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.

BP <140/90
NORMOTENSIVE
Recheck BP at least every 5y, more frequently if close to 140/90

BP 140–179
90–109
Patient may choose
(ABPM is best):

BP ≥180/110: severe hypertension.
Speak to doctor before patient leaves (usually repeat BP within a few days)
If ?phaeochromocytoma/ ?accelerated hypertension/ consider admission.
(NICE recommend immediate drug therapy)

Home BP readings (2x daily for 5d)
Each time take 2 readings ≥1min apart, whilst seated.
Discard 1st day's readings, average the remaining.

Appt Health Care Assistant for clinic BP x1
(if still elevated fit ABPM)
ABPM: at least 14 readings, daytime only

After ABPM/home BP readings

ABPM/HBPM <135/85
NORMOTENSIVE
Telephone follow-up Heath Care Assistant.
Tell pt normal

ABPM/HBPM ≥135/85
CONFIRMED HYPERTENSION
Surgery appointment Nurse: see protocol below.

Hypertension confirmed on ABPM/home readings

Average ABPM/HBPM ≥135/85: Appt Nurse for BP work up

1. **Look for end organ damage:** ECG
   Bloods: Glu, U&E/eGFR, chol, HDL, CRP (latter to exclude 2ndary causes)
   Urine for ACR & dipstick for haematuria
   Fundi for hypertensive retinopathy (dr)
2. **Assess CVD risk with QRISK**
3. **Start lifestyle counselling**

Average ABPM/HBPM
135–149
85–94
(= stage 1 hypertension)

Average ABPM/HBPM
≥150/95
(= stage 2 hypertension)

10y CVD risk <20%
AND
NO end organ damage

10y CVD risk ≥20%
OR
End organ damage present

CODE AS 'BORDERLINE HYPERTENSION: ANNUAL OBS'
(These people have hypertension but NICE requires only annual, not 6 monthly recall, so to avoid clinically unnecessary QOF triggered follow-up, code like this.)
Antihypertensives NOT recommended:
ANNUAL recall.
If <40y consider specialist referral as 10y CVD risk tools underestimated risk

CODE AS ESSENTIAL HYPERTENSION
OFFER ANTIHYPERTENSIVES
(see overleaf)

BP targets

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

Clinic BP readings of:		Ambulatory/home average readings of:	
<80y	**<140/90**	<80y	<135/85
≥80y	**<150/90**	≥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 maintenance 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^+ ≤4.5 (unlicensed) or higher doses of current thiazide-like diuretic if K^+ >4.5)
***or* α-blocker *or* β-blocker**
AND
consider specialist referral