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Abstract

Internationally as in the US stroke is the third leading cause of death and adult disability. In 2004 the cost of stroke was estimated at US$ 53,6 billion (direct and indirect) with a mean livetime cost estimated at US$ 140.048.

The global incidence of stroke will increase, since the number of people older than 65 years will rise from 390 million now to 800 million by 2025. Hypertension (HTN) is the most powerful modifiable risk factor for stroke in general population, affects approximately 50 million individuals in the US and about 1 billion world wide, including first ever and recurrent stroke. HTN is responsible for up 49% of stroke. It was 3-2 times more likely to experience stroke than non HTN, while the risk for pre-HTN was about 1,5 times. All forms of HTN, including isolated systolic, isolated diastolic and combined systolic and diastolic HTN are associated with increased risk of stroke. The relationship of blood pressure (BP) and stroke risk is continous down to a BP of 115/75 mmHg.

Because of this continum of risk, and because most strokes occur in individuals with mild HTN or even normal BP values, it is may be beneficial to begin to recognizing “pre-HTN” as stage in

which early recognition and intervention can be initiated. The benefit of HTN treatment for primary prevention of stroke is clear. Choice of specific regiment must be individualized, but reduction in BP is generally more important than the specific agent used to achieve this goal.

In clinical trials, anti hypertensive therapy has been associated with 35% to 40% mean reductions in stroke incidence. Recent clinical trials have demonstrated that effective BP control can be achieve in most patients with HTN, but the majority will require more than one BP lowering agents to control BP. Some evidence suggest that certain agents, including angiotensin-converting enzyme inhibitors, angiotensin receptor blockers, calcium channel blockers may have protective effects beyond BP lowering. “Overall, the degree of BP lowering is key”. Therefor most classes of BP-lowering agents may be recommended at this point. Live style modification is appropriate at all levels of intervention.

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