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Guidelines in practice hypertension

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Blood glucose lowering drugs and blood pressure 10 Follow-up 10.1 Hypertensive patients 10.2 Follow-up of patients with high normal blood pressure and whitecoat hypertension 10.3 Increased blood pressure control visits 10.4 Improvement in blood pressure control in hypertension: drug adherence 10.5 Further search for organ damage mediated by asymptomatic hypertension 10.6 Can antihypertensive drugs be reduced or stopped? 11 Gaps in evidence 12 key messages 13 What to do and what not to do messages in Appendix 14 to the Guideline. 15 References Volume 2, June 2020, 100038 the how an exercise pharmacist can support and advise patient patients with hypertension how an exercise pharmacist can work with the broad basic-care team to optimistic antihypertensive medication how NICE blood pressure treatment thresholds can be used to guide choice and intensity of medication. High blood pressure is defined by the World Health Organisation (WHO) as as persistently high blood pressure (BP),1 and more than 1 in 4 adults in the UK.2 Hypertension increases the risk of cardiovascular and related diseases, including heart attack, stroke, heart failure and chronic kidney disease (CKD).2 Globally, around half of deaths from stroke and heart disease can be attributed to high blood pressure.1 NHS health monitoring , clinics for well-functioning women run by healthcare assistants (HCAs) or nurses, as well as medical examinations by GPs, all provide a useful opportunity to identify people at risk of high blood pressure. Patients who have a high blood pressure risk can also identify incidentally as practice-based pharmacists during medication reviews or clinics associated with chronic diseases. Such options can help to ensure that people with hypertension are immediately diagnosed by their GP, recorded in the register of hypertension, and begin treatment. Practice-based pharmacists can then participate in the treatment of patients with hypertension by carrying out a continuous review of patients and optimizing antihypertensive drugs, while also providing non-pharmacological intervention advice. Note: NICE is expected to publish updated guidance on the diagnosis and treatment of hypertension in adults in August 2019. This Article is based on Article 3 of the Guidelines. For readers reference to the final version of the NICE hypertension guideline 2019. Diagnosing hypertension If the clinic's BP reading is between 140/90 mmHg and 180/110 mmHg, then the patient is considered at risk of hypertension. A A Guideline 2 recommends that ambulatory blood pressure monitoring (ABPM) be used to confirm the diagnosis. It refers patients with 180/110 mmHg or higher to their GP to test for possible severe hypertension. See clinical definitions of NICE for different severity levels (stages) of hypertension. Stage 1 hypertension: clinic BP ranging from 140/90 mmHg to 159/99 mmHg and subsequent ABPM daytime average or HBPM average BP ranging from 135/85 mmHg to 149/94 mmHg. Stage 2 hypertension: clinic BP 160/100 mmHg or higher, but less than 180/110 mmHg and subsequent ABPM daytime average or HBPM average BP 150/95 mmHg or higher. Stage 3 or severe hypertension: clinic systolic BP 180 mmHg or higher, or clinic diastolic BP 110 mmHg or higher. BP = blood pressure; ABPM = ambulatory blood pressure monitoring; HBPM = home blood pressure monitoring © NICE 2019. Hypertension in adults: diagnosis and treatment - draft consultation, 2019. Available: www.nice.org.uk/guidance/indevelopment/gid-ng10054/documents All rights reserved. Subject to notification of rights. NICE has prepared guidance for the National Health Service in England. All NICE guidelines are regularly reviewed and can be updated or withdrawn. NICE is not responsible for the use of its contents in the product/publication Blood pressure measurement: When using an automatic BP monitor, the patient must sit for 5 minutes with the lever at heart level.4 Devices for measuring BP must be checked, maintained and regularly recalibrated in accordance with the manufacturer's instructions.3.4 Automated devices may not result in accurate measurements if the patient has an irregular heart rate. NICE recommends that you feel the radial or brachial pulse before measuring BP to check for heart rate irregularity, and if there is any irregularity, manually measure BP with direct auscultation above the brachial artery.3 Any impulse irregularity can be a sign of another condition, for example, atrial fibrillation, therefore the patient should be referred to the GP for further examination.5 Some patients may exhibit a white coat effect (the clinic's BP exceeds the average daytime ABPM BP or average HBPM BP measurements by more than 20/10 mmHg), or masked hypertension (the clinic BP's measurements are normal [less than 140/90 Hgm], but higher when used outside the clinic by ABPM or HBPM). In these cases, consider the ABPM or HBPM supplemental school year in addition to the clinic's BP values to track the response to treatment or lifestyle modification.3 Further studies should also be carried out to determine whether there is evidence of target organ damage, such as left ventricular hypertrophy or chronic kidney disease (CKD):3 proteinuria test by sending a urine sample to estimate albumin:creatinine ratio and for a test to measure the hemoglobin (HbA1c), electrolytes, creatinine, estimated glomerular screening rate (eGFR), serum total cholesterol, and high-density lipoprotein cholesterol examine the fundamental presence of hypertensive retinopathy by arranging a 12-lead ecardiogram (ECG). The GP should also carry out an official assessment of cardiovascular risk using the Cardiovascular Risk Assessment Tool. If the patient has signs or symptoms that indicate a root cause (i.e. secondary hypertension),

consider whether special studies are needed.³ Routine monitoring of hypertension should be reviewed at least once a year to monitor BP, support lifestyle and discuss lifestyle, symptoms and medicines.³ If hypertension is not diagnosed after ABPM or HBPM, the patient should be called back for routine BP monitoring at least once every 5 years and more frequent measurements should be considered if his clinic's BP is close to 140/90 mmHg.³ Treatment goals A In practice, it is necessary to agree in practice in accordance with the Quality and Results Framework (QOF) framework of the General Medical Services (GMS) contract.⁶ Therapeutic objectives under QOF should be set in accordance with point 1.3.6 of the QOF and NICE guidelines. : Therapeutic targets for hypertension BP measured clinic/ABPM daytime average or HBPM mean Diabetes Non-diabetes Diabetes QOF standard⁶ \leq 140/90 mmHg (if older \geq 80 years) measured in the previous 12 months, \leq 140/80 mmHg measured in the previous 12 months without moderate or severe weakness Commissioners may require the contractor to discuss their plans to ensure that new diagnoses [of hypertension] are confirmed as necessary using ABPM or HBPM. NICE Guide³ \leq 140/90 Hgmm \leq 80 years \leq 150/90 MmHg in adults aged \geq 80 years (use of \geq clinical judgement of adults with type 2 diabetes) for type 2 diabetes: concretis not suffering from type 2 diabetes \leq 135/85 Hgmm for adults \leq 80 years old \leq 145/85 Hgmg for adults up to 80 years of age type 2 diabetes: same as type 1 diabetes in people without type 2 diabetes:7 \leq 135/85 Hgmm \leq 130/80 mmHg, if albuminuria or 2 or more metabolic syndrome characteristics type 1 diabetes mellitus:7 ABPM/HBPM targets are not defined in people with symptoms of postural hypotension (falls or postural dizziness): measure BP with blood pressure or sedentary blood pressure while that person stands for at least 1 minute at least 1 minute before measurement. Measure consisting of BP adults with hypertension who have type 2 diabetes, symptoms of postural hypertension, or aged 80 years or older Treat the target, consisting of BP people with significant postural drops or symptoms of postural hypotension. QOF also includes BP indicators for other related conditions. Please full version of BP-related QOF standards for coronary heart disease, stroke and ischemic seizure, and mental health. BP = blood pressure; ABPM = ambulatory blood pressure monitoring; HBPM = home blood pressure monitoring; QOF = Quality and results framework for non-pharmacological interventions Lifestyle intervention is an important component of hypertension treatment. Lifestyle advice can initially be offered by HCSAs and practising nurses, followed by GPs and pharmacists. Lifestyle changes can help reduce BP and thus the need for medication and reduce the risk of developing cardiovascular disease (CVD).⁸ NICE recommends the following non-pharmacological interventions to treat and prevent hypertension in adults:³ establishing a patient's diet and appropriate written or audiovisual advice: pharmacists' prescribers may consider prescribing weight loss flour as part of a comprehensive plan to treat obesity, In accordance with NICE Clinical Guidelines 189, Obesity: Identifying, Evaluating and Treating⁹ recommend that regular exercise advice on reduced sodium salt consumption encourage reduced alcohol consumption when drinking excessively discouraged excessive caffeine consumption by advising and helping smokers to stop smoking signpost local initiatives to support and promote healthy lifestyle changes. See table 2. These resources can also be used for the general public, but in particular help to reduce the risks of cardiovascular disease associated with hypertension or to reduce blood pressure. NHS.uk Advice and Guidelines for Diet www.nhs.uk/live-well/eat-well/ Salt Intake www.nhs.uk/conditions/vitamins-and-minerals/others/#sodium-chloride-salt Healthy Weight www.nhs.uk/live-well/healthy-weight/ Drinking www.nhs.uk/live-well/exercise/ Duration www.nhs.uk/live-well/alcohol-support/calculating-alcohol-units/ the NICE Guidelines for Drinking Alcohol in Nice Guidelines for Drinking Alcohol to Prevent Obesity www.nice.org.uk/cg43 Obesity: Identification, evaluation and treatment www.nice.org.uk/cg189 Prevention of cardiovascular disease www.nice.org.uk/ph25 Prevention of cardiovascular disease: risk assessment and reduction, including lipid modification www.nice.org.uk/cg181 cessation of smoking interventions and services www.nice.org.uk/ng92 Diet for stopping hypertension (DASH) is currently gaining momentum in the US and has been shown to reduce the average BP to approximately 8-14 mmHg. DASH diet is rich in fruits, vegetables and low-fat dairy products, with reduced saturated fat, total fat and sodium intake.^{10,11} Pharmacological interventions Start antihypertensive drugs are usually carried out by your GP, based on the stage/severity of hypertension, according to NICE guidelines (see box 1 condition), as well as any other comorbidity or risk. A for more information on the appropriate selection of interventions, see NICE's cascading algorithm (Figure 2). After initiation of antihypertensive treatment, the patient is recalled to the the drug review and the BP check. The appointment of a review usually takes place 4 weeks after the start of treatment, but sometimes after 2 weeks, if it is considered urgent or clinically necessary. The pharmacist should evaluate the response to the treatment and review any cover-up problems. If the patient is started with an angiotensin converting enzyme (ACE) inhibitor or angiotensin-II receptor blocker (ARB), renal function and serum electrolytes should be monitored before treatment begins and 1-2 weeks after initiation of treatment or dose increase.¹² Medication switches The pharmacist may check for side effects and adverse reactions and consider how to treat them. For example, a pharmacist prescribing can change the medication to another drug in the same class, or turn the drug into a different class. The NICE algorithm for the treatment of hypertension (Figure 2) is a good source to guide decision-making on which drug to prescribe. Changes in drug treatment include, for example, switching a patient with a persistent dry cough with an ACE inhibitor to a patient who inhibits ace inhibitors or shuts down ARB, if the patient has experienced angioedema and if patients have amlodipin ankle edema, they may switch to lercanidipine instead of adding a diuretic, as this dihydropiridine calcium channel blocker, which is least likely to cause peripheral edema.¹³ Pharmacists carried out by pharmacists carried out by pharmacists are any drug interaction when reviewing medicines. For example, some antihypertensives (e.g. amipidipine, diltiazem) interact with 40 mg simvastatin, which may increase the risk of myopathy.¹⁴ The pharmacist can identify the risk and then promote the transition to statin by reducing the risk of interaction with amborodipine (e.g. atorvastatin 20 mg), unless contraindicated.¹⁵ Years of hypertension review After optimising bp, the pharmacist may schedule a patient hypertension review for one year. or earlier if clinically justified. This is taken up by the practice's administration team to post annual hypertension review invitations. In patients with hypertension who have stable blood pressure within the target range, monitoring should usually be carried out annually with a trained HCA or training nurse. The 20-minute review consultation shall include: assessment of the waist circumcumb of the bp weight on the assessment of the overall health status of the non-pharmacological counselling debate on non-pharmacological counselling, symptoms and (if any) medications, including adverse effects¹² renal function tests (serum creatinine, electrolytes, eGFR and urine measuring rods for proteinuria):¹² if proteinuria is present, consider taking the patient's urine albumin:creatinine (ACR) , which can also be controlled by practical pharmacists. QRISK2 scores should be calculated for patients who do not take statins for the primary prevention of CVD. Prevent. the QRISK2 score exceeds 10%, they should make an appointment with the pharmacist to discuss starting statin treatment (usually atorvastatin 20 mg) for primary prevention of CVD.^{8,12} If the patient has resistant hypertension (i.e. below bp's target for optimal or maximum tolerated doses of oral hypotensives),³ specialist advice should be sought. If a patient with hypertension becomes pregnant, referral to a specialist should be offered.¹⁶ Role of pharmacist If the patient's BP persistently exceeds the established treatment targets, the pharmacist may see the patient to optimise BP control. Pharmacists can also take into account abnormal blood test results and refer to their GP if necessary. If patients experience low blood pressure and/or antihypertensive symptoms, they may also refer to the pharmacist for a possible dose reduction or a complete stoppage of oral blood pressure medicines with continuous monitoring.¹² Pharmacists' practice may be titrated (up to the maximum tolerated dose) and oral antihypertensive medicines started in secondary care may be monitored, for example, beta-blockers or ACE inhibitors in patients with aut coronary syndrome (ACS).¹⁷ Patients may make lifestyle changes and may reduce or discontinue the use of anti-tensive medicines. If the patient is at low cardiovascular risk and bp has been well controlled for years, they should be offered appropriate guidance to reduce a study or withdraw treatment and be followed for 6 months at 4-weekly intervals and then 2-3 times a year to ensure recurrence detection.¹² Patients' attitudes to hypertension and treatment experience are different. They can provide useful information about patient organisations that provide useful forums for sharing views and information, such as the British Heart Foundation (www.bhf.org.uk/publications/heart-conditions/pressure) or the Pressure Association (www.bpassoc.org.uk). It may be worth discussing exercise referral with the patient if it is clinically appropriate and the patient meets the relevant criteria. Practice-based pharmacists can successfully work as part of a team of multidisciplinary general practice to provide excellent clinical care in the treatment of patients with hypertension. This can improve patient health outcomes, provide value for money for practices (through compliance with QOF indicators and cost-effective prescribing), while significantly reducing the workload of GPs. Practitioner, Court View Surgery, Kent; Member of the Executive Board of the Pharmaceutical Cooperative World Health Organisation. Questions about hypertension. 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