

The following guideline recommends diagnostic evaluation, education and pharmacologic treatment that support effective patient self-management.

Eligible Population	Key Components	Recommendation and Level of Evidence
Adult patients ≥ 18 years of age. Not pregnant. Classification based on mean of 2 or more seated BP readings on each of 2 or more office visits.	Initial assessment	<ul style="list-style-type: none"> The objectives of the initial evaluation are to assess lifestyle, cardiovascular risk factors, concomitant disorders, reveal identifiable causes of hypertension and check for target organ damage and cardiovascular disease. Physical examination: 2 or more BP measurements using regularly calibrated equipment with the appropriate sized cuff and separated by at least 2 minutes, verification in contralateral arm, funduscopic exam, neck exam (bruits), heart and lung exam, abdominal exam for bruits or aortic aneurysm, extremity pulses. [A] Laboratory tests prior to initiating therapy: Potassium, creatinine, glucose, hematocrit, calcium, urinalysis, lipid panel, EKG. [D]
Normal BP <120/<80 Prehypertension 120-139/80-89	Patient education and nonpharmacologic interventions	<ul style="list-style-type: none"> Lifestyle modification: weight reduction (BMI goal < 25), reduction of dietary sodium to less than 2.4 gm/day, DASH diet [A] (i.e. diet high in fruits and vegetables, reduced saturated and total fat), aerobic physical activity ≥ 30 minutes most days of the week, tobacco avoidance, increased dietary potassium and calcium, moderation of alcohol consumption¹. [A] Use of self BP monitoring. Check accuracy of home measurement device regularly. Mean self measured BP > 135/85 generally considered to be hypertensive.
Hypertension: Stage 1 140-159/90-99 Stage 2 $\geq 160/\geq 100$	Goals of Therapy	<ul style="list-style-type: none"> If no other risk factors: target BP <140/90. Patients with risk factors: target BP <140/80 (<130/80 for patients with diabetes or kidney disease). [D] Caution: low diastolic or orthostatic symptoms may limit ability to control systolic. Use extreme caution if diastolic is below 60. For diabetics, mortality increases if diastolic is below 70.
	Pharmacologic interventions	<ul style="list-style-type: none"> Hypertension, Stage 1 (140-159/90-99): start with thiazide-type diuretics for most patients. ACE-I and long-acting DHP-CCB² (e.g. amlodipine) are first-choice additional agents. Hypertension, Stage 2 ($\geq 160/\geq 100$): consider two-drug combination (thiazide plus ACE-I or DHP-CCB²). In general, diuretics and DHP-CCB² appear to be more effective as an initial treatment in African-Americans. ACE-I recommended in patients with diabetes or heart failure. [A] Beta-blockers are recommended in patients with ischemic heart disease or heart failure. Use angiotensin-receptor blockers (ARB) if ACE-I not tolerated. Intensify treatment until treatments goals are met; 3 or more drugs may be necessary for some patients to achieve goal BP. Caution: NSAIDs may complicate management of hypertension and worsen renal function.
	Monitoring and adjustment of therapy [D]	<ul style="list-style-type: none"> Prehypertension without other risk factors: annual BP check with lifestyle modification counseling. Hypertension, Stage 1: initiate therapy and recheck at monthly intervals until goal is reached. Hypertension, Stage 2: initiate therapy and recheck weekly or more often if indicated. Symptomatic Stage 2 may require hospital monitoring and treatment. Modify antihypertensive therapy as needed if adverse effects become intolerable. Once BP controlled with medication: recheck every 3-6 months. Check serum potassium and creatinine at least 1-2 times/year for patients on diuretics/ACE-I/ARB.

¹Moderate alcohol consumption is generally defined as up to two drinks per day for men, one drink per day for women.

²DHP-CCB = long-acting dihydropyridine calcium channel blocker (e.g. amlodipine, felodipine)

Levels of Evidence for the most significant recommendations: A = randomized controlled trials; B = controlled trials, no randomization; C = observational studies; D = opinion of expert panel

This guideline represents core management steps. It is based on several sources including: Hypertension Diagnosis and Treatment, Institute for Clinical Systems Improvement, November 2008 ([icsi.org](http://www.icsi.org)). Individual patient considerations and advances in medical science may supersede or modify these recommendations.