

Reply to the Letter to the Editor: Two Overlooked Issues in Hypertension Management: Risk Thresholds and Obesity Integration

Editöre Mektup Yanıtı: Hipertansiyon Tedavisinde Gözden Kaçan İki Konu: Risk Eşikleri ve Obezitenin Tedaviye Dahil Edilmesi

To the Editor,

We would like to express our sincere gratitude to Dr. Oğuz Abdullah Uyaroğlu,¹ who evaluated our article.² The author focused on two points, and we would like to share our thoughts on these issues separately:

1. The Threshold for Defining High Risk in the SCORE-2 Risk Scoring System

As is well-known, the SCORE-2 and SCORE-2 OP risk assessment systems were developed jointly by the SCORE-2 working group and the Cardiovascular Risk sections of the European Society of Cardiology. These systems aim to predict the development of fatal or non-fatal atherosclerotic cardiovascular disease in patients without known cardiovascular disease or significant comorbidities, based on parameters such as age, gender, systolic blood pressure, and non-HDL cholesterol.^{3,4} These scores provide a numerical value representing the 10-year risk of developing atherosclerotic cardiovascular disease for patients. Guidelines that use these scores also categorize risks according to these numbers.


In the latest European Society of Cardiology hypertension guidelines, patients with SCORE-2 or SCORE-2 OP risks $\geq 10\%$ are considered high risk. In our guidelines, however, we have set a risk threshold of 15% for SCORE-2 and 20% for SCORE-2 OP in individuals without hypertension but with elevated blood pressure. This corresponds to a higher threshold than that used in the European Society of Cardiology Guidelines. The primary reason for this is that the potential positive effects of lowering blood pressure on mortality and morbidity in patients with elevated blood pressure have not been universally accepted. As the author mentions, the lack of clear proof of benefit does not mean the intervention is ineffective. However, since our report aims to convey clear messages, we chose to base our decision solely on the available evidence. We also believe that individualizing treatment and starting it earlier, especially in younger patients, may be appropriate.

Furthermore, risk markers are constantly changing and evolving to provide better results. We must keep in mind that the SCORE2 and SCORE2-OP risk markers we use may not provide perfect results. In this regard, a study published in our journal showed that the Pooled Cohort Equation risk calculator, another marker used by the American Heart Association and the American College of Cardiology, had better predictive power than SCORE2 markers in the Turkish population.⁵

2. Obesity

The authors of this consensus report agree that obesity plays a crucial role in the development and progression of hypertension. As noted by the author of the letter to the editor, obesity is not included in the SCORE-2 and SCORE-2 OP risk markers utilized in our report.^{3,4} The American Heart Association and the American College of Cardiology's 2025 hypertension guidelines use the PREVENT risk calculator for risk assessment.^{6,7} Although body mass index (BMI) is included in this scoring system, it is not used to determine the risk of cardiovascular disease

LETTER TO THE EDITOR REPLY EDİTÖRE MEKTUP YANITI

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or atherosclerotic cardiovascular disease. Instead, it is only employed to calculate the risk of developing heart failure. The exclusion of obesity as a parameter in determining the risk of cardiovascular disease or atherosclerotic cardiovascular disease in two of the most widely used hypertension guidelines may be due to insufficient data from studies on this topic. Furthermore, the risk-determining algorithms currently in use do not practically include all risk factors.

Although not directly included in risk assessment guidelines, the importance of obesity is discussed in detail in our report. This report is specifically prepared for primary care, so we have made every effort to ensure it is as simple, understandable, and practical as possible. Our recommendations are not meant to override clinicians' assessments but to assist them. Therefore, a comprehensive evaluation of all risk factors, especially in such a broad topic as hypertension, could compromise the integrity of this report.

Weight and height measurements, which are indispensable components of a physical examination, enable us to detect obesity in patients. From the summary onward, we have tried to emphasize that obesity is a risk factor. We also mentioned obesity as a risk factor when recommending treatment for patients with Diabetes Mellitus. In Türkiye, 60% of type 2 diabetes patients are obese, and treatment is indicated for these patients.⁸ Furthermore, the treatment of this risk factor is examined in detail under the section on lifestyle changes. Of course, considering the recent developments in obesity treatment, we will consider addressing this topic as a separate section in future versions of our report.

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