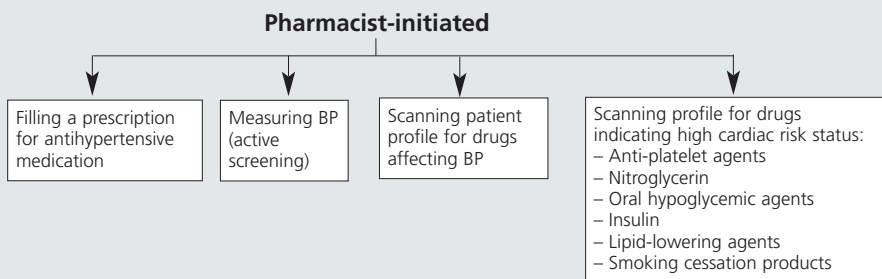
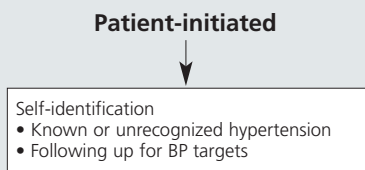


1 IDENTIFY



2 ASSESS

Gather patient history

- Demographics
- Medical history
- Cardiac risk factors
- Social history
- Clinical cardiovascular disease
- Target organ damage
- Medication history
- Physician responsible

Measure blood pressure

- Patient should be resting quietly for 5 minutes, not having had caffeine or smoked for 30–60 minutes before measurement
- Use mercury sphygmomanometer or recently calibrated electronic device (certified by the AAMI, BHS, or the International Protocol for the Validation of Automated Blood Pressure Measuring Devices)

Refer

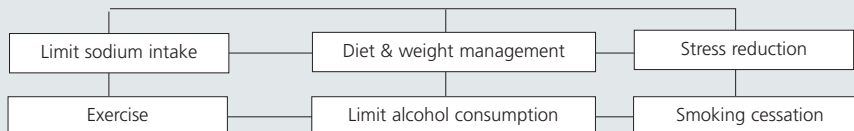
- To their primary care physician if the systolic blood pressure is ≥ 140 mmHg and/or the diastolic blood pressure is ≥ 90 mmHg. Patients with diabetes or chronic kidney disease and BP $\geq 130/80$ mmHg should also be referred.
- Immediately for medical treatment if BP $> 180/110$ or if symptoms of hypertensive crisis are present: headache, confusion, dizziness, weakness, numbness, blurred vision, angina, shortness of breath or decreased urine output.

Classify blood pressure (mmHg)

Classification	Systolic	Diastolic
Optimal	<120	<80
Normal	<130	<85
High-normal	130-139	85-89
Grade 1 hypertension (mild)	140-159	90-99
Grade 2 hypertension (mod.)	160-179	100-109
Grade 3 hypertension (severe)	≥ 180	≥ 110
Isolated systolic hypertension	≥ 160 and <90	

3 MANAGE MODIFIABLE RISK FACTORS

Educate patient on the following strategies



4 RECOMMEND THERAPY

Blood pressure stages (mmHg)	No risk factors No TOD/CCD	1 risk factor (other than DM) No TOD/CCD	TOD/CCD and/or DM
High-normal (130–139/ 85–89)	Lifestyle modifications (LOW risk)	Lifestyle modifications (MODERATE risk)	Drug therapy (VERY HIGH risk)
Grade 1 (140–159/ 90–99)	Lifestyle modifications (up to 12 months) (LOW risk)	Lifestyle modifications (up to 6 months) (MODERATE risk)	Drug therapy (VERY HIGH risk)
Grade 2 and 3 ($> 160/100$)	Drug therapy (HIGH risk)	Drug therapy (VERY HIGH risk)	Drug therapy (VERY HIGH risk)

A. Treatment decisions — Strongly consider antihypertensive therapy

No TOD or cardiac risk factors if average DBP ≥ 100 mmHg OR if average SBP ≥ 160 mmHg
 TOD or cardiac risk factors if average DBP ≥ 90 mmHg

B. Recommend antihypertensive therapy based upon concurrent disease

C. Discuss adherence strategies

D. Combination therapy

When using two drugs specifically to lower blood pressure, use this table to maximize the hypotensive effect. Combine an agent from column 1 with any in column 2.

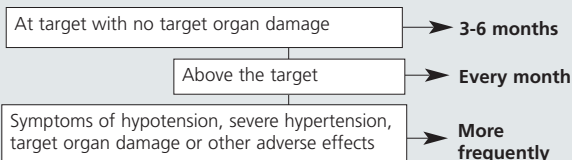
Column 1	Column 2	Dual combination of agents within column 1 and within column 2 have less than additive hypotensive affect but may be indicated in specific settings (e.g., column 2 drugs in patients following myocardial infarction).
Low-dose thiazide diuretics	Beta-blocker	
Long-acting dihydropyridine calcium channel blocker	ACE inhibitor	
	Angiotensin receptor blockers	

E. Review and discuss pharmacotherapy with patient

- Low-dose ASA therapy in all patients with controlled hypertension and no contraindications
- Recommend dyslipidemia treatment with statins in all patients with hypertension and 3 or more cardiovascular risk factors and for all patients with established atherosclerotic disease

5 MONITOR AND FOLLOW-UP

Frequency



Target BP values (mmHg)

>18 yrs with systolic/diastolic hypertension	<140/90
Isolated systolic hypertension	<140
Patients with diabetes	<130/80
Kidney disease	<130/80

Stepwise follow-up

