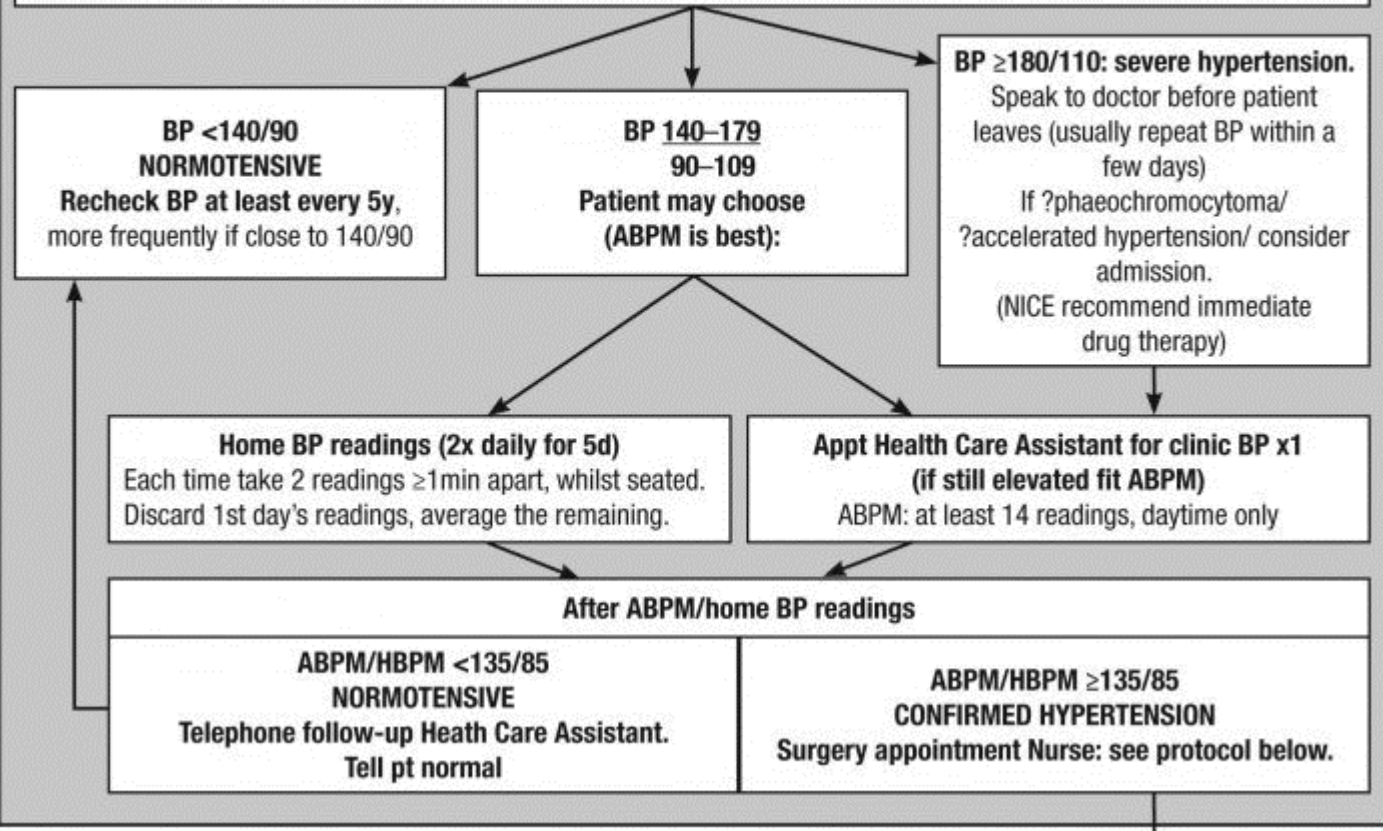


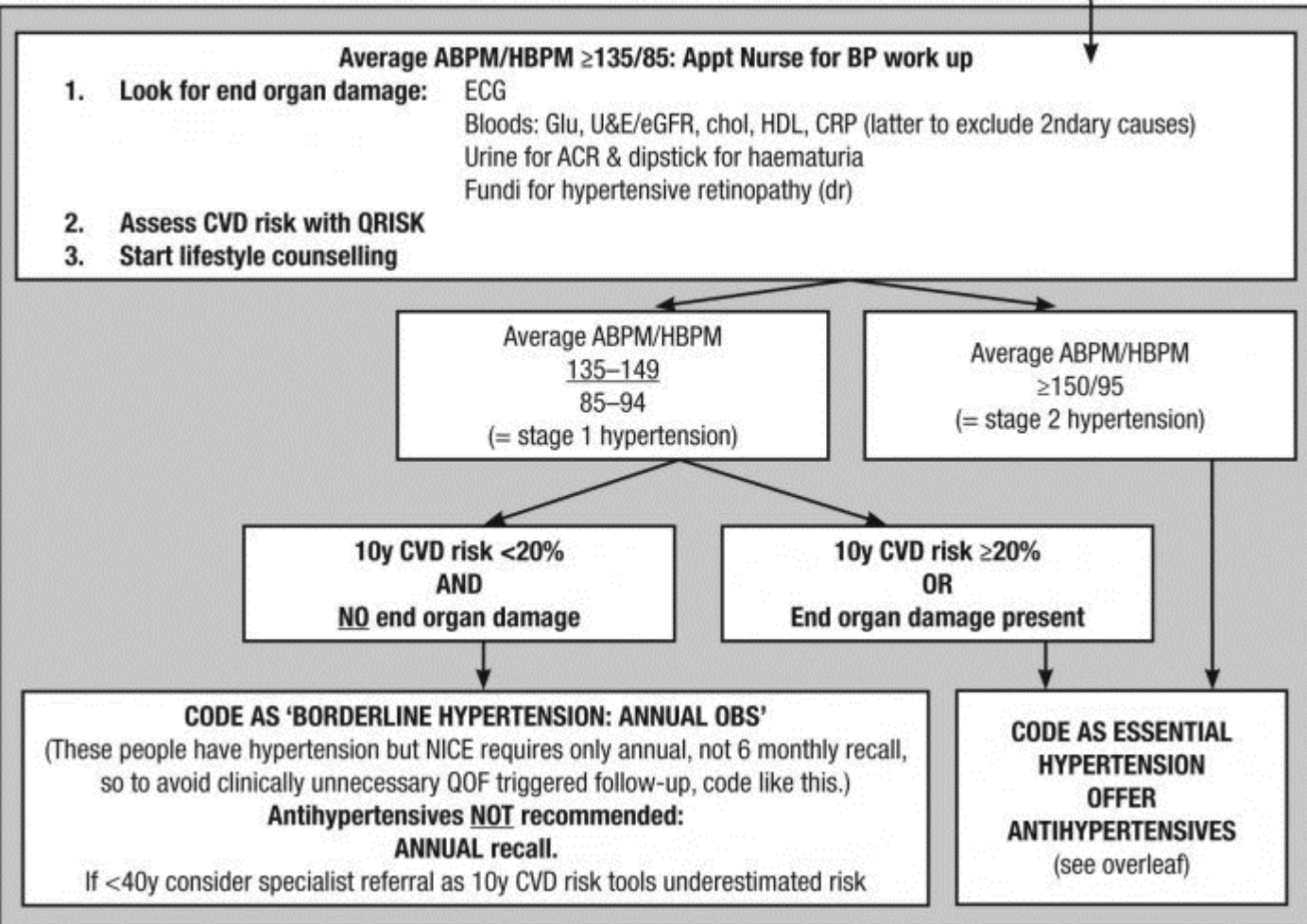
**Single clinic BP reading (NOT established hypertension)**

If BP > 140/90 in consultation, repeat during consultation. If 2nd reading substantially different from 1st, take a 3rd reading.

**Record the lower of the last 2 readings.**



**Hypertension confirmed on ABPM/home readings**



## BP targets

When to step up? Add additional therapy if the following BP targets are not achieved:

Clinic BP readings of:

<80y <140/90

≥80y <150/90

Ambulatory/home average readings of:

<80y <135/85

≥80y <145/85

Clinic readings are fine for treatment decisions, unless you suspect white coat hypertension (>20/10 difference between home/clinic readings at diagnosis).

## OFFER ANTIHYPERTENSIVES IF:

ABPM/home BP 135–149 & <80y old  
85–94

AND EITHER

10y CVD risk ≥20% (offer statin)

OR

established CVD/diabetes/renal disease

OR

end organ damage

OR

ABPM/home BP ≥150/95) at any age

Age <55y

Age ≥55y

African/Caribbean descent of any age

### ACE inhibitor

Use enalapril or lisinopril  
(for both start at 5mg, usual main-  
tenance dose 20mg. U&Es 2w after  
starting/dose increase)

### Calcium channel blocker (CCB)

Use amlodipine (10mg) (NOT felodipine)  
If failure/high risk of failure use thiazide-like diuretic (details below)

### ACE + CCB

If failure or high risk of failure or oedema: use ACE + thiazide-like diuretic  
In those of African/Caribbean descent consider ARBs in preference to ACE (ARB=losartan)

ACE + CCB + thiazide-like diuretic, **NOT** bendroflumethiazide  
Use indapamide (2.5mg normal release once daily, 56 tablets is cheapest)  
Do NOT use bendroflumethiazide!

ACE + CCB + thiazide-like diuretic plus  
further diuretic  
(spironolactone 25mg od if  $K^+ \leq 4.5$  (unlicensed) or higher doses of current thiazide-like diuretic if  $K^+ > 4.5$ )  
or  $\alpha$ -blocker or  $\beta$ -blocker  
AND  
consider specialist referral