



HYPERTENSION AND NEPHROLOGY

A Minisymposium

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CURRENT DEVELOPMENTS are the common denominator of the articles in a symposium from the Department of Hypertension and Nephrology, in this issue of the *Cleveland Clinic Journal of Medicine*. I believe physicians will find the presentations—on hypertension drug therapy, indications and outcome of certain surgical treatments, and management of end-stage renal disease—of practical clinical interest.

Three reviews deal with important issues in the management of patients with end-stage renal disease (ESRD): hypertension, anemia, and cyclosporine nephrotoxicity.

The majority of patients with ESRD experience significant hypertension. While usually secondary to their renal disease, it can, if not aggressively treated, contribute to morbidity and mortality. Heyka and Vidt discuss the mechanisms of hypertension in chronic renal failure and provide practical guidelines for management.

Moderate-to-severe anemia occurs universally in ESRD and contributes significantly to the constitutional symptoms observed in these patients. Paganini reviews the early experience with recombinant human erythropoietin, which suggests that the severe anemia can be corrected and that the dialysis patient's quality of life can be measurably improved.

Extensive clinical experience with cyclosporine has established the benefits of this new immunosuppressive agent on kidney survival following transplantation. However, widespread application of this agent has been complicated by nephrotoxicity. Steinmuller reviews the complex nature of the effects of cyclosporine on the kidney and discusses recommendations for safer administration of this important new immune suppressive agent.

The fourth Joint National Committee report on detection, evaluation, and treatment of hypertension was published in May 1988. Gifford succinctly outlines the differences between these latest recommendations and previous reports from the

National High Blood Pressure Education Program. He reviews the evolution from a stepped care approach to an individualized approach for drug therapy of our most common public health problem, arterial hypertension.

Clonidine TTS is the first antihypertensive agent to be marketed for transdermal delivery of pharmacologically effective doses of drug in the treatment of hypertension. Chen and Vidt present longitudinal clinical experience with this agent in ambulatory hypertensive patients. Adverse effects and limitations in long-term patient usage are reviewed and discussed. It remains to be seen whether similar problems will be observed with the transdermal antihypertensive medications still on the horizon.

Labetalol has become one of the more widely used agents in managing patients with hypertensive urgencies and emergencies. The drug is predictably effective by repeated IV bolus administration or continuous infusion. Increasingly, labetalol is being used in the surgical setting, as blood pressure surges with intubation can be prevented by pretreatment with labetalol, and intraoperative use can provide control of hypotension in selected procedures. Orlowski and colleagues review recent experience with labetalol for control of postoperative hypertension following major vascular procedures. The favorable hemodynamic profile, the ease of administration, and relative safety when used in this setting will be of particular interest to the clinician and anesthesiologist.

A 12-year period of extensive experience at the Cleveland Clinic with intestinal conduits for urinary diversion is reviewed by Klein et al and discussed in the editorial by Whitmore. The importance of optimal stomal care, thorough patient education, and careful technique and site selection are stressed as factors capable of minimizing stoma complications.

Finally, the case study by Wood and colleagues addresses the clinical and ethical issues involved in the decision to offer renal transplantation to a patient with metastatic carcinoma.