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Switching to another antihypertensive effective drug when using ACEIs/ARBs to treat arterial hypertension during COVID-19

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This Commentary refers to: 'SARS-CoV2: should inhibitors of the renin–angiotensin system be withdrawn in patients with COVID-19?', by G.M. Kuster *et al.*, doi:10.1093/eurheartj/ehaa235.

I appreciated the well-argued paper by Kuster *et al*; however, it seems that the authors forget that, at least to treat arterial hypertension, we have the possibility to choose other effective drugs such as calcium channel blockers, an antihypertensive master class.[2] Indeed, even if there are no data supporting a causal relationship between angiotensin-converting enzyme 2 (ACE2) activity and COVID-19-associated mortality, we should not underestimate the way in which SARS-CoV-2 enters the cell that is well documented with an entry risk map, based on expression of ACE2 that, coincidentally, follows the initial clinical presentation of COVID-19.[3] Furthermore, data updated on 20 March from the Italian Health Institute on a sample of 3200 deaths[4] support: (i) a high mortality rate for elderly subjects (mean age 78.5, median 80, range 31–103, IQR 73–85); (ii) high co-existence of comorbidities (98.7% have ≥1 comorbidity); (iii) high blood pressure as the prevailing comorbidity since 73.8% of the subjects were hypertensives; and (iv) use of ACEIs/ARBs documented in 52% of deaths. We don't know if this is merely a coincidence and we do not have data on patients affected by COVID-19 that are receiving ACEIs/ARBs and their relative mortality rates in China; nonetheless, if we exclude subjects with heart failure and/or ischaemic heart disease, what would be the reason not to switch to another drug to treat high blood pressure, obviously, without destabilizing blood pressure control?

Conflict of interest: none declared.

References

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