of this initiative was to develop and evaluate locally applicable new strategies for the improvement of health in poor rural communities. In order that the interventions selected address the leading burdens of disease and their cause the collaboration has collected data about morbidity and mortality through a large-scale survey and a mortality surveillance system.



The survey used simple standardized instruments to measure the prevalence of non-fatal cardiovascular disease and cardiovascular risk factors amongst a random sample of 4535 adults aged 30 years and over (response rate 81%) in 20 villages broadly representative of the East and West Godavari region of Andhra Pradesh.



The mortality surveillance system was established in 45 villages and all deaths occurring in the villages (population 180,162) were recorded during a 12-month period in 2003-4. Primary healthcare workers trained in the use of a standard verbal autopsy tool collected data about the deaths. Algorithms were used to define causes of death according to a limited list derived from the international classification of disease version 10. Causes were assigned by two independent physicians with disagreements resolved by a third.

The survey found high levels of diabetes (13.2%), hypertension (27.0%), overweight/obesity (men 18.4%, women 26.3%) and smoking (men 45.2% and women 4.8%). A third of the adult population had total cholesterol above 5.2

mmol/l and 15.2% had a positive family history of cardiovascular disease. A diagnosis of coronary heart disease (myocardial infarction and angina) was reported by 4.8% and stroke by 2.0%.

1354 deaths were identified (crude death rate 7.5/1000) with verbal autopsies completed for 98% of all deaths. Cardiovascular diseases were the leading causes of mortality, responsible for 33% of all deaths. The rates of ischemic heart disease and cerebrovascular disease were similar and these two constituted the majority of the vascular deaths recorded (ischaemic heart disease 14%, cerebrovascular disease 13%, and other vascular causes 6%). Cardiovascular diseases were responsible for a greater proportion of deaths among men than women and about one quarter of all cardiovascular deaths occurred below the age of 60 years.

Conclusions

Cardiovascular disease is a surprisingly large health problem in this developing rural region. In addition to the many deaths caused by vascular disease there are also a significant number of very high-risk individuals with prevalent cardiovascular disease and many with substantially abnormal levels of other major risk factors. It appears that in large part the burden of cardiovascular disease in this community is attributable to broadly the same chief causes as in other parts of the world. Addressing the problem will however present a significant challenge to a health system whose resources are currently focused on communicable diseases and reproductive health. Novel low-cost strategies that are suited to this very resource poor setting need to be developed and evaluated if the epidemic of vascular disease affecting India is to be attenuated. The collaboration is currently midway through a first cluster-randomised trial evaluating a strategy seeking to identify and treat some of the highest risk individuals.

Table 1: Cardiovascular morbidity and mortality in rural Andhra Pradesh

Cardiovascular risk factors	Male (n)	%	Female (n)	%
History of MI or angina	119	4.7%	114	5.0%
History of stroke	66	2.5%	39	1.4%
Diabetes	361	14.6%	294	12.2%
Hypertension	667	26.6%	686	27.5%
Current smoking	1034	45.2%	120	4.8%
Overweight/obesity BMI \geq 25	405	18.4%	609	26.3%
Total cholesterol > 5.2 mmol/L	141	26.5%	204	33.9%
Family history of premature CVD	340	16.1%	326	14.2%

Top five causes of death	Male (n)	%	Female (n)	%
Diseases of the circulatory system	258	34.2	173	30.1
<i>Ischaemic heart disease</i>	121	16.0	62	10.8
<i>Cerebrovascular disease</i>	87	11.5	83	14.5
<i>Others</i>	50	6.6	28	4.9
Injury	110	14.6	67	11.7
Infectious and parasitic diseases	88	11.7	69	12.0
Neoplasm	41	5.4	56	9.8
Diseases of the respiratory system	44	5.8	27	4.7

The Rishi Valley Vascular Disease Survey

Mandy Thrift from the Baker Heart Research Institute

Although the most common causes of disease burden in countries such as India include malnutrition and infectious disease, vascular disease is being increasingly recognized as an emerging epidemic. In urban Indian populations, changes in lifestyle exposures (resembling those seen in developed nations) may underlie this phenomenon. However, even less is known about the burden of vascular disease in those living in rural communities. The aim of this study is to obtain important baseline data



on the extent of vascular disease (heart disease, stroke) and its risk factors in a typical rural Indian community.

This survey is being conducted in the Rishi Valley, an area situated in the interior of rural Andhra Pradesh, a major South Indian State. It is a sheltered, drought-prone valley about 140 km northeast of the city of Bangalore, and is home to the villages of a stable rural community of approximately 35,000 residents. The population consists primarily of shepherds and marginal subsistence farmers, with landholdings of less than one acre. The average monthly income for a family of five (husband, wife, two children, and one dependent elder) ranges from between Rs. 700 to Rs. 1,000 per month (which is equivalent to 65 to 93 cents per day). This is well below the global standard for poverty.

Residents of the villages are being interviewed to obtain information about their lifestyle (diet, activity, smoking, alcohol). Blood pressure, height, weight, waist and hip are being measured using standard criteria. In addition, finger-prick tests for blood glucose, cholesterol, triglyceride and haemoglobin are also being performed.

This survey will provide important and comprehensive data regarding the prevalence of vascular disease risk factors in a rural Indian community. It will be the first major step in planning effective public health interventions to treat or prevent vascular disease in a disadvantaged Indian community.

This is a collaborative project between Mandy Thrift, Sharyn Fitzgerald (Baker Heart Research Institute), Velandai Srikanth, Roger Evans (Monash University), Kartik Kalyanram and Kamakshi Kartik (Rishi Valley Rural Health Centre).

The Heart of Soweto Study

By Geraldine Lee and Melinda Carrington (Baker Heart Research Institute)



The Heart of Soweto study is a landmark study initiated to establish the baseline profile of heart disease and its antecedents in the population of Soweto, South Africa. The project is co-ordinated by expert personnel in cardiology (Professor Karen Sliwa, Witswatersrand University), preventative cardiology (Professor Simon Stewart, Baker Heart Research Institute) and Professor David Wilkinson, from the School of Medicine, University of Queensland).

Soweto in South Africa comprises of a series of townships and is located southwest of Johannesburg. It contains the largest urban concentration of Black Africans with an estimated population of 1 to 1.5 million, which includes a steady influx of migrants. The townships are undergoing economic transition leading to increased affluence. This in turn has resulted in the development of chronic forms of cardiovascular disease (CVD) and this has necessitated the need for

systematic surveillance programs to monitor & implement prevention/management programs for the emerging CVD.

The primary goal of the “*Heart of Soweto Study*” is to systematically examine and respond to the epidemiologic transition in risk behaviours and clinical presentations of heart disease in the internationally renowned and celebrated community of Soweto. Within the Baragwanath Hospital (with a 3,500 bed capacity), the Coronary Care Unit has observed more than a 10-fold increase with patients suffering heart attacks over the past 20 years and approximately 100 patients a day attend the out-patient clinic for heart-related complaints. Approximately 5000 patients per annum are diagnosed with heart disease.

A clinical registry of all patients managed by the Cardiology Unit has been established. The Cardiologists/Trainee Cardiologists carries out medical reviews according to standard protocols and diagnoses and the data are validated and entered on-site via a dedicated research team with support, verification and analyses via University of Queensland & the Baker Heart Research Institute in Australia.

The clinical registry has revealed that at least 20% of new cases of heart disease presenting to the Cardiology Unit at the Baragwanath Hospital have developed CHF; this equates to approximately 250 new

cases of heart failure presenting to the clinic each year. The aetiology of heart failure includes dilated cardiomyopathy, valvular heart failure right heart failure and ischaemic cardiomyopathy.

Several sub studies have also been initiated in areas including HIV, nutrition, screening for CVD risk factors, ECG abnormalities and socio-economic status. In summary, demonstrated the broad & substantive spectrum of heart disease in Soweto, South Africa, the high prevalence of risk factors such as hypertension, smoking and a positive family history and late clinical presentations. The study has demonstrated the need for sustained surveillance & new health care programs.

References: Stewart S, et al.. Mapping the emergence of heart disease in a black, urban population in Africa: The Heart of Soweto Study. Int J Cardiol 2006;108: 101-108

The ChinaQUEST (QUality Evaluation of Stroke care and Treatment) study

Professor Craig Anderson, The George Institute for International Health

Background: China, as the most populous country on earth, has a heavy burden of stroke and other vascular diseases. According to WHO estimates, nearly 30% of the 5.5 million deaths from stroke that occurred in the world in 2002 were in China, reflecting the very large (1.4 billion) population who are at high risk of vascular disease. Studies have shown marked geographical variation in rates, prevalence and case fatality of stroke in China, with a well-described North-South gradient favouring southerners and a widening urban-rural gap in the burden of disease. The extent to which current patterns of stroke in China are driven by differences in the prevalence of risk factors and case fatality is unclear. The decreasing stroke mortality rate seen in the WHO-MONICA study in China during 1982-1995 was almost all due to improvements in survival rather than a fall in stroke incidence per se. This may be due to improved medical care for stroke patients, although changes in stroke risk factors over time may have lead to the occurrence of milder forms of stroke with improved outcomes.

Currently, the country is experiencing significant management issues in stroke arising from the increasing numbers of patients from the rapidly ageing population who are undergoing social and economic change. There has traditionally been a heavy reliance of acute hospital care for chronic diseases and very little preventative and community care. Only recently has a health insurance scheme been introduced to help support the cost of health care in a largely fee-for-service health care setting. In the absence of reliable epidemiological data, it is difficult to quantify the degree of disparities in care and plan services, both preventative and therapeutic, in an equitable and evidence-based manner.

Methods: The ChinaQUEST (QUality Evaluation of Stroke Care and Treatment) project is a large-scale, China-Australia partnership, epidemiological project that aims to (a) describe current patterns of stroke management in China, and (b) determine the influence of various socio-economic and organisational variables on key clinical and health outcomes. The project has enrolled over 6,400 patients with acute stroke (ischaemic and haemorrhagic) through a 62 hospital (36 city) registry network in representative urban and semi-urban sites over a 5-month period in late 2006. Data collection has occurred over four time points (baseline, hospital discharge, and 3 months of follow-up, or death if this occurs earlier) and the assessment of survivors to 12 months of follow-up is currently ongoing. Outcomes being assessed include case fatality, disability, health-related quality of life, adherence to secondary prevention strategies, and economic and social impact.

Preliminary observations: In China, strokes occur at approximately a decade younger age and are more often haemorrhagic and lacunar (ischaemic) in nature than in Australia. There is a heavy reliance on unproven traditional Chinese medicines alongside modern therapeutic agents and technology as part of routine care. Patients stay in hospital for long periods of time and few receive community care follow.

This article has been reproduced by kind permission of the Newsletter of the High Blood Pressure Council of Australia, July 2007.



CALL FOR BIDS

ISH BIENNIAL SCIENTIFIC MEETING 2016

The Council of the International Society of Hypertension (ISH) would welcome bids from scientists, research groups or National Societies of Hypertension to host the ISH Biennial Scientific Meeting in 2016.

Previous conferences have attracted more than 5,000 delegates and local organisers should be prepared to host a meeting of at least this size and to meet with the terms set by the Society.

Prospective applicants should prepare a comprehensive proposal to be submitted to the ISH Secretariat electronically by no later than 29 February, 2008. Please contact Helen Horsfield at the Secretariat to receive a copy of the full bid requirements. Contact details are shown below.

A final decision will be made by the ISH Council at the forthcoming meeting in Berlin on 14 June 2008. Shortlisted applicants may present further printed material at this meeting and also make a 10 minute presentation of their respective bid.

Contact:

Helen Horsfield
ISH Secretariat, c/o Hampton Medical Conferences
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TW12 1NJ
United Kingdom
Tel: +44 (0) 20 8979 8300
Email: secretariat@ish-world.com



UPCOMING MEETINGS

2007

26 – 28 October 2007

2nd International Conference on Frontiers in Vascular Medicine
Melbourne, Australia
www.frontiers-in-vascular-medicine.info

16 – 19 November 2007

6th Meeting of the Asian Pacific Society of Hypertension
Beijing, China
www.apsh2007.com

29 November – 2 December 2007

ISN Nexus Symposium on Hypertension and the Kidney
Vienna, Austria
<http://www.associationhq.com/ISN/nexus/hypertension/>

2008

7 – 10 February 2008

International Conference on Fixed Combination in the Treatment of
Hypertension and Dyslipidemia
Budapest, Hungary
www.paragon-conventions.com/fixed

2 – 5 April 2008

1st International Congress on Prehypertension & Cardiometabolic Risk
Prague, Czech Republic
www.kenes.com/prehypertension

14 – 19 June 2008

Hypertension 2008:
22nd Scientific Meeting of the International Society of Hypertension & 18th
Scientific Meeting of the European Society of Hypertension
Berlin, Germany
www.hypertension2008.com

24 – 27 June 2008

5th International EDHF Symposium
Tampere, Finland
www.EDHF2008.org

17 – 20 September 2008

2nd International Symposium on Pheochromocytoma
Queens' College, Cambridge, UK
www.isp2008.ukevents.org

26 – 27 September 2008

Artery 8, Ghent, Belgium
www.artery.uk.net

30 October – 2 November 2008

2nd World Congress on Controversies in Diabetes, Obesity & Hypertension
Barcelona, Spain
www.codhy.com

ISH Future Meetings



14 – 19 June 2008
Berlin, Germany



26 – 30 September 2010
Vancouver, Canada



30 September – 3 October 2012
Sydney, Australia

2014
Athens, Greece

2016
Bids are welcomed for this meeting.



GENERAL SOCIETY INFORMATION

Membership

If you have not yet renewed your ISH membership for 2007 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 the membership section of www.ish-world.com.

Please note: **You will be required to quote your membership number** (if you do not know this, it can be obtained by emailing Helen Horsfield at secretariat@ish-world.com).

We would like to take this opportunity to remind you of the Society's Constitution concerning Membership. *"Members shall pay annual dues in the amount and within the time period determined by the Executive Committee. Membership shall automatically cease upon failure to pay the annual subscription fee for two consecutive years."*

Members Only Area of the Website

The Members' Only Area on the ISH website (www.ish-world.com) is now active. To view these pages you will need to register, again using your membership number. (If you do not know this, it can be obtained by emailing Helen Horsfield at secretariat@ish-world.com).

Current information in this section includes the following.

- Past copies of the ISH Newsletter
- A list of ISH Members
- Access to the Journal of Hypertension for those who are eligible for free online access. This free online access is available for new members (since 2006) who reside or work in one of the resource poor countries, zones and territories defined by HINARI).

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 ISH please ask them to complete the downloadable Application Form that can be found in the Membership section of the Society's website: 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 or recruiting new members, please do not hesitate to contact us.

Fax: +44 (0)20 8979 6700 / Email: secretariat@ish-world.com



CONTACT UPDATE FORM

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

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Any additional details	



The ISH would like to acknowledge the support of our Corporate Members



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