



Self-reported hypertension as a public health surveillance tool: don't throw out the baby with the bathwater

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Self-reported hypertension as a public health surveillance tool: don't throw out the baby with the bathwater

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3 Based on a thorough systematic review of epidemiological studies comparing the
4 identification of hypertension by self-reporting with measured blood pressure, Gonçalves et
5 al. showed that self-reported hypertension would have a low sensitivity for the identification
6 of hypertensive individuals.¹ More precisely, they showed that, on average, less than half of
7 patients with hypertension would be identified by self-reporting.¹ Nevertheless, the author did
8 not consider, first, that most studies based on measured blood pressure overestimate the
9 prevalence of hypertension and, second, that self-reported hypertension entails important
10 advantages as a public health surveillance tool.

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12 Hypertension is a state of sustained elevated blood pressure and it is well known that an
13 individual with elevated blood pressure at an initial visit will often have a much lower blood
14 pressure at subsequent visits, due to habituation and regression to the mean phenomena.²
15 Therefore, in practice, hypertension diagnosis is based on multiple blood pressure
16 measurements, ideally gathered at three separated visits or more.³ However, in most
17 epidemiological studies, blood pressure is measured at a limited number of visits, and often at
18 only one. For instance, in the meta-analysis of Gonçalves et al., ten studies have measured
19 blood pressure at one visit, four at two visits, and none at three visits.¹ The way blood
20 pressure is measured in epidemiological studies allows assessing the prevalence of elevated
21 blood pressure, but not the prevalence of hypertension. Self-reported hypertension is less
22 exposed to this bias because participants are asked if they are taking hypertensive drugs or if
23 they had been diagnosed with hypertension by a physician or another healthcare professional.
24 In both situations, we can assume that blood pressure has been measured more than once.

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26 Of course, measuring blood pressure has unique advantages compared with self-reporting.
27 Hence, when the goal is to identify individuals with hypertension in order to make treatment
28 decisions, the measurement method needs to be highly sensitive and to provide accurate blood
29 pressure estimates, and using self-reported hypertension is not conceivable.⁴ Studies designed
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3 to tackle the etiology of hypertension should also use measured blood pressure. However,
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5 when the goal is to identify prevalence and evolution of hypertension at a population level,
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7 surveys using self-report can be sufficiently informative.⁵ Although estimates based on self-
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9 report can lead to an under- or overestimation of the true prevalence of hypertension,
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11 depending on age, sex, culture, education, and proximity to health care,⁶ this method is
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13 simple, low-cost, and easy to apply to representative and large samples of a country.⁵ Further,
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15 if the degree of bias is relatively stable across time,⁷ surveillance organisms can correctly
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17 assess hypertension trends over time, and draw conclusions and forecasts on evolution of
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19 hypertension and hypertension-related complications among a population.
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23 Hence, self-reported hypertension is an imperfect proxy for the identification of hypertension
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25 and has a potential for bias. Nevertheless, it entails other important features, such as access to
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27 high shares of the population at low cost. By acknowledging the risk for bias and being aware
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29 of potential underlying causes of these biases, surveillance organisms can generate relevant
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31 estimates of hypertension trends to, in fine, guide hypertension management programs at a
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33 country or a regional level.⁸
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