Re: Postpartum management of hypertension

I was interested to read Kate Bramham's article on Postpartum Management of Hypertension, in which she points out that high blood pressure can have endocrine causes. My own serious rise in blood pressure occurred after a cone biopsy rather than a pregnancy, but I would thoroughly endorse what she says about the importance of investigating the causes of high blood pressure in comparatively young women. My own unfortunate experience in which nearly 30 years of my life were blighted unnecessarily by illness highlights the disastrous consequences of not doing so.

I lost a lot of blood during my first pregnancy and did have raised blood pressure in the postpartum period, though this problem resolved in a few days. However, my blood pressure first rose in a sustained way in 1981 when I was 34, and it was initially controlled with a diuretic, Hygroton K.

By 1987 I had rapidly gained weight and was suffering from fatigue, muscle and joint pain, pins and needles, dizziness and metabolic alkalosis. I had hypokalaemia, sodium at the high end of normal range and raised triglycerides. I had gynaecological problems and low T4 was noted. My blood pressure had been well controlled up until then, but when for some reason Hygroton was discontinued, my blood pressure immediately rose. I felt very ill by this stage, and a locum told me “stress of work” could be affecting my health. I went on sick leave in 1988. I did this with sharp regret because I had a successful career with BT and was looking forward to a promotion. In fact my employment was terminated on health grounds in 1989, when I was only 42.

In 1990 I was once more prescribed anti-hypertensive medication, but my blood pressure was now difficult to control, despite experimentation with several different medications. My gynaecological problems were not resolved. I was given annual anion gap tests from 1992-5, but no investigations were arranged to discover why my blood pressure remained difficult to control.

My triglycerides were not checked between 1988 and 1997, but a blood sample given for an annual routine blood test in 1997 was described as “a grossly lipaemic sample, unsuitable for analysis.”

In 1999 I was referred to a cardiologist because of my blood pressure and raised triglycerides, but although he treated me until 2001 he did not discover the cause.

Things looked up in 2002 when I changed my GP. She associated raised triglycerides with hypothyroidism, which was diagnosed and treated. She referred me to a gynaecologist who discovered fibroids, for which I was operated on, and my gynaecological problems ceased, with my periods. My blood pressure also improved and one of my three antihypertensive medications was dropped.

However, in 2006 my health was deteriorating once more, and my GP referred me to an ophthalmologist, a cardiologist and finally an endocrinologist.

The endocrinologist thought I might have primary hyperaldosteronism. He arranged an aldosterone: renin ratio test, but unfortunately the testing protocol was not followed and it gave a normal result. He also gave me a short synacthen test, which again produced a normal result. Consequently he diagnosed me retrospectively with Chronic Fatigue Syndrome going back to the 1980s.

In 2010, I was diagnosed with Conn’s syndrome, primary hyperaldosteronism. In 2012 I had a glucagon stimulation test, which revealed deficiency in growth hormone and cortisol, and I was

finally diagnosed with likely lymphocytic hypopophysitis, which is defined as inflammation of the pituitary gland due to autoimmunity.

The short synacthen test I had been given in 2006 might have been expected to show the cortisol deficiency, but as I now discovered, this test is only reliable for diagnosing primary hypoadrenalism when the problem is in the adrenals, not hypoadrenalism as caused by pituitary dysfunction, where it misses 40% of cases.

I have been prescribed hydrocortisone for cortisol deficiency and I already feel considerably better. It is the first Christmas for a long time that I have not had an infection and have felt able to cook Christmas lunch, and in the last few weeks although this may seem trivial I have been able to wear make up, the first time since 1994.

Following the glucagon test, I have started a trial of human growth hormone.

What lessons can be learnt from nearly 30 years of needless ill health and my loss of what I feel would have been a satisfying and successful career? Experiences like mine can seem less dispiriting and wasteful if they save other people from the same fate.

First, as Kate Bramley's article makes clear, if my raised blood pressure as a young woman had been properly investigated when it became difficult to control, I might have got my life back comparatively quickly. Secondly, my raised triglycerides should have rung warning bells far sooner than they did. The lack of awareness that aldosterone production is also stimulated by the action of ACTH produced by the pituitary gland is concerning. Finally, I feel strongly that there should be much more widespread awareness about the inadequacies of the short synacthen test, and much greater caution before telling a patient they have chronic fatigue syndrome. This should be a diagnosis of absolutely last resort, when the pituitary possibilities have been thoroughly checked out.

Competing interests: No competing interests

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