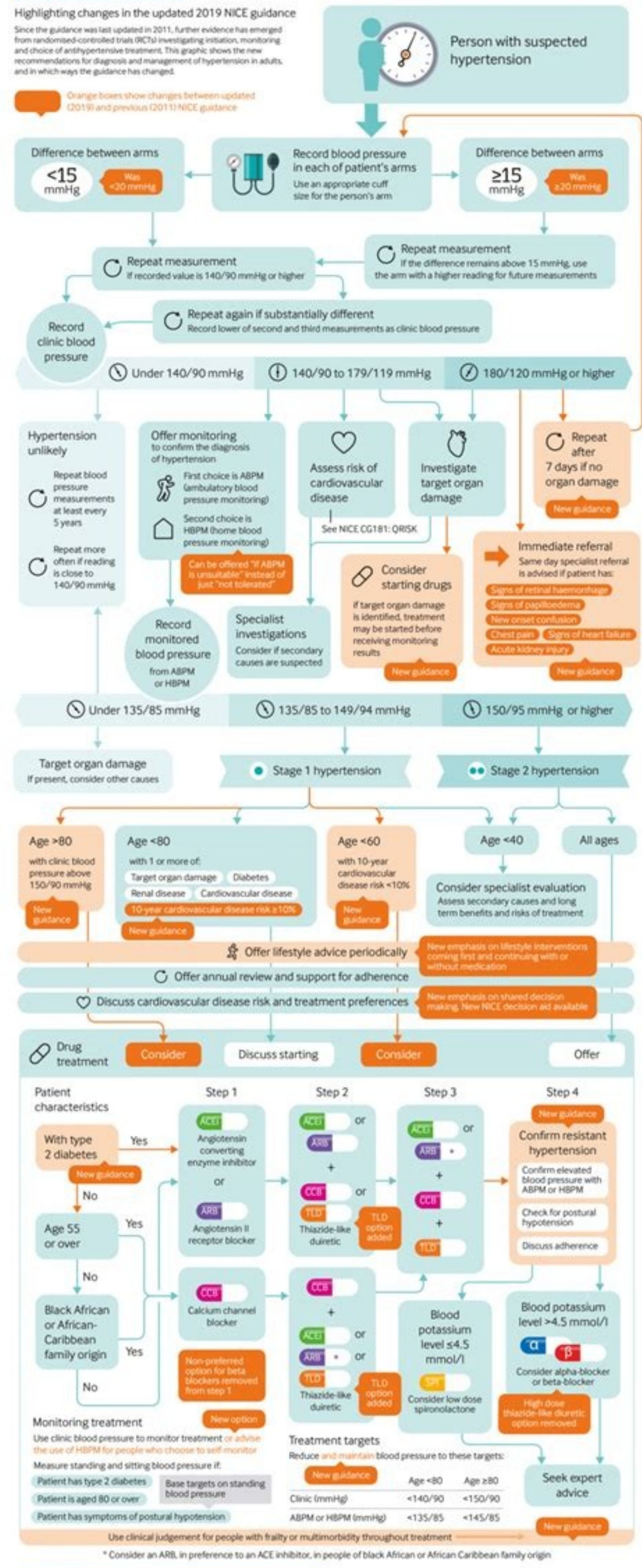


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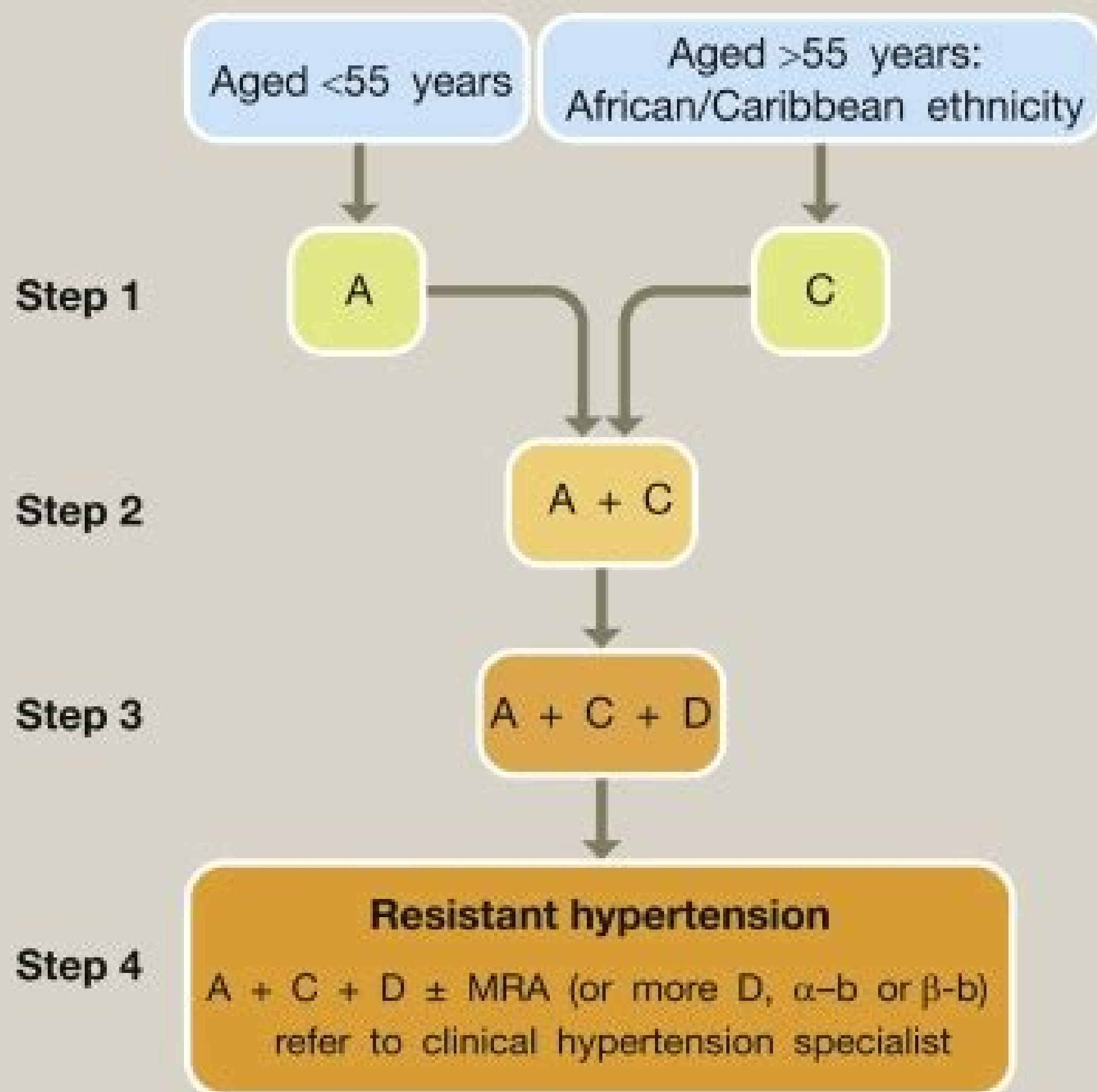
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## Treatment algorithm for hypertension. Adapted from UK NICE guidelines<sup>1</sup>



A, angiotensin-converting enzyme inhibitor or low-cost angiotensin II-receptor blocker;  $\alpha$ -b,  $\alpha$ -adrenoceptor blocker;  $\beta$ -b,  $\beta$ -adrenoceptor blocker; C, calcium-channel blocker; D, thiazide-like diuretic; MRA, mineralocorticoid receptor antagonist.

Nice hypertension guidelines 2019. Nice hypertension guidelines.

In August 2019, the National Institute for Health and Care Excellence (NICE) released its new hypertension guidelines.<sup>1</sup> This article highlights the key recommendations and changes since 2011. The diagnostic threshold for hypertension remains 140/90 mmHg on clinic blood pressure (BP). As previously, it is recommended that diagnosis is based on out-of-office measurement, given the risk of white-coat hypertension, defined as a difference of >20/10 mmHg between clinic readings and average daytime home or ambulatory measurements. The gold standard is ambulatory BP monitoring (ABPM) but, as this is not suitable or tolerated by everyone, home BP monitoring (HBPM) is offered as an alternative. For HBPM, patients should be advised to take at least two recordings, 1 minute apart, twice a day for 4 to 7 days. The first day of readings should be discounted and the mean of the remaining readings used. If the mean BP is close to the diagnostic threshold, ABPM may be needed to confirm the diagnosis, particularly in younger people (for example, aged 20 mmHg), treatment should be targeted at the standing BP. BP should be checked in both arms at the time of diagnosis as a significant difference in readings between arms is an important marker of vascular disease and can lead to undertreatment.<sup>2</sup> In recognition, NICE lowered its definition of what is considered a significant between-arm difference from 20 mmHg to 15 mmHg. BP should be measured consistently in the arm with higher BP during subsequent monitoring where possible. Urgent admission for BP assessment or control is only recommended for individuals with stage 3 hypertension (BP >180/120 mmHg) (Table 1) who also have signs of acute end organ damage, including papilloedema or retinal haemorrhage, or life-threatening symptoms such as acute chest pain, confusion, or decompensated heart failure. Urgent admission is also recommended if a pheochromocytoma is suspected based on significant hypertension alongside symptoms such as headache, abdominal pain, pallor, or diaphoresis. Hypertension stage CBPM threshold ABPM/HBPM threshold Stage 1 140/90/135/85 Stage 2 160/100/150/95 Stage 3 180/120 Does not require ABPM/HBPM In the absence of one of these indications for acute referral, NICE suggests assessing for target organ damage and, if present, considering initiating treatment without waiting for ABPM or HBPM. If there is no evidence of target organ damage, the clinician should repeat a clinic BP within 1 week and re-evaluate. Patients newly diagnosed with hypertension should be offered tests for target organ damage (fundoscopy, urinalysis, renal function, ECG) and a cardiovascular risk score calculated (for example, using the latest version of the QRISK score for patients residing in the UK). Treatment is now suggested for patients aged

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