



# HEALTH AWARENESS

## Hispanics Largely Unaware Of Their High Blood Pressure, Despite Risk Factors

(NAPSA)—Hispanics are the fastest-growing minority group in the United States, currently comprising 14 percent of the total population. By 2050, this number is expected to increase to nearly 25 percent. As a result, the access to and quality of care for Hispanics will become increasingly important as this community continues to grow.

Hypertension, also referred to as high blood pressure, is a major risk factor for heart disease, the leading cause of death in Hispanics. Uncontrolled high blood pressure can eventually lead to heart attack, stroke and kidney failure. Despite the seriousness, Hispanics tend to have a lower awareness of their hypertension, are less likely to be treated with medication for the condition, and have lower blood pressure control compared with African Americans and Caucasians. Furthermore, Hispanics have higher rates of diabetes and obesity compared with Caucasians, additional risk factors for developing hypertension.

“Hypertension often has no warning signs or symptoms, and many people don’t realize they have it, so it’s important for people, especially those at increased risk, to visit their doctor and get their blood pressure checked regularly,” explains Henry Punzi, M.D., clinical assistant professor, Department of Family and Community Medicine, University of Texas Southwestern Medical Center in Dallas, Texas.



**Steps you can take to control high blood pressure can help you save your own life.**

The good news is there are steps you can take to prevent high blood pressure or to treat it if it is already high. A healthy, low-fat, low-sodium diet including several servings of fruits and vegetables can not only help keep your blood pressure down but can reduce the risk of diabetes and obesity. Exercising, quitting smoking and limiting alcohol use can also help lower blood pressure.

If changes in lifestyle and behavior do not work, talk to your doctor about available medications, such as beta blockers, which are an important option in the treatment of hypertension. In fact, results from a recent medical study of Hispanics with hypertension found Bystolic (nebivolol), a beta blocker, achieved double-digit reductions in blood pressure with a low incidence of side effects. For more information, talk to your doctor or visit [www.Bystolic.com](http://www.Bystolic.com).

### Editor's Note: **Indication**

BYSTOLIC is indicated for the treatment of hypertension. BYSTOLIC may be used alone or in combination with other antihypertensive agents.

### Important Safety Information

#### Contraindications

- BYSTOLIC is contraindicated in patients with severe bradycardia, heart block greater than first degree, cardiogenic shock, decompensated cardiac failure, sick sinus syndrome (unless a permanent pacemaker is in place), severe hepatic impairment (Child-Pugh >B), and in patients who are hypersensitive to any component of this product.

#### Warnings and Precautions

- Do not abruptly discontinue BYSTOLIC therapy in patients with coronary artery disease. Severe exacerbation of angina, myocardial infarction, and ventricular arrhythmias have been reported following the abrupt discontinuation of therapy with beta blockers. Myocardial infarction and ventricular arrhythmias may occur with or without preceding exacerbation of the angina pectoris. Caution patients without overt coronary artery disease against interruption or abrupt discontinuation of therapy. As with other beta blockers, when discontinuation of BYSTOLIC is planned, carefully observe and advise patients to minimize physical activity. Taper BYSTOLIC over 1 to 2 weeks when possible. If the angina worsens or acute coronary insufficiency develops, restart BYSTOLIC promptly, at least temporarily.

- BYSTOLIC was not studied in patients with angina pectoris or who had a recent MI.

- In general, patients with bronchospastic diseases should not receive beta blockers.

- Because beta blocker withdrawal has been associated with an increased risk of MI and chest pain, patients already on beta blockers should generally continue treatment throughout the perioperative period. If BYSTOLIC is to be continued perioperatively, monitor patients closely when anesthetic agents which depress myocardial function, such as ether, cyclopropane, and trichloroethylene are used. If beta-blocking therapy is withdrawn prior to major surgery, the impaired ability of the heart to respond to reflex adrenergic stimuli may augment the risks of general anesthesia and surgical procedures.

The beta-blocking effects of BYSTOLIC can be reversed by beta agonists, eg, dobutamine or isoproterenol. However, such patients may be subject to protracted severe hypotension. Additionally, difficulty in restarting and maintaining the heartbeat has been reported with beta blockers.

- Beta blockers may mask some of the manifestations of hypoglycemia, particularly tachycardia. Advise patients subject to spontaneous hypoglycemia and diabetic patients receiving insulin or oral hypoglycemic agents about these possibilities.

- Beta blockers may mask clinical signs of hyperthyroidism, such as tachycardia. Abrupt withdrawal of beta blockers in these patients may be followed by an exacerbation of symptoms or may precipitate a thyroid storm.

- Beta blockers can precipitate or aggravate symptoms of arterial insufficiency in patients with peripheral vascular disease.

- Because of significant negative inotropic and chronotropic effects in patients treated with beta blockers and calcium channel blockers of the verapamil and diltiazem type, monitor the ECG and blood pressure of patients treated concomitantly with these agents.

- Use caution when BYSTOLIC is co-administered with CYP2D6 inhibitors (quinidine, propafenone, fluoxetine, paroxetine, etc). When BYSTOLIC is co-administered with an inhibitor or an inducer of CYP2D6, monitor patients closely and adjust the nebivolol dose according to blood pressure response. The dose of BYSTOLIC may need to be reduced. When BYSTOLIC is administered with fluoxetine, significant increases in d-nebivolol may be observed (ie, an 8-fold increase in AUC and a 3-fold increase in Cmax for d-nebivolol).

- Renal clearance of nebivolol is decreased in patients with severe renal impairment. In patients with severe renal impairment (ClCr less than 30 mL/min) the recommended initial dose is 2.5 mg once daily; titrate up slowly if needed. BYSTOLIC has not been studied in patients receiving dialysis.

- Metabolism of nebivolol is decreased in patients with moderate hepatic impairment. In patients with moderate hepatic impairment, the recommended initial dose is 2.5 mg once daily; titrate up slowly if needed. BYSTOLIC has not been studied in patients with severe hepatic impairment and therefore it is not recommended in that population.

- Patients with a history of severe anaphylactic reactions to a variety of allergens may be more reactive to repeated challenge and may be unresponsive to the usual doses of epinephrine while taking beta blockers.

- In patients with known or suspected pheochromocytoma, initiate an alpha blocker prior to the use of any beta blocker.

#### Drug Interactions

- Do not use BYSTOLIC with other beta blockers.

- Both digitalis glycosides and beta blockers slow atrioventricular conduction and decrease heart rate. Concomitant use can increase the risk of bradycardia.

- BYSTOLIC can exacerbate the effects of myocardial depressants or inhibitors of AV conduction, such as certain calcium antagonists (particularly of the phenylalkylamine [verapamil] and benzothiazepine [diltiazem] classes), or antiarrhythmic agents, such as disopyramide.

#### Use in Specific Populations

- Use BYSTOLIC during pregnancy only if the potential benefit justifies the potential risk to the fetus. BYSTOLIC is not recommended during nursing.

- The safety and effectiveness of BYSTOLIC have not been established in pediatric patients.

- In a placebo-controlled trial of 2128 patients (1067 BYSTOLIC, 1061 placebo) over 70 years of age with chronic heart failure receiving a maximum dose of 10 mg per day for a median of 20 months, no worsening of heart failure was reported with nebivolol compared to placebo. However, if heart failure worsens, consider discontinuation of BYSTOLIC.

#### Adverse Reactions

- The most common adverse events with BYSTOLIC versus placebo (approximately ≥1% and greater than placebo) were headache, fatigue, dizziness, diarrhea, nausea, insomnia, chest pain, bradycardia, dyspnea, rash, and peripheral edema. The most common adverse events that led to discontinuation of BYSTOLIC were headache (0.4%), nausea (0.2%), and bradycardia (0.2%).