

Oral Magnesium for Hypertension

Subjects: [Allergy](#)

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Oral magnesium therapy added to treatment regimens of patients with partially controlled hypertension holds promise as a way of safely achieving lower BP without increasing antihypertensive medications. Prescribing magnesium supplements to hypertensive but untreated patients may not lower BP unless the daily magnesium dose meets or exceeds 600 mg/day, which can be safely and economically accomplished, but magnesium doses below this level can achieve other cardiovascular risk factor improvements without the side effects of antihypertensive medications.

[Oral Magnesium](#)

[Hypertension](#)

[Anti-hypertension medications](#)

1. Introduction

More than any other modifiable risk factor, hypertension is responsible for cardiovascular disease deaths both globally [\[1\]](#)[\[2\]](#) and in the United States [\[3\]](#). Given the potential harms and costs of hypertension and the need for safe lowering of this important risk factor [\[4\]](#)[\[5\]](#)[\[6\]](#)[\[7\]](#)[\[8\]](#), we probed the large trove of research on oral magnesium therapy for hypertension and BP hoping to discern any prescription guidance.

Oral magnesium therapy for the treatment of hypertension has been well studied over the last 35 years but results are highly mixed. The trials differ not only in oral magnesium dose and form of magnesium but also in normotensive vs. hypertensive status at baseline as well as use or non-use of antihypertensive medications. Fourteen clinical trials have shown that oral magnesium therapy significantly lowers both systolic blood pressure (SBP) and diastolic blood pressure (DBP), whereas > twice that number of studies have shown no statistically significant lowering of either SBP, DBP, or both with oral magnesium therapy. Of six meta-analyses on this topic conducted to date [\[9\]](#)[\[10\]](#)[\[11\]](#)[\[12\]](#)[\[13\]](#)[\[14\]](#), one shows no effect of oral magnesium on BP, one shows lowering of DBP but not SBP, four show that oral magnesium therapy lowers both SBP and DBP but only one of these suggests that the BP reductions are clinically relevant. Such results do not lend confidence in prescribing oral magnesium therapy to control or prevent high blood pressure. However, magnesium's low cost, safety, positive research in cardiovascular risks [\[15\]](#)[\[16\]](#)[\[17\]](#) plus its partial beneficial BP results encourages this inclusive analytical categorization of all of these studies.

2. Effectively Prescribing Oral Magnesium Therapy for Hypertension

This categorization clearly shows that NT study subjects, both Controlled Hypertensives and Normotensive (i.e., those with an untreated healthy BP), will not show lower BP with oral magnesium therapy, even at high doses. However, several studies in these normotensive categories reported significant improvement in blood magnesium, lipoproteins, C-reactive protein, fasting glucose and insulin resistance, reversal of retinal vasospasm and increased sodium excretion, all of cardiovascular risk factor benefit. Oral magnesium therapy in NT patients, treated with antihypertensive medications or not, may not show improved BP readings, but these individuals may benefit from improved cardiovascular risk factors.

Among subjects who are hypertensive ($\geq 140/90$ mm Hg; MBP ≥ 106 mm Hg) at baseline, both low and high doses of oral magnesium therapy show significant decreases in both SBP and DBP only if the subjects are concurrently taking antihypertensive medications, i.e., partially or Uncontrolled Hypertensives. In the studies of Untreated Hypertensive subjects taking no antihypertensive medications, only the studies with Mg supplement doses >600 mg/day demonstrated statistically significant improvements in blood pressure by the criteria of this analysis. Subjects on lower magnesium doses showed other improvements in measures important to cardiovascular health such as serum magnesium, endothelial function and sodium excretion.

Magnesium-replete subjects, even those who are hypertensive, did not show a decrease in BP with oral magnesium therapy, even at doses as high as 972 mg/day [18]. This finding indicates that a person can have adequate magnesium status and still have high BP. Other essential electrolytes besides magnesium can impact BP. For these patients, potassium could be low, especially when concurrent with a high sodium and/or low calcium intake.

The main limitation to this study is the lack of quantification of the BP changes, instead using the statistics and conclusions from each individual study, which varied widely. This study is not a precise meta-analysis and makes no attempt to fully quantify the impact of the categories derived from this analysis. This, rather, is the job of future meta-analyses, and we see this categorization as a preliminary study to guide future meta-analysis that may provide enhanced information about oral Mg therapy for BP while hopefully achieving lower heterogeneity than existing meta-analyses without losing precision. Nonetheless, this categorization of studies by hypertensive as well as medication status plus magnesium dose yields an informative framework for the prescription of oral magnesium therapy for high BP. It well accommodates large and small studies ($n = 7$ –227 receiving magnesium therapy), short-term and long-term studies (2–26 weeks), 11 different forms of magnesium preparations (four inorganic and seven organic), parallel as well as crossover study designs, and placebo control or not (see Michon et al. [19], Sebekova et al. [20], Shafique et al. [21], Motoyama et al. [22], Cohen et al. [23], and Haga [24], which are studies not included in most meta-analyses due to no true placebo group).

Over 30 years ago, magnesium was shown to alter vascular constriction [25] and several studies have since shown that the physiology and cellular biochemistry of magnesium is important to the functionality of endothelial and smooth muscle cells and regulation of vascular tone [26]. Decreased magnesium concentrations have been implicated in altered vascular reactivity, endothelial dysfunction, vascular inflammation, and structural remodeling [27]. Low dietary magnesium has been associated with a higher risk of hypertension [28]. In the United States, 67%

of the population aged ≥ 51 years is low in dietary magnesium [29] and 55% of adults aged 19 to 50 years, 60% aged 51 to 70 years, and 78% aged > 71 years do not consume their estimated average requirement for magnesium [30]. Therefore, it is not surprising that prescribing oral magnesium therapy can lower a high BP. However, this categorized review of clinical trials shows that medication status, hypertensive status, and magnesium dose all must be considered in the use of this inexpensive, non-invasive, safe, readily available, “lifestyle” therapy to prevent and treat high BP as well as other conditions for which high BP is a risk factor. Pervasive low dietary magnesium status affects the health and health care systems of national and global populations [31][32]. Chronic low dietary magnesium quite likely constitutes one of the “lifestyle” components in the high risk of cardiovascular disease of our time [31][33][34].

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