

DIABETES MELLITUS AND HYPERTENSION

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SUMMARY: It has been recently estimated that arterial hypertension affects 10-30% of type 1 and even 30-70% of type 2 diabetic patients. In patients with type 1 diabetes, hypertension usually becomes manifest during the course of nephropathy, typically about the time that patients develop microalbuminuria. In patients with type 2 diabetes, it may also be due to coexisting "essential" hypertension, isolated systolic hypertension attributed to accelerated atherosclerosis, a part of insulin-resistance syndrome and, in some cases, the consequence of renal vascular disease. In these patients hypertension is diagnosed if found to have blood pressure $\geq 130/80$ mmHg on three separate occasions. Numerous epidemiological and clinical data have rationalised and approved aiming at more tight control and lower target levels of blood pressure in these patients compared with those with essential hypertension. According to the most recent recommendations of American Diabetes Association lifestyle modifications, without simultaneous pharmacological therapy, are approved only in diabetic patients with a systolic blood pressure of 130–139 mmHg or a diastolic pressure of 80–89 mmHg, and for no longer than 3 months if targets are not achieved. It is, however, well-known that there is no ideal anti-hypertensive drug for treating hypertensive diabetic patients. With longer duration of disease, increasing number of anti-hypertensive agents are required to maintain blood pressure lower than target levels and question of an optimal drug loses its importance. For hypertensive type 2 diabetic patients so-called "anti-hypertensive cocktail" containing ACE inhibitor, non-dihydropyridine calcium channel blocker and a low-dose diuretic is recommended.

Key words: diabetes mellitus, arterial hypertension, lifestyle modifications, angiotensin-converting enzyme inhibitors (ACEi)