The Laragh Method Of Treating Hypertension And Preventing Its Fatal Complications

As indicated, the complete interview will appear in a subsequent Newsletter since there is only enough space left for me to summarize a few key points. The Laragh Method is based on the hypothesis that essential hypertension is either salt-volume related or caused by renin-angiotensin. The key to differentiating these is the plasma renin activity (PRA) assay developed by Sealey and Laragh. Salt-volume (V) hypertension is associated with low renin values (PRA less than 0.65) and is seen in about a third of patients with high blood pressure. It is treated with natriuretic and anti-volume drugs such as spironolactone, thiazides, calcium channel blockers and alpha blockers. Renin-angiotensin mediated vasoconstrictive (R) hypertension is twice as common and is also more likely to result in heart attacks, congestive failure, strokes, and kidney failure. These patients are treated primarily with one of three types of antirenin medications, an angiotensin converting enzyme inhibitor, angiotensin receptor blocker or beta blocker. More details to follow but the bottom line is that blood pressure can be controlled with one drug for life in over half of both (V) and (R) patients and probably in 60-80% of the total group.

The difficulty I and many other physicians encountered 25 years ago was that the PRA assay was not widely available nor reimbursed by medical insurance and seemed to be very labor intensive. At the time, I served as a consultant for Paul Brown, who had founded Metpath Laboratories, and I recall hauling John over to Hackensack to meet with him. Metpath was well on its way to becoming the largest clinical laboratory in the U.S. and we wanted to add renin testing to the hypertensive profile. Nothing apparently came of that but Metpath subsequently became Quest Laboratories, which now offers an automated direct Renin assay. This has obviated some of the early problems although it may not be as sensitive or accurate in measuring low renin values.

It is also possible to bypass renin testing by single trials of a V or an R drug and discontinuing those that don't work. About 20% may need a V and an R medication but that's still preferable to the latest official recommendations. These advise starting out with a thiazide diuretic and to add other drugs until the blood pressure is controlled. Since diuretics are clearly not indicated in the 2 out of 3 patients with high renin hypertension, most have to keep adding other drugs and some can wind up taking four or more. Placing high renin hypertensives on perpetual and often increasing doses of diuretics leads to potassium depletion, cardiac arrhythmias and a significant increase in diabetes. More importantly, it may deny these patients protection from cardiovascular complications that antirenin medications can provide.

Hypertension is emerging as a complex metabolic disorder with adverse effects not solely related to the degree and duration of elevated blood pressure measurements. Governmental guidelines may be endangering the lives of millions of hypertensives unnecessarily and John Laragh's comments should be required reading for anyone with high blood pressure. - stay tuned!

Paul J. Rosch, M.D., F.A.C.P.
Editor-in-Chief