Insufficient control of blood pressure and incident diabetes

Diabetes and blood pressure control

Short title:

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Submitted 23 October 2008 and accepted 3 February 2009.

This is an uncopyedited electronic version of an article accepted for publication in Diabetes Care. The American Diabetes Association, publisher of Diabetes Care, is not responsible for any errors or omissions in this version of the manuscript or any version derived from it by third parties. The definitive publisher-authenticated version will be available in a future issue of Diabetes Care in print and online at http://care.diabetesjournals.org.
Objectives: Incidence of type 2 diabetes might be associated with preexisting hypertension. There is no information on whether incident diabetes is predicted by blood pressure (BP) control. We evaluated the hazard of diabetes in relation to BP control in treated hypertensive patients.

Research design and Methods: Non-diabetic, otherwise healthy, hypertensive patients (n=1754, age 52±11yrs, 43% women) participated in a network over 3.4±1yr follow-up. BP was considered uncontrolled when systolic ≥140mmHg or/and diastolic ≥90mmHg at last outpatient visit. Diabetes was defined according to ADA guidelines.

Results: Uncontrolled BP despite antihypertensive treatment was found in 712 patients (41%). At baseline, patients with uncontrolled BP were slightly younger than patients with controlled BP (51±11 vs 53±12yrs; p<0.001) with no differences in gender distribution, body mass index, duration of hypertension, baseline BP, fasting glucose, serum creatinine and potassium, lipid profile or prevalence of metabolic syndrome. During follow-up, 109 subjects developed diabetes. Incidence of diabetes was significantly higher in patients with uncontrolled BP (8%) than in those with controlled BP (4 %; OR= 2.08; p<0.0001). In Cox analysis, controlling for baseline systolic BP and body mass index, familiarity and physical activity, uncontrolled BP doubled risk of incident diabetes (HR= 2.10; p<0.001), independently of significant effect of age (HR= 1.02/yr; p=0.03) and baseline fasting glucose (HR=1.10/mg×dL⁻¹; p<0.001).

Conclusion: In a large sample of treated non-diabetic hypertensive subjects, uncontrolled BP is associated with 2-fold increased risk of incident diabetes independently of age, body mass index, baseline BP and fasting glucose.
Arterial hypertension is common in patients with type 2 diabetes. A survey of over 1,500 patients with diabetes, conducted between 1988 and 1994, determined that 60–80% had blood pressure higher than 130/85 mmHg or had been prescribed antihypertensive medication (1). Results from the MRFIT study indicated that diabetes confers greater cardiovascular risk for comparable levels of other cardiovascular risk factors, suggesting that blood pressure (BP) control should be more rigorous in the presence of diabetes (2). However, there is no clearly defined temporal relationship between diabetes and hypertension.

Incidence of type 2 diabetes, in fact, also increases with increased baseline BP in women without prevalent diabetes, based on modified categories of BP from ESH/ESC 2007 guidelines (3). There is increasing evidence of a substantial interplay of metabolic factors with arterial hypertension (4; 5). We have recently shown that optimal control of BP is blunted by coexisting metabolic risk factors, clustering the phenotype of metabolic syndrome (4). There is no information about whether a suboptimal control of BP might be also associated with incident diabetes, independently of confounders. Accordingly, we tested the hypothesis that insufficient control of BP is an independent risk factor for diabetes in a cohort of hypertensive patients with initial normal fasting plasma glucose.

**METHODS**

Population study: As previously reported (6), beginning in 1997 we generated a network among the Hypertension Center of the Federico II University Hospital (Naples, Italy), 23 Community Hospital-based Hypertension Clinics and 60 General Practitioners from our district area (CampaniaSalute Network) including over 12,000 cardiovascular patients, of whom 10,254 had arterial hypertension. Among hypertensive subjects, 7,422 were initially free of prevalent cardiovascular disease (6). Prevalent cardiovascular disease was defined at the first examination in our outpatient clinic, and included previous myocardial infarction or angina or procedures of coronary revascularization, stroke or transitory ischemic attack or congestive heart failure. Prevalent cardiovascular disease was excluded by the Committee for Event Adjudication in the Hypertension Center, and was based on patients’ history, contact with the reference general practitioner and clinical records documenting the occurrence of disease.

Criteria for selection in the present study included the availability of a follow-up of at least 2 years, and absence of diabetes at the time of the first visit. According to these criteria, we excluded 5,668 patients: 4,957 with follow up less than 2 years (3,258 due to enrolment in the past 2 years and 1,699 lost to follow-up), 386 with prevalent diabetes and 325 with reported impaired fasting glucose at the time of the first visit. Thus, we analyzed 1,754 Caucasian hypertensive patients (43% women, age 52±11 years), with normal fasting glucose, who had been followed up for 3.5±1.8 years. All eligible participants underwent at least 2 control visits after the first examination.

The data-base generation of the CampaniaSalute Network was approved by the Federico II University Hospital Ethic Committee. Signed informed consent for the possibility of using data for scientific purposes was obtained.

Laboratory tests and definitions: Fasting plasma glucose and lipid profiles were measured by standard methods. Glomerular filtration rate was estimated from

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serum creatinine by the modified MDRD equation (7).

According to a questionnaire, patients were asked to classify their lifestyle as sedentary or non-sedentary. This information was used in the analysis as a raw indicator of physical activity.

Systolic and diastolic blood pressures were measured at each visit by standard sphygmomanometer after 5 min in sitting position, according to the guidelines of the European Society of Hypertension/European Society of Cardiology (8). Three blood pressure measurements were always obtained in the sitting position at 2-min intervals. The average of these measurements was used for the analysis (8).

Body mass index (BMI) was calculated at each visit. When BMI ≥ 30 kg/m², patients were classified as obese and were assumed to have central fat distribution (9). Diagnosis of metabolic syndrome was, therefore, issued according to modified ATP III criteria (4; 5), and included at least two metabolic risk factors among plasma triglycerides ≥ 150 mg/dl, fasting plasma glucose ≥ 110 mg/dl, high-density lipoprotein (HDL)-cholesterol ≤ 40 mg/dl for men or ≤ 50 mg/dl for women, BMI ≥ 30 kg/m² (as a surrogate of increased waist girth). Non-HDL cholesterol was also calculated as the difference between total and HDL cholesterol.

The number of antihypertensive medications used at the time of each visit was also evaluated. Blood pressure was considered controlled when < 140/90 mmHg, otherwise it was classified as uncontrolled. Reported medical diagnostic codes for diabetes and prescriptions of oral hypoglycaemic drugs or insulin were used to identify prevalent and incident cases of diabetes. Prevalent and incident diabetes was also diagnosed when fasting plasma glucose was > 125 mg/dL, according to ADA guidelines (10).

Statistical Analysis: Data were analyzed using SPSS (version 12.0; SPSS, Chicago, IL) and expressed as means ± 1SD. All variables deviating from normal distribution were log-transformed before parametric statistics. Descriptive statistics were performed using ANOVA or chi-square distribution, using Monte Carlo simulation to generate exact p-values.

The last available value of BP was used to classify controlled or uncontrolled patients. For patients developing diabetes, we used the last available BP control before diabetes was diagnosed. Incidence of diabetes in relation to controlled or uncontrolled BP was evaluated using Cox regression, by enter procedure, controlling for baseline values of age (years), sex, BMI, fasting plasma glucose, familiarity for diabetes, BP at the time of the first visit, and sedentary or non-sedentary lifestyle. Alternative models were also computed using the last available BP value instead of categories of controlled/uncontrolled BP.

To account for by therapy in the Cox model, single classes of medications, including anti-renin-angiotensin system (RAS: ACE inhibitors and/or AT1 receptor antagonists), calcium-channel blockers (CCB), β-blockers, thiazide diuretics, were dichotomized according to their overall use during the individual follow-up, based on the frequency of prescription during the control visits. Thus, all medications used for more than 50% of control visits were considered as covariates in a new proportional hazard analysis. In this Cox model we used a hierarchical model with a 1st step in which all covariates used in the previous Cox analysis were entered by a backward model building procedure (p-to-enter < 0.05, p-to-remove ≥ 0.15), and a 2nd step in which the classes of medications were thereafter forced into the model.

RESULTS
Uncontrolled BP despite therapy was found in 712 patients (41% of population). Baseline characteristics in relation to control of blood pressure are shown in Table 1. At baseline, patients with subsequent uncontrolled BP were younger (p<0.001) and had higher heart rate (p=0.02) than patients with controlled BP, with no differences in gender distribution, BMI, reported duration of hypertension, baseline BP values, metabolic profile (glucose, uric acid and lipids), serum creatinine and electrolytes, GFR, and prevalence of metabolic syndrome. Uncontrolled BP was also associated with a slightly reduced number of control visits over the follow-up period (p=0.05).

During follow-up, 109 patients (6% of population, 41% women) developed diabetes. At baseline, patients with subsequent diabetes were older (56.2 ±9.7 vs 51.6±11.6 years) and had greater BMI (29.2±4 vs 27.3±4 Kg/m²), fasting glucose (107.9±10 vs 92.5±11.6 mg/dl), uric acid (5.7±1.8 vs 5.0±1.5 mg/dl), plasma triglycerides (169.4±112.7 vs 126.5±68.4 mg/dl) and prevalence of metabolic syndrome (60.7% vs 21.4%) than patients without incident diabetes (all p<0.001). In univariate cross tabulation, incident diabetes was 35% less in non-sedentary than in sedentary participants (p = 0.041; OR = 0.65; 95% of CI = 0.44 – 0.97). Reported duration of hypertension was also longer (8.7±7.5 vs 6.8±6.7 years, p = 0.013) and familiarity for diabetes more frequent (8.2% vs 5.1%, p=0.017). In univariate cross tabulation, incident diabetes was 2.45 fold higher in participants with BMI≥30 kg/m² (p < 0.0001; OR = 2.45; 95% of CI = 1.62 – 3.71). No differences were found in gender distribution, number of visit/year, baseline BP values and heart rate, serum creatinine and electrolytes, GFR, cholesterol, HDL, and uric acid. There was no significant variation of BMI over time in both groups.

**Prediction of Incident Diabetes and BP control:** Risk of incident diabetes was significantly higher in patients with uncontrolled BP (8%) than in those with controlled BP (4%; OR=2.08; p<0.0001). In Cox analysis, controlling for age at the time of the first visit, sex, baseline values of systolic BP, family history of diabetes, fasting glucose, BMI and reported physical activity, incident diabetes remained more than 2-fold higher in patients with uncontrolled BP than in those with controlled BP (HR=2.1, 95%CI=1.41-3.12, p<0.0003), with additional significant effect for higher baseline fasting glucose (HR=1.1, 95%CI=1.08-1.13, p<0.0001), and older age (HR=1.02, 95%CI=1.00-1.04, <0.03), and no detectable effect for the other covariates. Wald statistics suggests that fasting plasma glucose was the strongest predictor of incident diabetes and that suboptimal control of BP was the second strongest predictor.

**Alternative Cox models were generated using BP as continuous variable instead of dichotomizing controlled and uncontrolled BP. In these alternative models, either systolic (not diastolic) BP (HR=1.02/mmHg; 95%CI=1.01-1.03, p<0.01) or mean BP (HR=1.03/mmHg; 95%CI=1.01-1.06, p<0.01) were significant, independent predictors of incident diabetes.**

In another Cox model, using modified ATP III definition of metabolic syndrome instead of fasting plasma glucose and BMI, together with the risk of incident diabetes associated with metabolic syndrome (HR=4.4 [2.9-6.7]), uncontrolled BP maintained or even increased its predictive value (HR=2.7 [1.7-4.1], both p<0.0001).

**Antihypertensive Therapy:** During follow-up, slightly more antihypertensive medications were prescribed in patients with controlled BP than in those with uncontrolled BP (1.57±0.94 vs 1.47±0.90 drugs; p<0.03). Single classes of antihypertensive
medications were, therefore, examined in relation to incident diabetes, considering the frequency of use over the entire follow-up time in censored and uncensored observations. We arbitrarily evaluated medications prescribed in more than 50% of available visits. Due to potential pharmacologic interaction favouring development of diabetes, the association between thiazides and β-blockers was also specifically examined.

Thus, classes of antihypertensive medications analyzed were: thiazides, β-blockers, anti-RAS, CCB and combination of thiazides and β-blockers.

Frequency of prescription of β-blockers was 2-fold higher in patients with incident diabetes than in those without incident diabetes (HR=2.04, 95%CI=1.36-3.07; p<0.0008). Similarly, combination of thiazides and β-blockers was 3-fold more frequent in patients with than in those without incident diabetes (HR=3.00, 95%CI=1.72-5.26; p<0.0002). There was no difference in prescriptions for thiazides without β-blockers, anti-RAS and CCB.

Another Cox model was, therefore, generated, including also classes of antihypertensive medications, in addition to the covariates used in the previous Cox model. Table 2 shows that uncontrolled BP retained a near 2-fold higher probability to be associated with incident diabetes, independently of all covariates also including treatment. In this model, additional significant predictors were older age, higher baseline fasting glucose, higher BMI, and therapy with β-blockers (table 2).

**DISCUSSION**

In this study, for the first time we demonstrate that suboptimal control of BP is a strong predictor of incident type 2 diabetes in initially normo-glycemic, hypertensive individuals after a follow-up of at least 2 years on antihypertensive treatment. This effect is independent of age, baseline fasting glucose, presence of metabolic syndrome and type of antihypertensive therapy. Prescription of β-blockers, but not of thiazides, is also strongly and independently associated with new onset of diabetes.

Our findings extend previous observations indicating that incident type 2 diabetes is more frequent in hypertensive than in normotensive subjects (3; 11). In particular, Conen et al. (3) recently reported a clear correlation between higher incidence of type 2 diabetes and BP levels in a large population of women, based on modified categories from ESH/ESC 2007 guidelines.

The relation between suboptimal control of BP and incident diabetes paralleled also evidence of different follow-up profiles in censored and uncensored individuals. Patients with incident diabetes underwent fewer visits each year, assumed a smaller number of medications and presented with a larger BMI. It is possible that a less attentive adherence to the suggestions of the specialist both in terms of compliance to the treatment and changes in life style could be at least in part associated with the increased risk of developing diabetes. However, this possibility was partly contradicted by our previous demonstration that the phenotype of metabolic syndrome, a potent risk factor for diabetes also in our analysis, is associated with high likelihood of uncontrolled blood pressure, despite the greater number of prescribed medications.

The other interesting aspect emerging from our analysis is the evidence of the independent relation of β-blocker therapy to the incidence of diabetes, which was consistent with recent literature (12). In contrast, diuretic therapy did not independently predict diabetes, a finding that was inconsistent with some (13), but not all
studies (11; 14). Gress et al. (11) have shown no significant, independent effect of thiazides in their population-based study, once demographic, environmental and metabolic co-factors were taken into account. In the ALLHAT study, clorthalidone, increased risk of diabetes after 2 and 4 years (14), but no multivariate adjustment comparable with the model used in this study was attempted to verify whether or not this effect was independent of confounders. In addition, while in the ALLHAT study design diuretic therapy was not associated with any anti-RAS medication (and in fact, $\mathrm{K}^+$ levels were significantly lower in the group on diuretic), in all analyzed patients in this study thiazides were associated with other medications and $\mathrm{K}^+$ levels were indistinguishable between the groups. Another characteristic to consider in our population is that thiazides were used at very low doses. There is some evidence that thiazides may also produce or increase hepatic insulin resistance, but this effect is dose-dependent and associated with hypokalaemia (15).

The two main findings in our study (i.e. relation of uncontrolled BP and use of $\beta$-blockers to incident diabetes) are biologically plausible and fitting with most recent findings suggesting that microvascular alterations might precede development of diabetes (16). Because the goal of our study was to assess the risk of incident diabetes in poorly controlled hypertensive patients, independent of the therapeutic aggressiveness (and therefore also including patients with possible suboptimal therapy at the time of censoring), these findings suggest that timing of achieving target BP values might be substantially relevant also to prevent diabetes, a possibility that should be tested in ad hoc clinical trials.

The temporal sequence observed in our study opens to some possibilities to be explored in future research. First, both hypertension and diabetes might share a common abnormality of microvascular function that might be corrected or not by antihypertensive therapy. When generalized, dysfunction is more easily detectable with increased blood pressure than with metabolic alterations preceding diabetes, which provides explanation of why hypertension appears before diabetes. This hypothesis is supported by the increasing evidence that microvascular dysfunction might be the background abnormality in experimental diabetes (17). However, although vascular rarefaction has been generally suggested to contribute to insulin resistance (17), cause and effect relationship has not been demonstrated. Another possibility is that the lack of effective control of BP parallels persistent neurohormonal abnormalities that in the long run participate in the precipitation of diabetes, including sympathetic system (18) or/and RAS activity (19).

The unfavourable metabolic consequence of $\beta$-blockade are likely due to both decreased insulin sensitivity also demonstrated in hypertensive patients (20), associated with insulin-related metabolic features (21), and deleterious effects on insulin secretion (22). As widely reported, insulin-resistance evolves into diabetes once $\beta$-cell failure occurs (23). In addition to this mechanism, $\beta$-receptors blockade might favour enhancement of hepatic glucose output, which has been demonstrated in rats but not in humans (24).

Limitations of the study: A potential limitation of this study is the absence of direct information on body fat distribution. Due to this limitation, in addition to use BMI as a continuous variable, we also used cut-point of BMI to categorize obesity. The cut-point of BMI for obesity has been previously used as a surrogate of waist girth in studies on metabolic syndrome and the International Diabetes Federation indicates that when BMI
is in the range of obesity, a central fat distribution can be assumed. In addition, at least in terms of prediction of diabetes, BMI has been shown to be as informative as waist circumference, waist/hip ratio or direct visceral fat measured by computed tomography (25). Finally, the prevalence of obesity in this population is likely affected by our initial selection, excluding subjects with type 2 diabetes or impaired fasting glucose at baseline examination.

Another potential limitation of this study is the unavailability of albuminuria, because the data collection was initiated at a time when albuminuria was not yet required as a primary work-up test in all outpatients. According to selection criteria in the present study, we included relatively healthy patients who did not require assessment of albuminuria.
REFERENCES


Figure 1: Cumulative hazard of incident diabetes in non-diabetic, hypertensive patients, under antihypertensive therapy, in relation to BP control, after adjusting for age, sex, systolic BP, familiarity for diabetes, BMI and plasma glucose at baseline (see text for explanation).
Table 1. Demographic, clinical and laboratory characteristics of the study population. Data are expressed as mean ± SD or percentage of the relevant group of patients.

|                          | BP controlled n = 1042 | BP uncontrolled n = 712 | p ≤  
|--------------------------|------------------------|-------------------------|------
| Age (years)              | 52.7 ± 11.6            | 50.6 ± 11.3             | 0.0001 |
| Gender (M/F %)           | 58/42                  | 56/44                   | NS   |
| BMI (Kg/m²)              | 27.3±3.9               | 27.6±4.1                | NS   |
| Reported duration of hypertension (years) | 7.2 ± 7.1              | 6.5 ± 6.3               | NS   |
| Number of visit/year     | 2.34±1.03              | 2.25±1.06               | 0.047 |
| Systolic BP (mmHg)       | 159.8±21.8             | 158.0±19.2              | NS   |
| Diastolic BP (mmHg)      | 99.6±10.8              | 99.6±10.2               | NS   |
| Heart rate (bpm)         | 71.87±11.29            | 73.16±12.58             | 0.028 |
| Fasting glucose (mg/dl)  | 93.5±12.2              | 93.2±12.0               | NS   |
| Uric acid (mg/dl)        | 5.1±1.4                | 5.1±1.7                 | NS   |
| Blood urea nitrogen (mg/dl) | 37.6±10.1           | 36.3±11.8               | NS   |
| Serum creatinine (mg/dl) | 0.94±0.2               | 0.93±0.2                | NS   |
| GFR (ml/min)             | 82.7±19.9              | 83.7±19.1               | NS   |
| K⁺ (mEq/l)               | 4.4±0.4                | 4.4±0.4                 | NS   |
| Na⁺ (mEq/l)              | 141.2±3.3              | 141.3±3.1               | NS   |
| Cholesterol (mg/dl)      | 206.5±38.6             | 207.2±37.4              | NS   |
| HDL cholesterol (mg/dl)  | 50.2±12.3              | 50.7±12.7               | NS   |
| Non-HDL cholesterolemia (mg/dl) | 156.5±37.9          | 156.7±37.7              | NS   |
| Triglycerides (mg/dl)    | 129.2±67.7             | 128.8±79.0              | NS   |
| Metabolic syndrome (%)   | 24.2                   | 23.6                    | NS   |

Table 2. Hazard of incident diabetes in non-diabetic, treated hypertensive patients, including classes of antihypertensive medications.

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*BMI = Body max index
*BP = Blood pressure