

JNC 7 Express

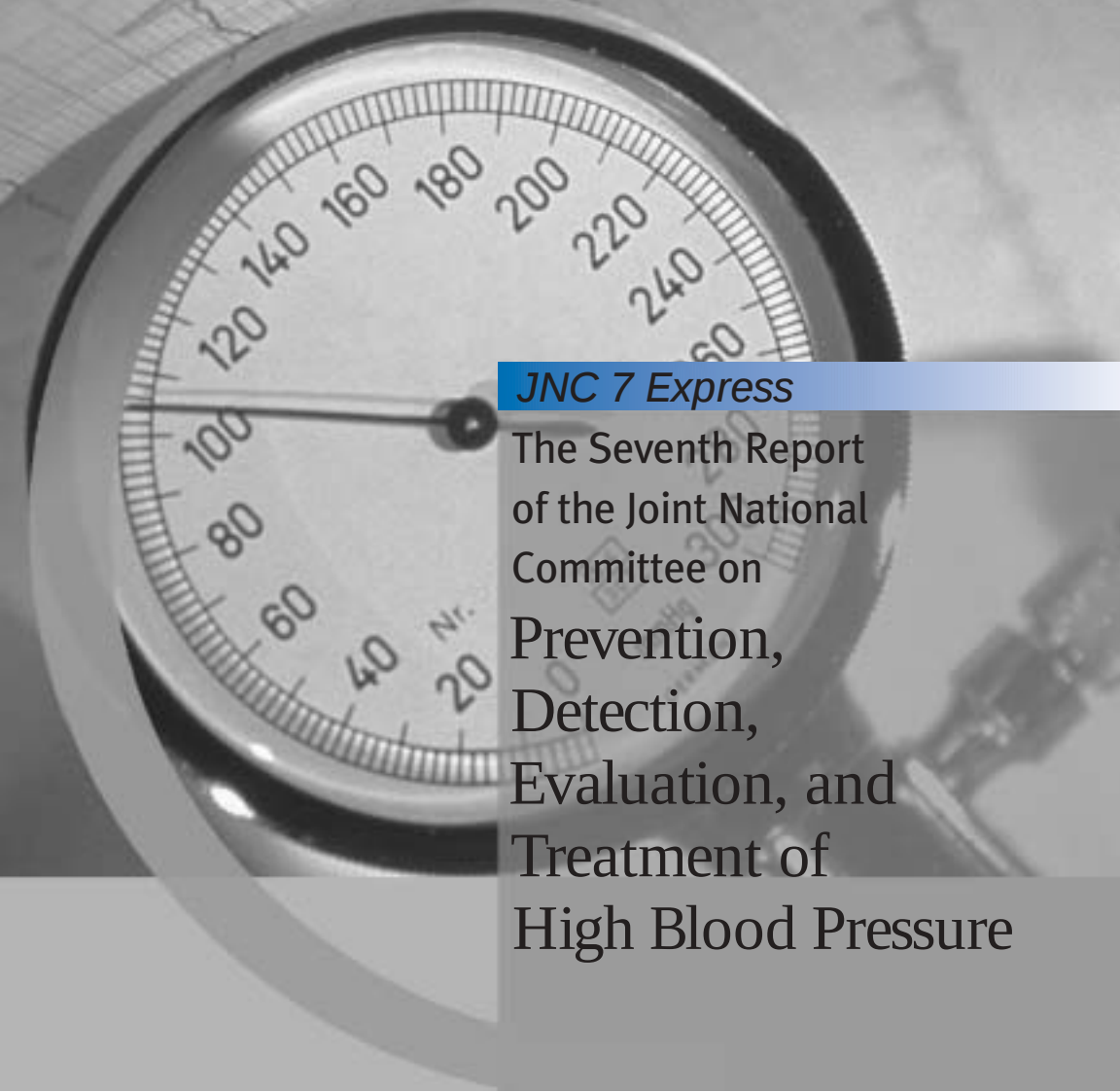
The Seventh Report
of the Joint National
Committee on
Prevention,
Detection,
Evaluation, and
Treatment of
High Blood Pressure



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

National Institutes of Health

National Heart, Lung, and Blood Institute



JNC 7 Express

The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure

This work was supported entirely by the National Heart, Lung, and Blood Institute. The Executive Committee, writing teams, and reviewers served as volunteers without remuneration.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute
National High Blood Pressure Education Program

NIH Publication No. 03-5233
May 2003

Chair

Aram V. Chobanian, M.D. (Boston University Medical Center, Boston, MA)

Executive Committee

George L. Bakris, M.D. (Rush Presbyterian-St. Luke's Medical Center, Chicago, IL); Henry R. Black, M.D. (Rush Presbyterian-St. Luke's Medical Center, Chicago, IL); William C. Cushman, M.D. (Veterans Affairs Medical Center, Memphis, TN); Lee A. Green, M.D., M.P.H. (University of Michigan, Ann Arbor, MI); Joseph L. Izzo, Jr., M.D. (State University of New York at Buffalo School of Medicine, Buffalo, NY); Daniel W. Jones, M.D. (University of Mississippi Medical Center, Jackson, MS); Barry J. Materson, M.D., M.B.A. (University of Miami, Miami, FL); Suzanne Oparil, M.D. (University of Alabama at Birmingham, Birmingham, AL); Jackson T. Wright, Jr., M.D., Ph.D. (Case Western Reserve University, Cleveland, OH)

Executive Secretary

Edward J. Roccella, Ph.D., M.P.H. (National Heart, Lung, and Blood Institute, Bethesda, MD)

National High Blood Pressure Education Program

Coordinating Committee Participants

Claude Lenfant, M.D., Chair (National Heart, Lung, and Blood Institute, Bethesda, MD); George L. Bakris, M.D. (Rush Presbyterian-St. Luke's Medical Center, Chicago, IL); Henry R. Black, M.D. (Rush Presbyterian-St. Luke's Medical Center, Chicago, IL); Vicki Burt, Sc.M., R.N. (National Center for Health Statistics, Hyattsville, MD); Barry L. Carter, Pharm.D. (University of Iowa, Iowa City, IA); Jerome D. Cohen, M.D. (Saint Louis University School of Medicine, St. Louis, MO); Pamela J. Colman, D.P.M. (American Podiatric Medical Association, Bethesda, MD); William C. Cushman, M.D. (Veterans Affairs Medical Center, Memphis, TN); Mark J. Cziraky, Pharm.D., F.A.H.A. (Health Core, Inc., Newark, DE); John J. Davis, P.A.-C. (American Academy of Physician Assistants, Memphis, TN); Keith Copelin Ferdinand, M.D., F.A.C.C. (Heartbeats Life Center, New Orleans, LA); Ray W. Gifford, Jr., M.D., M.S. (Cleveland Clinic Foundation, Fountain Hills, AZ); Michael Glick, D.M.D. (UMDNJ—New Jersey Dental School, Newark, NJ); Lee A. Green, M.D., M.P.H. (University of Michigan, Ann Arbor, MI); Stephen Havas, M.D., M.P.H., M.S. (University of Maryland School of Medicine, Baltimore, MD); Thomas H. Hostetter, M.D. (National Institute of Diabetes and Digestive and Kidney Diseases, Bethesda, MD); Joseph L. Izzo, Jr., M.D. (State University of New York at Buffalo School of Medicine, Buffalo, NY); Daniel W. Jones, M.D. (University of Mississippi Medical Center, Jackson, MS); Lynn Kirby, R.N., N.P., C.O.H.N.-S. (Sanofi-Synthelabo Research, Malvern, PA); Kathryn M. Kolasa, Ph.D., R.D., L.D.N.

(Brody School of Medicine at East Carolina University, Greenville, NC); Stuart Linas, M.D. (University of Colorado Health Sciences Center, Denver, CO); William M. Manger, M.D., Ph.D. (New York University Medical Center, New York, NY); Edwin C. Marshall, O.D., M.S., M.P.H. (Indiana University School of Optometry, Bloomington, IN); Barry J. Materson, M.D., M.B.A. (University of Miami, Miami, FL); Jay Merchant, M.H.A. (Centers for Medicare & Medicaid Services, Washington, DC); Nancy Houston Miller, R.N., B.S.N. (Stanford University School of Medicine, Palo Alto, CA); Marvin Moser, M.D. (Yale University School of Medicine, Scarsdale, NY); William A. Nickey, D.O. (Philadelphia College of Osteopathic Medicine, Philadelphia, PA); Suzanne Oparil, M.D. (University of Alabama at Birmingham, Birmingham, AL); Otelio S. Randall, M.D., F.A.C.C. (Howard University Hospital, Washington, DC); James W. Reed, M.D., F.A.C.P., F.A.C.E. (Morehouse School of Medicine, Atlanta, GA); Edward J. Roccella, Ph.D., M.P.H. (National Heart, Lung, and Blood Institute, Bethesda, MD); Lee Shaughnessy (National Stroke Association, Englewood, CO); Sheldon G. Sheps, M.D. (Mayo Clinic, Rochester, MN); David B. Snyder, R.Ph., D.D.S. (Health Resources and Services Administration, Rockville, MD); James R. Sowers, M.D. (SUNY Health Science Center at Brooklyn, Brooklyn, NY); Leonard M. Steiner, M.S., O.D. (Eye Group, Oakhurst, NJ); Ronald Stout, M.D., M.P.H. (Procter and Gamble, Mason, OH); Rita D. Strickland, Ed.D., R.N. (New York Institute of Technology, Springfield Gardens, NY); Carlos Vallbona, M.D. (Baylor College of Medicine, Houston, TX); Howard S. Weiss, M.D., M.P.H. (Georgetown University Medical Center, Washington Hospital Center, Walter Reed Army Medical Center, Washington, DC); Jack P. Whisnant, M.D. (Mayo Clinic and Mayo Medical School, Rochester, MN); Laurie Willshire, M.P.H., R.N. (American Red Cross, Falls Church, VA); Gerald J. Wilson, M.A., M.B.A. (Citizens for Public Action on High Blood Pressure and Cholesterol, Inc., Potomac, MD); Mary Winston, Ed.D., R.D. (American Heart Association, Dallas, TX); Jackson T. Wright, Jr., M.D., Ph.D., F. A.C.P. (Case Western Reserve University, Cleveland, OH)

Reviewers

William B. Applegate, M.D., M.P.H. (Wake Forest University School of Medicine, Winston Salem, NC); Jan N. Basile, M.D., F.A.C.P. (Veterans Administration Hospital, Charleston, SC); Robert Carey, M.D., (University of Virginia Health System, Charlottesville, VA); Victor Dzau, M.D. (Brigham and Women's Hospital, Boston, MA); Brent M. Egan, M.D. (Medical University of South Carolina, Charleston, SC); Bonita Falkner, M.D. (Jefferson Medical College, Philadelphia, PA); John M. Flack, M.D., M.P.H. (Wayne State University School of Medicine, Detroit, MI); Edward D. Frohlich, M.D. (Ochsner Clinic Foundation, New Orleans, LA); Haralambos Gavras, M.D. (Boston University School of Medicine, Boston, MA); Martin Grais, M.D. (Feinberg School of Medicine, Northwestern University, Chicago, IL); Willa A. Hsueh, M.D. (David Geffen School of Medicine, UCLA Department of Medicine, Los Angeles, CA); Kenneth A. Jamerson, M.D. (University of Michigan Medical Center, Ann Arbor, MI); Norman M. Kaplan, M.D. (University of Texas Southwestern Medical Center, Dallas, TX); Theodore A. Kotchen, M.D. (Medical College of Wisconsin, Milwaukee, WI); Daniel Levy, M.D. (National Heart, Lung, and Blood Institute, Framingham, MA); Michael A. Moore, M.D. (Dan River Region Cardiovascular Health Initiative Program, Danville, VA); Thomas J. Moore, M.D. (Boston University Medical Center, Boston, MA); Vasilios Papademetriou, M.D., F.A.C.P., F.A.C.C. (Veterans Affairs Medical Center, Washington, DC); Carl J. Pepine, M.D. (University of Florida, College of Medicine, Gainesville, FL); Robert A. Phillips, M.D., Ph.D. (New York University, Lenox Hill Hospital, New York, NY); Thomas G. Pickering, M.D., D.Phil. (Mount Sinai Medical Center, New York, NY); L. Michael Prisant, M.D., F.A.C.C., F.A.C.P. (Medical College of Georgia, Augusta, GA); C. Venkata S. Ram, M.D. (University of Texas Southwestern Medical Center and Texas Blood Pressure Institute, Dallas, TX); Elijah Saunders, M.D., F.A.C.C., F.A.C.P. (University of Maryland School of Medicine, Baltimore, MD); Stephen C. Textor, M.D. (Mayo Clinic, Rochester, MN); Donald G. Vidt, M.D. (Cleveland Clinic Foundation, Cleveland, OH); Myron H. Weinberger, M.D. (Indiana University School of Medicine, Indianapolis, IN); Paul K. Whelton, M.D., M.Sc. (Tulane University Health Sciences Center, New Orleans, LA)

Staff

Joanne Karimbakas, M.S., R.D. (Prospect Associates, Ltd., now part of American Institutes for Research Health Program, Silver Spring, MD)

We appreciate the assistance of Carol Creech, M.I.L.S. and Gabrielle Gessner (Prospect Associates, Ltd., now part of American Institutes for Research Health Program, Silver Spring, MD).

The National High Blood Pressure Education Program (NHBPEP)

Coordinating Committee Member Organizations

American Academy of Family Physicians
American Academy of Neurology
American Academy of Ophthalmology
American Academy of Physician Assistants
American Association of Occupational Health Nurses
American College of Cardiology
American College of Chest Physicians
American College of Occupational and Environmental Medicine
American College of Physicians-American Society of Internal Medicine
American College of Preventive Medicine
American Dental Association
American Diabetes Association
American Dietetic Association
American Heart Association
American Hospital Association
American Medical Association
American Nurses Association
American Optometric Association
American Osteopathic Association
American Pharmaceutical Association
American Podiatric Medical Association
American Public Health Association
American Red Cross
American Society of Health-System Pharmacists
American Society of Hypertension
American Society of Nephrology
Association of Black Cardiologists
Citizens for Public Action on High Blood Pressure and Cholesterol, Inc.
Hypertension Education Foundation, Inc.
International Society on Hypertension in Blacks
National Black Nurses Association, Inc.
National Hypertension Association, Inc.
National Kidney Foundation, Inc.
National Medical Association
National Optometric Association
National Stroke Association
NHLBI Ad Hoc Committee on Minority Populations
Society for Nutrition Education
The Society of Geriatric Cardiology

Federal Agencies:

Agency for Healthcare Research and Quality
Centers for Medicare & Medicaid Services
Department of Veterans Affairs
Health Resources and Services Administration
National Center for Health Statistics
National Heart, Lung, and Blood Institute
National Institute of Diabetes and Digestive and Kidney Diseases

CONTENTS

Preface	xi
Abstract	xiii
Introduction	1
Methodology	1
Classification of Blood Pressure	2
Cardiovascular Disease Risk	2
Benefits of Lowering Blood Pressure	3
Blood Pressure Control Rates	4
Accurate Blood Pressure Measurement in the Office	4
Ambulatory Blood Pressure Monitoring	5
Self-Measurement of Blood Pressure	5
Patient Evaluation	5
Laboratory Tests and Other Diagnostic Procedures	6
Treatment	7
Goals of Therapy	7
Lifestyle Modifications	7
Pharmacologic Treatment	7
Achieving Blood Pressure Control in Individual Patients	13
Followup and Monitoring	14
Special Considerations	14
Compelling Indications	14
Ischemic Heart Disease	14
Heart Failure	15
Diabetic Hypertension	15
Chronic Kidney Disease	16
Cerebrovascular Disease	16

Other Special Situations	16
Minorities	16
Obesity and the metabolic syndrome	16
Left ventricular hypertrophy	17
Peripheral arterial disease	17
Hypertension in older persons	17
Postural hypotension	17
Dementia	17
Hypertension in women	18
Hypertension in children and adolescents	18
Hypertensive urgencies and emergencies	18
Additional Considerations in Antihypertensive Drug Choices	19
Potential favorable effects	19
Potential unfavorable effects	19
Improving Hypertension Control	19
Adherence to Regimens	19
Resistant Hypertension	20
Public Health Challenges and Community Programs	21
Evidence Classification	23
Study Abbreviations	25
Reference List	27

PREFACE

Since the “Sixth Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 6)” was released in 1997, new knowledge has come to light from a variety of sources. The National High Blood Pressure Education Program Coordinating Committee (NHBPEP CC), which represents 46 professional, voluntary, and Federal organizations, has periodically reviewed the emerging findings during its biannual meetings. Eventually, a critical mass of information accumulated that generated much demand for a seventh report. My decision to appoint a JNC 7 Committee was predicated on four reasons: (1) publication of many new hypertension observational studies and clinical trials; (2) need for a new, clear, and concise guideline that would be useful for clinicians; (3) need to simplify the classification of blood pressure; and (4) clear recognition that the JNC reports were not being used to their maximum benefit.

Dr. Aram Chobanian was selected as the JNC 7 chair because, like his predecessors, he is well versed in hypertension, yet independent of these major studies. The JNC 7 Executive Committee and writing teams were selected entirely from the NHBPEP CC because they are recognized as experts in their disciplines by their peers. Dr. Chobanian and his colleagues set—and met—a goal of completing and publishing this work in 5 months because of the urgency of applying the new information to improve hypertension prevention and treatment.

This has been a remarkable accomplishment, but the task of NHBPEP CC numbers is far from over. They and many others are now charged with disseminating the JNC 7 report, because none of this—neither the research studies nor the recommendations—will matter, unless the JNC 7 is applied. To facilitate its application, the JNC 7 will be produced in two versions. A “JNC 7 Express” has been developed for busy clinicians. A longer version to be published later will provide for a broader and more detailed review of the recommendations. Additional professional and patient education tools will support implementation of the JNC 7 recommendations.

Dr. Chobanian has our deep appreciation for leading the JNC 7 Executive and Coordinating Committee members in developing this new report. I feel confident that this represents a landmark document and that its application will greatly improve our ability to address a very important public health problem.



Claude Lenfant, M.D.
Director
National Heart, Lung, and Blood Institute
Chair
National High Blood Pressure Education
Program

ABSTRACT

The “Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure” provides a new guideline for hypertension prevention and management. The following are the report’s key messages:

- In persons older than 50 years, systolic blood pressure greater than 140 mmHg is a much more important cardiovascular disease (CVD) risk factor than diastolic blood pressure.
- The risk of CVD beginning at 115/75 mmHg doubles with each increment of 20/10 mmHg; individuals who are normotensive at age 55 have a 90 percent lifetime risk for developing hypertension.
- Individuals with a systolic blood pressure of 120–139 mmHg or a diastolic blood pressure of 80–89 mmHg should be considered as prehypertensive and require health-promoting lifestyle modifications to prevent CVD.
- Thiazide-type diuretics should be used in drug treatment for most patients with uncomplicated hypertension, either alone or combined with drugs from other classes. Certain high-risk conditions are compelling indications for the initial use of other antihypertensive drug classes (angiotensin converting enzyme inhibitors, angiotensin receptor blockers, beta-blockers, calcium channel blockers).
- Most patients with hypertension will require two or more antihypertensive medications to achieve goal blood pressure (<140/90 mmHg, or <130/80 mmHg for patients with diabetes or chronic kidney disease).
- If blood pressure is >20/10 mmHg above goal blood pressure, consideration should be given to initiating therapy with two agents, one of which usually should be a thiazide-type diuretic.
- The most effective therapy prescribed by the most careful clinician will control hypertension only if patients are motivated. Motivation improves when patients have positive experiences with, and trust in, the clinician. Empathy builds trust and is a potent motivator.
- In presenting these guidelines, the committee recognizes that the responsible physician’s judgment remains paramount.

INTRODUCTION

For more than three decades, the National Heart, Lung, and Blood Institute (NHLBI) has coordinated the National High Blood Pressure Education Program (NHBPEP), a coalition of 39 major professional, public, and voluntary organizations and seven Federal Agencies. One important function is to issue guidelines and advisories designed to increase awareness, prevention, treatment, and control of hypertension (high blood pressure (BP)). Since the publication of the “Sixth Report of the Joint National Committee on the Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 6)” released in 1997,¹ many large-scale clinical trials have been published. The decision to appoint a JNC 7 committee was based on four factors: (1) publication of many new hypertension observational studies and clinical trials; (2) need for a new, clear, and concise guideline that would be useful for clinicians; (3) need to simplify the classification of blood pressure; and (4) clear recognition that the JNC reports were not being used to their maximum benefit. This JNC report is presented in two separate publications: a current, succinct, practical guide and a more comprehensive report to be published separately, which will provide a broader discussion and justification for the current recommendations. In presenting these guidelines, the committee recognizes that the responsible physician’s judgment is paramount in managing patients.

METHODOLOGY

Since the publication of the JNC 6 report, the NHBPEP Coordinating Committee (CC), chaired by the director of the NHLBI, has regularly reviewed and discussed the hypertension clinical trials at its biannual meetings. In many instances, the principal investigator of the larger studies has presented the information directly to the CC. The committee’s presentations and reviews are summarized and posted on the NHLBI Web site.² In agreeing to commission a new report, the Director requested that the CC members provide in writing a detailed rationale explaining the necessity to update the guidelines and to describe the critical issues and concepts to be considered for a new report. The JNC 7 chair was selected, plus a nine-member Executive Committee appointed entirely from the NHBPEP CC membership. The NHBPEP CC served as members of five writing teams, each of which was cochaired by two Executive Committee members. The concepts identified by the NHBPEP CC membership were used to develop the report outline. A timeline was developed to complete and publish the work in 5 months. Based on the identified critical issues and concepts, the Executive Committee identified relevant Medical Subject Headings (MeSH) terms and keywords to further review the

scientific literature. These MeSH terms were used to generate MEDLINE searches that focused on English language peer-reviewed scientific literature from January 1997 through April 2003. Various systems of grading the evidence were considered, and the classification scheme used in the JNC 6 report and other NHBPEP clinical guidelines was selected^{3,4} which classifies studies in a process adapted from Last and Abramson.⁵ The Executive Committee met on six occasions, two of which included meetings with the entire NHBPEP CC. The writing teams also met by teleconference and used electronic communications to develop the report. Twenty-four drafts were created and reviewed in a reiterative fashion. At its meetings, the Executive Committee used a modified nominal group process to identify and resolve issues. The NHBPEP CC reviewed the penultimate draft and provided written comments to the Executive Committee. In addition, 33 national hypertension leaders reviewed and commented on the document. The NHBPEP CC approved the JNC 7 report.

CLASSIFICATION OF BLOOD PRESSURE

Table 1 provides a classification of BP for adults ages 18 and older. The classification is based on the average of two or more properly measured, seated BP readings on each of two or more office visits. In contrast to the classification provided in the JNC 6 report, a new category designated prehypertension has been added, and stages 2 and 3 hypertension have been combined. Patients with prehypertension are at increased risk for progression to hypertension; those in the 130–139/80–89 mmHg BP range are at twice the risk to develop hypertension as those with lower values.⁶

CARDIOVASCULAR DISEASE RISK

Hypertension affects approximately 50 million individuals in the United States and approximately 1 billion worldwide. As the population ages, the prevalence of hypertension will increase even further unless broad and effective preventive measures are implemented. Recent data from the Framingham Heart Study suggest that individuals who are normotensive at age 55 have a 90 percent lifetime risk for developing hypertension.⁷

The relationship between BP and risk of CVD events is continuous, consistent, and independent of other risk factors. The higher the BP, the greater is the chance of heart attack, heart failure, stroke, and kidney disease. For individu-

Table 1. Classification and management of blood pressure for adults*

BP CLASSIFICATION	SBP* mmHg	DBP* mmHg	LIFESTYLE MODIFICATION	INITIAL DRUG THERAPY	
				WITHOUT COMPELLING INDICATION	WITH COMPELLING INDICATIONS (SEE TABLE 8)
NORMAL	<120	and <80	Encourage		
PREHYPERTENSION	120–139	or 80–89	Yes	No antihypertensive drug indicated.	Drug(s) for compelling indications.‡
STAGE 1 HYPERTENSION	140–159	or 90–99	Yes	Thiazide-type diuretics for most. May consider ACEI, ARB, BB, CCB, or combination.	Drug(s) for the com- pelling indications.‡ Other antihypertensive drugs (diuretics, ACEI, ARB, BB, CCB) as needed.
STAGE 2 HYPERTENSION	≥160	or ≥100	Yes	Two-drug combination for most† (usually thiazide-type diuretic and ACEI or ARB or BB or CCB).	

DBP, diastolic blood pressure; SBP, systolic blood pressure.

Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; BB, beta-blocker; CCB, calcium channel blocker.

* Treatment determined by highest BP category.

† Initial combined therapy should be used cautiously in those at risk for orthostatic hypotension.

‡ Treat patients with chronic kidney disease or diabetes to BP goal of <130/80 mmHg.

als 40–70 years of age, each increment of 20 mmHg in systolic BP (SBP) or 10 mmHg in diastolic BP (DBP) doubles the risk of CVD across the entire BP range from 115/75 to 185/115 mmHg.⁸

The classification “prehypertension,” introduced in this report (table 1), recognizes this relationship and signals the need for increased education of health care professionals and the public to reduce BP levels and prevent the development of hypertension in the general population.⁹ Hypertension prevention strategies are available to achieve this goal. (See “Lifestyle Modifications” section.)

BENEFITS OF LOWERING BLOOD PRESSURE

In clinical trials, antihypertensive therapy has been associated with reductions in stroke incidence averaging 35–40 percent; myocardial infarction, 20–25 percent; and heart failure, more than 50 percent.¹⁰ It is estimated that in patients with stage 1 hypertension (SBP 140–159 mmHg and/or DBP 90–99 mmHg) and additional cardiovascular risk factors, achieving a sustained 12 mmHg reduction in SBP over 10 years will prevent 1 death for every 11 patients treated. In the presence of CVD or target organ damage, only 9 patients would require such BP reduction to prevent a death.¹¹

Table 2. Trends in awareness, treatment, and control of high blood pressure in adults ages 18–74*

	NATIONAL HEALTH AND NUTRITION EXAMINATION SURVEY, PERCENT			
	II (1976–80)	III (PHASE 1 1988–91)	III (PHASE 2 1991–94)	1999–2000
Awareness	51	73	68	70
Treatment	31	55	54	59
Control†	10	29	27	34

* High blood pressure is systolic blood pressure (SBP) ≥ 140 mmHg or diastolic blood pressure (DBP) ≥ 90 mmHg or taking antihypertensive medication.

† SBP < 140 mmHg and DBP < 90 mmHg.

Sources: Unpublished data for 1999–2000 computed by M. Wolz, National Heart, Lung, and Blood Institute; JNC 6.¹

BLOOD PRESSURE CONTROL RATES

Hypertension is the most common primary diagnosis in America (35 million office visits as the primary diagnosis).¹² Current control rates (SBP < 140 mmHg and DBP < 90 mmHg), though improved, are still far below the Healthy People 2010 goal of 50 percent; 30 percent are still unaware they have hypertension. (See table 2.) In the majority of patients, controlling systolic hypertension, which is a more important CVD risk factor than DBP except in patients younger than age 50¹³ and occurs much more commonly in older persons, has been considerably more difficult than controlling diastolic hypertension. Recent clinical trials have demonstrated that effective BP control can be achieved in most patients who are hypertensive, but the majority will require two or more antihypertensive drugs.^{14,15} When clinicians fail to prescribe lifestyle modifications, adequate antihypertensive drug doses, or appropriate drug combinations, inadequate BP control may result.

ACCURATE BLOOD PRESSURE MEASUREMENT IN THE OFFICE

The auscultatory method of BP measurement with a properly calibrated and validated instrument should be used.¹⁶ Persons should be seated quietly for at least 5 minutes in a chair (rather than on an exam table), with feet on the floor, and arm supported at heart level. Measurement of BP in the standing position is indicated periodically, especially in those at risk for postural hypotension. An appropriate-sized cuff (cuff bladder encircling at least 80 percent of the arm) should be used to ensure accuracy. At least two measurements should be made. SBP is the point at which the first of two or more sounds is heard

(phase 1), and DBP is the point before the disappearance of sounds (phase 5). Clinicians should provide to patients, verbally and in writing, their specific BP numbers and BP goals.

AMBULATORY BLOOD PRESSURE MONITORING

Ambulatory blood pressure monitoring (ABPM)¹⁷ provides information about BP during daily activities and sleep. ABPM is warranted for evaluation of “white-coat” hypertension in the absence of target organ injury. It is also helpful to assess patients with apparent drug resistance, hypotensive symptoms with antihypertensive medications, episodic hypertension, and autonomic dysfunction. The ambulatory BP values are usually lower than clinic readings. Awake, individuals with hypertension have an average BP of more than 135/85 mmHg and during sleep, more than 120/75 mmHg. The level of BP measurement by using ABPM correlates better than office measurements with target organ injury.¹⁸ ABPM also provides a measure of the percentage of BP readings that are elevated, the overall BP load, and the extent of BP reduction during sleep. In most individuals, BP decreases by 10 to 20 percent during the night; those in whom such reductions are not present are at increased risk for cardiovascular events.

SELF-MEASUREMENT OF BLOOD PRESSURE

BP self measurements may benefit patients by providing information on response to antihypertensive medication, improving patient adherence with therapy,¹⁹ and in evaluating white-coat hypertension. Persons with an average BP more than 135/85 mmHg measured at home are generally considered to be hypertensive. Home measurement devices should be checked regularly for accuracy.

PATIENT EVALUATION

Evaluation of patients with documented hypertension has three objectives: (1) to assess lifestyle and identify other cardiovascular risk factors or concomitant disorders that may affect prognosis and guide treatment (table 3); (2) to reveal identifiable causes of high BP (table 4); and (3) to assess the presence or absence of target organ damage and CVD. The data needed are acquired through medical history, physical examination, routine laboratory tests, and other diagnostic procedures. The physical examination should

Table 3. Cardiovascular risk factors

MAJOR RISK FACTORS
Hypertension*
Cigarette smoking
Obesity* (body mass index ≥ 30 kg/m ²)
Physical inactivity
Dyslipidemia*
Diabetes mellitus*
Microalbuminuria or estimated GFR < 60 mL/min
Age (older than 55 for men, 65 for women)
Family history of premature cardiovascular disease (men under age 55 or women under age 65)

TARGET ORGAN DAMAGE

Heart

- Left ventricular hypertrophy
- Angina or prior myocardial infarction
- Prior coronary revascularization
- Heart failure

Brain

- Stroke or transient ischemic attack

Chronic kidney disease

Peripheral arterial disease

Retinopathy

GFR, glomerular filtration rate.

* Components of the metabolic syndrome.

Table 4. Identifiable causes of hypertension

Sleep apnea
Drug-induced or related causes (see table 9)
Chronic kidney disease
Primary aldosteronism
Renovascular disease
Chronic steroid therapy and Cushing's syndrome
Pheochromocytoma
Coarctation of the aorta
Thyroid or parathyroid disease

include an appropriate measurement of BP, with verification in the contralateral arm; examination of the optic fundi; calculation of body mass index (BMI) (measurement of waist circumference also may be useful); auscultation for carotid, abdominal, and femoral bruits; palpation of the thyroid gland; thorough examination of the heart and lungs; examination of the abdomen for enlarged kidneys, masses, and abnormal aortic pulsation; palpation of the lower extremities for edema and pulses; and neurological assessment.

Laboratory Tests and Other Diagnostic Procedures

Routine laboratory tests recommended before initiating therapy include an electrocardiogram; urinalysis; blood glucose and hematocrit; serum potassium, creatinine (or the corresponding estimated glomerular filtration rate [GFR]), and calcium;²⁰ and a lipid profile, after 9- to 12-hour fast, that includes high-density lipoprotein cholesterol and low-density lipoprotein cholesterol, and triglycerides. Optional tests include measurement of urinary albumin excretion or albumin/creatinine ratio. More extensive testing for identifiable causes is not indicated generally unless BP control is not achieved.

Goals of Therapy

The ultimate public health goal of antihypertensive therapy is the reduction of cardiovascular and renal morbidity and mortality. Since most persons with hypertension, especially those age ≥ 50 years, will reach the DBP goal once SBP is at goal, the primary focus should be on achieving the SBP goal.

Treating SBP and DBP to targets that are $<140/90$ mmHg is associated with a decrease in CVD complications. In patients with hypertension and diabetes or renal disease, the BP goal is $<130/80$ mmHg.^{21,22}

Lifestyle Modifications

Adoption of healthy lifestyles by all persons is critical for the prevention of high BP and is an indispensable part of the management of those with hypertension. Major lifestyle modifications shown to lower BP include weight reduction in those individuals who are overweight or obese,^{23,24} adoption of the Dietary Approaches to Stop Hypertension (DASH) eating plan²⁵ which is rich in potassium and calcium,²⁶ dietary sodium reduction,^{25–27} physical activity,^{28,29} and moderation of alcohol consumption. (See table 5.)³⁰ Lifestyle modifications reduce BP, enhance antihypertensive drug efficacy, and decrease cardiovascular risk. For example, a 1,600 mg sodium DASH eating plan has effects similar to single drug therapy.²⁵ Combinations of two (or more) lifestyle modifications can achieve even better results.

Pharmacologic Treatment

There are excellent clinical outcome trial data proving that lowering BP with several classes of drugs, including angiotensin converting enzyme inhibitors (ACEIs), angiotensin receptor blockers (ARBs), beta-blockers (BBs), calcium channel blockers (CCBs), and thiazide-type diuretics, will all reduce the complications of hypertension.^{10,31–37} Tables 6 and 7 provide a list of commonly used antihypertensive agents.

Thiazide-type diuretics have been the basis of antihypertensive therapy in most outcome trials.³⁷ In these trials, including the recently published Antihypertensive and Lipid Lowering Treatment to Prevent Heart Attack Trial (ALLHAT),³³ diuretics have been virtually unsurpassed in preventing the cardiovascular complications of hypertension. The exception is the Second Australian National Blood Pressure trial which reported slightly better outcomes in White men with a regimen that began with an ACEI compared to one starting with a diuretic.³⁶ Diuretics enhance the antihypertensive efficacy

Table 5. Lifestyle modifications to manage hypertension†**

MODIFICATION	RECOMMENDATION	APPROXIMATE SBP REDUCTION (RANGE)
Weight reduction	Maintain normal body weight (body mass index 18.5–24.9 kg/m ²).	5–20 mmHg/10 kg weight loss ^{23,24}
Adopt DASH eating plan	Consume a diet rich in fruits, vegetables, and lowfat dairy products with a reduced content of saturated and total fat.	8–14 mmHg ^{25,26}
Dietary sodium reduction	Reduce dietary sodium intake to no more than 100 mmol per day (2.4 g sodium or 6 g sodium chloride).	2–8 mmHg ^{25–27}
Physical activity	Engage in regular aerobic physical activity such as brisk walking (at least 30 min per day, most days of the week).	4–9 mmHg ^{28,29}
Moderation of alcohol consumption	Limit consumption to no more than 2 drinks (1 oz or 30 mL ethanol; e.g., 24 oz beer, 10 oz wine, or 3 oz 80-proof whiskey) per day in most men and to no more than 1 drink per day in women and lighter weight persons.	2–4 mmHg ³⁰

DASH, Dietary Approaches to Stop Hypertension.

* For overall cardiovascular risk reduction, stop smoking.

† The effects of implementing these modifications are dose and time dependent, and could be greater for some individuals.

of multidrug regimens, can be useful in achieving BP control, and are more affordable than other antihypertensive agents. Despite these findings, diuretics remain underutilized.³⁹

Thiazide-type diuretics should be used as initial therapy for most patients with hypertension, either alone or in combination with one of the other classes (ACEIs, ARBs, BBs, CCBs) demonstrated to be beneficial in randomized controlled outcome trials. The list of compelling indications requiring the use of other antihypertensive drugs as initial therapy are listed in table 8. If a drug is not tolerated or is contraindicated, then one of the other classes proven to reduce cardiovascular events should be used instead.

Table 6. Oral antihypertensive drugs*

CLASS	DRUG (TRADE NAME)	USUAL DOSE RANGE IN MG/DAY (DAILY FREQUENCY)
Thiazide diuretics	chlorothiazide (Diuril)	125–500 (1)
	chlorthalidone (generic)	12.5–25 (1)
	hydrochlorothiazide (Microzide, HydroDIURIL [†])	12.5–50 (1)
	polythiazide (Renese)	2–4 (1)
	indapamide (Lozol [†])	1.25–2.5 (1)
	metolazone (Mykrox)	0.5–1.0 (1)
	metolazone (Zaroxolyn)	2.5–5 (1)
Loop diuretics	bumetanide (Bumex [†])	0.5–2 (2)
	furosemide (Lasix [†])	20–80 (2)
	torsemide (Demadex [†])	2.5–10 (1)
Potassium-sparing diuretics	amiloride (Midamor [†])	5–10 (1–2)
	triamterene (Dyrenium)	50–100 (1–2)
Aldosterone receptor blockers	eplerenone (Inspra)	50–100 (1–2)
	spironolactone (Aldactone [†])	25–50 (1–2)
Beta-blockers	atenolol (Tenormin [†])	25–100 (1)
	betaxolol (Kerlone [†])	5–20 (1)
	bisoprolol (Zebeta [†])	2.5–10 (1)
	metoprolol (Lopressor [†])	50–100 (1–2)
	metoprolol extended release (Toprol XL)	50–100 (1)
	nadolol (Corgard [†])	40–120 (1)
	propranolol (Inderal [†])	40–160 (2)
	propranolol long-acting (Inderal LA [†])	60–180 (1)
	timolol (Blocadren [†])	20–40 (2)
Beta-blockers with intrinsic sympathomimetic activity	acebutolol (Sectral [†])	200–800 (2)
	penbutolol (Levatol)	10–40 (1)
	pindolol (generic)	10–40 (2)
Combined alpha- and beta-blockers	carvedilol (Coreg)	12.5–50 (2)
	labetalol (Normodyne, Trandate [†])	200–800 (2)

Table 6. Oral antihypertensive drugs* (CONTINUED)

CLASS	DRUG (TRADE NAME)	USUAL DOSE RANGE IN MG/DAY (DAILY FREQUENCY)
ACE inhibitors	benazepril (Lotensin [†])	10–40 (1–2)
	captopril (Capoten [†])	25–100 (2)
	enalapril (Vasotec [†])	2.5–40 (1–2)
	fosinopril (Monopril)	10–40 (1)
	lisinopril (Prinivil, Zestril [†])	10–40 (1)
	moexipril (Univasc)	7.5–30 (1)
	perindopril (Aceon)	4–8 (1–2)
	quinapril (Accupril)	10–40 (1)
	ramipril (Altace)	2.5–20 (1)
	trandolapril (Mavik)	1–4 (1)
Angiotensin II antagonists	candesartan (Atacand)	8–32 (1)
	eprosartan (Tevetan)	400–800 (1–2)
	irbesartan (Avapro)	150–300 (1)
	losartan (Cozaar)	25–100 (1–2)
	olmesartan (Benicar)	20–40 (1)
	telmisartan (Micardis)	20–80 (1)
	valsartan (Diovan)	80–320 (1)
Calcium channel blockers— non-Dihydropyridines	diltiazem extended release (Cardizem CD, Dilacor XR, Tiazac [†])	180–420 (1)
	diltiazem extended release (Cardizem LA)	120–540 (1)
	verapamil immediate release (Calan, Isoptin [†])	80–320 (2)
	verapamil long acting (Calan SR, Isoptin SR [†])	120–360 (1–2)
	verapamil—Coer (Covera HS, Verelan PM)	120–360 (1)
Calcium channel blockers— Dihydropyridines	amlodipine (Norvasc)	2.5–10 (1)
	felodipine (Plendil)	2.5–20 (1)
	isradipine (Dynacirc CR)	2.5–10 (2)
	nicardipine sustained release (Cardene SR)	60–120 (2)
	nifedipine long-acting (Adalat CC, Procardia XL)	30–60 (1)
	nisoldipine (Sular)	10–40 (1)

Table 6. Oral antihypertensive drugs* (CONTINUED)

CLASS	DRUG (TRADE NAME)	USUAL DOSE RANGE IN MG/DAY (DAILY FREQUENCY)
Alpha ₁ -blockers	doxazosin (Cardura) prazosin (Minipress [†]) terazosin (Hytrin)	1–16 (1) 2–20 (2–3) 1–20 (1–2)
Central alpha ₂ -agonists and other centrally acting drugs	clonidine (Catapres [†]) clonidine patch (Catapres-TTS) methyldopa (Aldomet [†]) reserpine (generic) guanfacine (generic)	0.1–0.8 (2) 0.1–0.3 (1wkly) 250–1,000 (2) 0.05 [‡] –0.25 (1) 0.5–2 (1)
Direct vasodilators	hydralazine (Apresoline [†]) minoxidil (Loniten [†])	25–100 (2) 2.5–80 (1–2)

* These dosages may vary from those listed in the “Physicians’ Desk Reference.”³⁸

† Are now or will soon become available in generic preparations.

‡ A 0.1 mg dose may be given every other day to achieve this dosage.

Table 7. Combination drugs for hypertension

COMBINATION TYPE*	FIXED-DOSE COMBINATION, mg†	TRADE NAME
ACEIs and CCBs	Amlodipine/benazepril hydrochloride (2.5/10, 5/10, 5/20, 10/20) Enalapril maleate/felodipine (5/5) Trandolapril/verapamil (2/180, 1/240, 2/240, 4/240)	Lotrel Lexxel Tarka
ACEIs and diuretics	Benazepril/hydrochlorothiazide (5/6.25, 10/12.5, 20/12.5, 20/25) Captopril/hydrochlorothiazide (25/15, 25/25, 50/15, 50/25) Enalapril maleate/hydrochlorothiazide (5/12.5, 10/25) Lisinopril/hydrochlorothiazide (10/12.5, 20/12.5, 20/25) Moexipril HCl/hydrochlorothiazide (7.5/12.5, 15/25) Quinapril HCl/hydrochlorothiazide (10/12.5, 20/12.5, 20/25)	Lotensin HCT Capozide Vaseretic Prinzide Uniretic Accuretic
ARBs and diuretics	Candesartan cilexetil/hydrochlorothiazide (16/12.5, 32/12.5) Eprosartan mesylate/hydrochlorothiazide (600/12.5, 600/25) Irbesartan/hydrochlorothiazide (150/12.5, 300/12.5) Losartan potassium/hydrochlorothiazide (50/12.5, 100/25) Telmisartan/hydrochlorothiazide (40/12.5, 80/12.5) Valsartan/hydrochlorothiazide (80/12.5, 160/12.5)	Atacand HCT Teveten/HCT Avalide Hyzaar Micardis/HCT Diovan/HCT
BBs and diuretics	Atenolol/chlorthalidone (50/25, 100/25) Bisoprolol fumarate/hydrochlorothiazide (2.5/6.25, 5/6.25, 10/6.25) Propranolol LA/hydrochlorothiazide (40/25, 80/25) Metoprolol tartrate/hydrochlorothiazide (50/25, 100/25) Nadolol/bendrofluthiazide (40/5, 80/5) Timolol maleate/hydrochlorothiazide (10/25)	Tenoretic Ziac Inderide Lopressor HCT Corzide Timolide
Centrally acting drug and diuretic	Methyldopa/hydrochlorothiazide (250/15, 250/25, 500/30, 500/50) Reserpine/chlorothiazide (0.125/250, 0.25/500) Reserpine/hydrochlorothiazide (0.125/25, 0.125/50)	Aldoril Diupres Hydropres
Diuretic and diuretic	Amiloride HCl/hydrochlorothiazide (5/50) Spironolactone/hydrochlorothiazide (25/25, 50/50) Triamterene/hydrochlorothiazide (37.5/25, 50/25, 75/50)	Moduretic Aldactone Dyazide, Maxzide

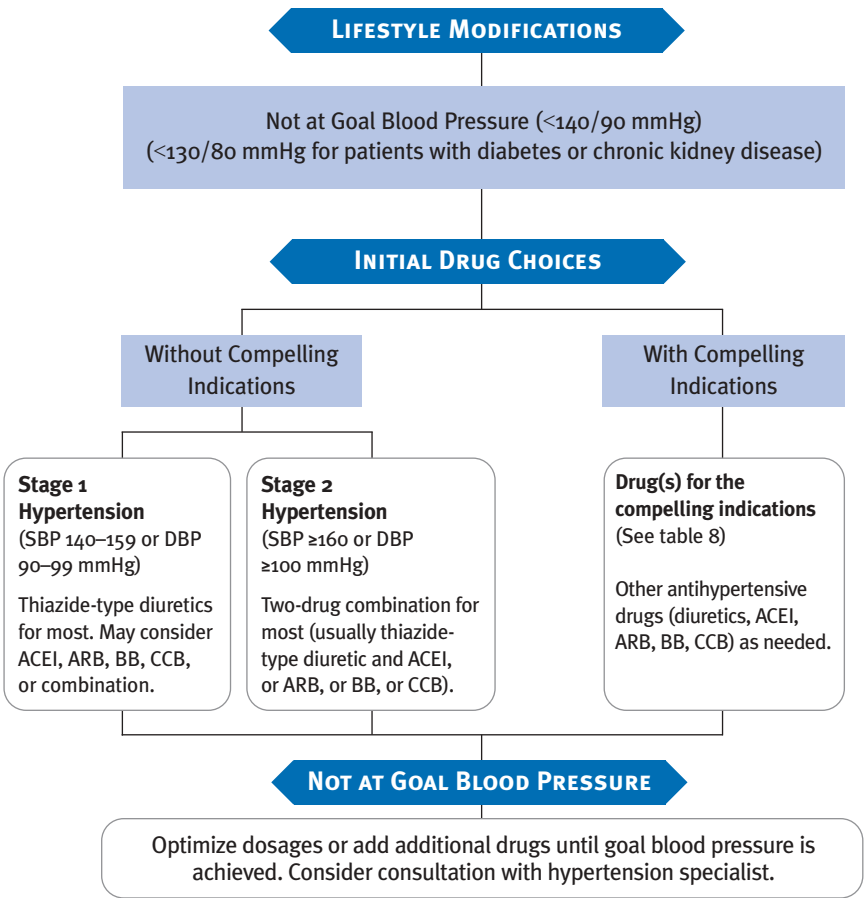
* Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; BB, beta-blocker; CCB, calcium channel blocker.

† Some drug combinations are available in multiple fixed doses. Each drug dose is reported in milligrams.

Achieving Blood Pressure Control in Individual Patients

Most patients who are hypertensive will require two or more antihypertensive medications to achieve their BP goals.^{14,15} Addition of a second drug from a different class should be initiated when use of a single drug in adequate doses fails to achieve the BP goal. When BP is more than 20/10 mmHg above goal, consideration should be given to initiating therapy with two drugs, either as separate prescriptions or in fixed-dose combinations. (See figure 1.) The initiation of drug therapy with more than one agent may increase the likelihood of achieving the BP goal in a more timely fashion, but particular caution is advised in those at risk for orthostatic hypotension, such as patients with diabetes, autonomic dysfunction, and some older persons. Use of generic drugs or combination drugs should be considered to reduce prescription costs.

Figure 1. Algorithm for treatment of hypertension



DBP, diastolic blood pressure; SBP, systolic blood pressure.
Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; BB, beta-blocker; CCB, calcium channel blocker.

Followup and Monitoring

Once antihypertensive drug therapy is initiated, most patients should return for followup and adjustment of medications at approximately monthly intervals until the BP goal is reached. More frequent visits will be necessary for patients with stage 2 hypertension or with complicating comorbid conditions. Serum potassium and creatinine should be monitored at least 1–2 times/year.⁶⁰ After BP is at goal and stable, followup visits can usually be at 3- to 6-month intervals. Comorbidities, such as heart failure, associated diseases such as diabetes, and the need for laboratory tests influence the frequency of visits. Other cardiovascular risk factors should be treated to their respective goals, and tobacco avoidance should be promoted vigorously. Low-dose aspirin therapy should be considered only when BP is controlled, because the risk of hemorrhagic stroke is increased in patients with uncontrolled hypertension.⁶¹

SPECIAL CONSIDERATIONS

The patient with hypertension and certain comorbidities requires special attention and followup by the clinician.

Compelling Indications

Table 8 describes compelling indications that require certain antihypertensive drug classes for high-risk conditions. The drug selections for these compelling indications are based on favorable outcome data from clinical trials. A combination of agents may be required. Other management considerations include medications already in use, tolerability, and desired BP targets. In many cases, specialist consultation may be indicated.

Ischemic Heart Disease

Ischemic heart disease (IHD) is the most common form of target organ damage associated with hypertension. In patients with hypertension and stable angina pectoris, the first drug of choice is usually a BB; alternatively, long-acting CCBs can be used.¹ In patients with acute coronary syndromes (unstable angina or myocardial infarction), hypertension should be treated initially with BBs and ACEIs,⁴⁹ with addition of other drugs as needed for BP control. In patients with postmyocardial infarction, ACEIs, BBs, and aldosterone antagonists have proven to be most beneficial.^{50,52,53,62} Intensive lipid management and aspirin therapy are also indicated.

Table 8. Clinical trial and guideline basis for compelling indications for individual drug classes

COMPELLING INDICATION*	RECOMMENDED DRUGS†						CLINICAL TRIAL BASIS‡
	DIURETIC	BB	ACEI	ARB	CCB	ALDO ANT	
Heart failure	•	•	•	•		•	ACC/AHA Heart Failure Guideline, ⁴⁰ MERIT-HF, ⁴¹ COPERNICUS, ⁴² CIBIS, ⁴³ SOLVD, ⁴⁴ AIRE, ⁴⁵ TRACE, ⁴⁶ ValHEFT, ⁴⁷ RALES ⁴⁸
Postmyocardial infarction		•	•			•	ACC/AHA Post-MI Guideline, ⁴⁹ BHAT, ⁵⁰ SAVE, ⁵¹ Capricorn, ⁵² EPHEUS ⁵³
High coronary disease risk	•	•	•		•		ALLHAT, ³³ HOPE, ³⁴ ANBP2, ³⁶ LIFE, ³² CONVINCE ³¹
Diabetes	•	•	•	•	•		NKF-ADA Guideline, ^{21,22} UKPDS, ⁵⁴ ALLHAT ³³
Chronic kidney disease			•	•			NKF Guideline, ²² Captopril Trial, ⁵⁵ RENAAL, ⁵⁶ IDNT, ⁵⁷ REIN, ⁵⁸ AASK ⁵⁹
Recurrent stroke prevention	•		•				PROGRESS ³⁵

* Compelling indications for antihypertensive drugs are based on benefits from outcome studies or existing clinical guidelines; the compelling indication is managed in parallel with the BP.

† Drug abbreviations: ACEI, angiotensin converting enzyme inhibitor; ARB, angiotensin receptor blocker; Aldo ANT, aldosterone antagonist; BB, beta-blocker; CCB, calcium channel blocker.

‡ Conditions for which clinical trials demonstrate benefit of specific classes of antihypertensive drugs.

Heart Failure

Heart failure (HF), in the form of systolic or diastolic ventricular dysfunction, results primarily from systolic hypertension and IHD. Fastidious BP and cholesterol control are the primary preventive measures for those at high risk for HF.⁴⁰ In asymptomatic individuals with demonstrable ventricular dysfunction, ACEIs and BBs are recommended.^{52,62} For those with symptomatic ventricular dysfunction or end-stage heart disease, ACEIs, BBs, ARBs and aldosterone blockers are recommended along with loop diuretics.^{40–48}

Diabetic Hypertension

Combinations of two or more drugs are usually needed to achieve the target goal of <130/80 mmHg.^{21,22} Thiazide diuretics, BBs, ACEIs, ARBs, and CCBs are beneficial in reducing CVD and stroke incidence in patients with diabetes.^{33,54,63} ACEI- or ARB-based treatments favorably affect the progression of diabetic nephropathy and reduce albuminuria,^{55,56} and ARBs have been shown to reduce progression to macroalbuminuria.^{56,57}

Chronic Kidney Disease

In people with chronic kidney disease (CKD), as defined by either (1) reduced excretory function with an estimated GFR below 60 ml/min per 1.73 m² (corresponding approximately to a creatinine of >1.5 mg/dL in men or >1.3 mg/dL in women),²⁰ or (2) the presence of albuminuria (>300 mg/day or 200 mg albumin/g creatinine), therapeutic goals are to slow deterioration of renal function and prevent CVD. Hypertension appears in the majority of these patients, and they should receive aggressive BP management, often with three or more drugs to reach target BP values of <130/80 mmHg.^{59,64} ACEIs and ARBs have demonstrated favorable effects on the progression of diabetic and nondiabetic renal disease.^{55–59,64} A limited rise in serum creatinine of as much as 35 percent above baseline with ACEIs or ARBs is acceptable and is not a reason to withhold treatment unless hyperkalemia develops.⁶⁵ With advanced renal disease (estimated GFR <30 ml/min 1.73 m², corresponding to a serum creatinine of 2.5–3 mg/dL), increasing doses of loop diuretics are usually needed in combination with other drug classes.

Cerebrovascular Disease

The risks and benefits of acute lowering of BP during an acute stroke are still unclear; control of BP at intermediate levels (approximately 160/100 mmHg) is appropriate until the condition has stabilized or improved. Recurrent stroke rates are lowered by the combination of an ACEI and thiazide-type diuretic.³⁵

Other Special Situations

Minorities

BP control rates vary in minority populations and are lowest in Mexican Americans and Native Americans.¹ In general, the treatment of hypertension is similar for all demographic groups, but socioeconomic factors and lifestyle may be important barriers to BP control in some minority patients. The prevalence, severity, and impact of hypertension are increased in African Americans, who also demonstrate somewhat reduced BP responses to monotherapy with BBs, ACEIs, or ARBs compared to diuretics or CCBs. These differential responses are largely eliminated by drug combinations that include adequate doses of a diuretic. ACEI-induced angioedema occurs 2–4 times more frequently in African American patients with hypertension than in other groups.³³

Obesity and the metabolic syndrome

Obesity (BMI ≥ 30 kg/m²) is an increasingly prevalent risk factor for the development of hypertension and CVD. The Adult Treatment Panel III guideline

for cholesterol management defines the metabolic syndrome as the presence of three or more of the following conditions: abdominal obesity (waist circumference >40 inches in men or >35 inches in women), glucose intolerance (fasting glucose ≥ 110 mg/dL), BP $\geq 130/85$ mmHg, high triglycerides (≥ 150 mg/dL), or low HDL (<40 mg/dL in men or <50 mg/dL in women).⁶⁶ Intensive lifestyle modification should be pursued in all individuals with the metabolic syndrome, and appropriate drug therapy should be instituted for each of its components as indicated.

Left ventricular hypertrophy

Left ventricular hypertrophy (LVH) is an independent risk factor that increases the risk of subsequent CVD. Regression of LVH occurs with aggressive BP management, including weight loss, sodium restriction, and treatment with all classes of antihypertensive agents except the direct vasodilators hydralazine, and minoxidil.^{1,67}

Peripheral arterial disease

Peripheral arterial disease (PAD) is equivalent in risk to IHD. Any class of antihypertensive drugs can be used in most PAD patients. Other risk factors should be managed aggressively, and aspirin should be used.

Hypertension in older persons

Hypertension occurs in more than two-thirds of individuals after age 65.¹ This is also the population with the lowest rates of BP control.⁶⁸ Treatment recommendations for older people with hypertension, including those who have isolated systolic hypertension, should follow the same principles outlined for the general care of hypertension. In many individuals, lower initial drug doses may be indicated to avoid symptoms; however, standard doses and multiple drugs are needed in the majority of older people to reach appropriate BP targets.

Postural hypotension

A decrease in standing SBP >10 mmHg, when associated with dizziness or fainting, is more frequent in older patients with systolic hypertension, diabetes, and those taking diuretics, venodilators (e.g., nitrates, alpha-blockers, and sildenafil-like drugs), and some psychotropic drugs. BP in these individuals should also be monitored in the upright position. Caution should be used to avoid volume depletion and excessively rapid dose titration of antihypertensive drugs.

Dementia

Dementia and cognitive impairment occur more commonly in people with hypertension. Reduced progression of cognitive impairment may occur with effective antihypertensive therapy.^{69,70}

Hypertension in women

Oral contraceptives may increase BP, and the risk of hypertension increases with duration of use. Women taking oral contraceptives should have their BP checked regularly. Development of hypertension is a reason to consider other forms of contraception. In contrast, menopausal hormone therapy does not raise BP.⁷¹

Women with hypertension who become pregnant should be followed carefully because of increased risks to mother and fetus. Methyldopa, BBs, and vasodilators are preferred medications for the safety of the fetus.⁷² ACEI and ARBs should not be used during pregnancy because of the potential for fetal defects and should be avoided in women who are likely to become pregnant. Preeclampsia, which occurs after the 20th week of pregnancy, is characterized by new-onset or worsening hypertension, albuminuria, and hyperuricemia, sometimes with coagulation abnormalities. In some patients, preeclampsia may develop into a hypertensive urgency or emergency and may require hospitalization, intensive monitoring, early fetal delivery, and parenteral antihypertensive and anticonvulsant therapy.⁷²

Hypertension in children and adolescents

In children and adolescents, hypertension is defined as BP that is, on repeated measurement, at the 95th percentile or greater adjusted for age, height, and gender.⁷³ The fifth Korotkoff sound is used to define DBP. Clinicians should be alert to the possibility of identifiable causes of hypertension in younger children (i.e., kidney disease, coarctation of the aorta). Lifestyle interventions are strongly recommended, with pharmacologic therapy instituted for higher levels of BP or if there is insufficient response to lifestyle modifications.⁷⁴ Choices of antihypertensive drugs are similar in children and adults, but effective doses for children are often smaller and should be adjusted carefully. ACEIs and ARBs should not be used in pregnant or sexually active girls. Uncomplicated hypertension should not be a reason to restrict children from participating in physical activities, particularly because long-term exercise may lower BP. Use of anabolic steroids should be strongly discouraged. Vigorous interventions also should be conducted for other existing modifiable risk factors (e.g., smoking).

Hypertensive urgencies and emergencies

Patients with marked BP elevations and acute target-organ damage (e.g., encephalopathy, myocardial infarction, unstable angina, pulmonary edema, eclampsia, stroke, head trauma, life-threatening arterial bleeding, or aortic dissection) require hospitalization and parenteral drug therapy.¹ Patients with markedly elevated BP but without acute target organ damage usually do not require hospitalization, but they should receive immediate combination oral

antihypertensive therapy. They should be carefully evaluated and monitored for hypertension-induced heart and kidney damage and for identifiable causes of hypertension. (See table 4.)

Additional Considerations in Antihypertensive Drug Choices

Antihypertensive drugs can have favorable or unfavorable effects on other comorbidities.

Potential favorable effects

Thiazide-type diuretics are useful in slowing demineralization in osteoporosis. BBs can be useful in the treatment of atrial tachyarrhythmias/fibrillation, migraine, thyrotoxicosis (short term), essential tremor, or perioperative hypertension. CCBs may be useful in Raynaud's syndrome and certain arrhythmias, and alpha-blockers may be useful in prostatism.

Potential unfavorable effects

Thiazide diuretics should be used cautiously in patients who have gout or who have a history of significant hyponatremia. BBs should generally be avoided in individuals who have asthma, reactive airways disease, or second or third degree heart block. ACEIs and ARBs should not be given to women likely to become pregnant and are contraindicated in those who are. ACEIs should not be used in individuals with a history of angioedema. Aldosterone antagonists and potassium-sparing diuretics can cause hyperkalemia and should generally be avoided in patients who have serum potassium values more than 5.0 mEq/L while not taking medications.

IMPROVING HYPERTENSION CONTROL

Adherence to Regimens

Behavioral models suggest that the most effective therapy prescribed by the most careful clinician will control hypertension only if the patient is motivated to take the prescribed medication and to establish and maintain a health-promoting lifestyle. Motivation improves when patients have positive experiences with and trust in their clinicians. Empathy both builds trust and is a potent motivator.⁷⁵

Patient attitudes are greatly influenced by cultural differences, beliefs, and previous experiences with the health care system.⁷⁶ These attitudes must be understood if the clinician is to build trust and increase communication with patients and families.

Failure to titrate or combine medications, despite knowing the patient is not at goal BP, represents clinical inertia and must be overcome.⁷⁷ Decision support systems (i.e., electronic and paper), flow sheets, feedback reminders, and involvement of nurse clinicians and pharmacists can be helpful.⁷⁸

The clinician and the patient must agree upon BP goals. A patient-centered strategy to achieve the goal and an estimation of the time needed to reach goal are important.⁷⁹ When BP is above goal, alterations in the plan should be documented. BP self-monitoring can also be useful.

Patients' nonadherence to therapy is increased by misunderstanding of the condition or treatment, denial of illness because of lack of symptoms or perception of drugs as symbols of ill health, lack of patient involvement in the care plan, or unexpected adverse effects of medications. The patient should be made to feel comfortable in telling the clinician all concerns and fears of unexpected or disturbing drug reactions.

The cost of medications and the complexity of care (i.e., transportation, patient difficulty with polypharmacy, difficulty in scheduling appointments, and life's competing demands) are additional barriers that must be overcome to achieve goal BP.

All members of the health care team (e.g., physicians, nurse case managers, and other nurses, physician assistants, pharmacists, dentists, registered dietitians, optometrists, and podiatrists) must work together to influence and reinforce instructions to improve patients' lifestyles and BP control.⁸⁰

Resistant Hypertension

Resistant hypertension is the failure to reach goal BP in patients who are adhering to full doses of an appropriate three-drug regimen that includes a diuretic. After excluding potential identifiable hypertension (see table 4), clinicians should carefully explore reasons why the patient is not at goal BP. (See table 9.) Particular attention should be paid to diuretic type and dose in relation to renal function. (See "Chronic Kidney Disease" section.) Consultation with a hypertension specialist should be considered if goal BP cannot be achieved.

Table 9. Causes of resitant hypertension

Improper BP Measurement
Volume Overload and Pseudotolerance
• Excess sodium intake • Volume retention from kidney disease • Inadequate diuretic therapy
Drug-Induced or Other Causes
• Nonadherence • Inadequate doses • Inappropriate combinations • Nonsteroidal anti-inflammatory drugs; cyclooxygenase 2 inhibitors • Cocaine, amphetamines, other illicit drugs • Sympathomimetics (decongestants, anorectics) • Oral contraceptives • Adrenal steroids • Cyclosporine and tacrolimus • Erythropoietin • Licorice (including some chewing tobacco) • Selected over-the-counter dietary supplements and medicines (e.g., ephedra, ma haung, bitter orange)
Associated Conditions
• Obesity • Excess alcohol intake
Identifiable Causes of Hypertension. (See table 4.)

PUBLIC HEALTH CHALLENGES AND COMMUNITY PROGRAMS

Public health approaches, such as reducing calories, saturated fat, and salt in processed foods and increasing community/school opportunities for physical activity, can achieve a downward shift in the distribution of a population’s BP, thus potentially reducing morbidity, mortality, and the lifetime risk of an individual’s becoming hypertensive. This becomes especially critical as the increase in BMI of Americans has reached epidemic levels. Now, 122 million adults are overweight or obese, which contributes to the rise in BP and related conditions.⁸¹ The JNC 7 endorses the American Public Health Association resolution that the food manufacturers and restaurants reduce sodium in the food supply by 50 percent over the next decade. When public health intervention strategies address the diversity of racial, ethnic, cultural, linguistic, religious, and social factors in the delivery of their services, the likelihood of their acceptance by the community increases. These public health approaches can provide an attractive opportunity to interrupt and prevent the continuing costly cycle of managing hypertension and its complications.

EVIDENCE CLASSIFICATION

The studies that provided evidence supporting the recommendations of this report were classified and reviewed by the staff and the Executive Committee. The classification scheme is from the JNC 6 report.²

- M** Meta-analysis; use of statistical methods to combine the results from clinical trials
- RA** Randomized controlled trials; also known as experimental studies
- RE** Retrospective analyses; also known as case-control studies
- F** Prospective study; also known as cohort studies, including historical or prospective followup studies.
- X** Cross-sectional survey; also known as prevalence studies
- PR** Previous review or position statements
- C** Clinical interventions (nonrandomized)

STUDY ABBREVIATIONS

AASK	African American Study of Kidney Disease and Hypertension
ACC/AHA	American College of Cardiology/American Heart Association
AIRE	Acute Infarction Ramipril Efficacy
ALLHAT	Antihypertensive and Lipid-Lowering Treatment To Prevent Heart Attack Trial
ANBP2	Second Australian National Blood Pressure Study
BHAT	β-Blocker Heart Attack Trial
CIBIS	Cardiac Insufficiency Bisoprolol Study
CONVINCE	Controlled Onset Verapamil Investigation of Cardiovascular End Points
COPERNICUS	Carvedilol Prospective Randomized Cumulative Survival Study
EPHESUS	Eplerenone Post-Acute Myocardial Infarction Heart Failure Efficacy and Survival Study
HOPE	Heart Outcomes Prevention Evaluation Study
IDNT	Irbesartan Diabetic Nephropathy Trial
LIFE	Losartan Intervention For Endpoint Reduction in Hypertension Study
MERIT-HF	Metoprolol CR/XL Randomized Intervention Trial in Congestive Heart Failure
NKF-ADA	National Kidney Foundation-American Diabetes Association
PROGRESS	Perindopril Protection Against Recurrent Stroke Study
RALES	Randomized Aldactone Evaluation Study
REIN	Ramipril Efficacy in Nephropathy Study
RENAAL	Reduction of Endpoints in Non Insulin Dependent Diabetes Mellitus With the Angiotensin II Antagonist Losartan Study
SAVE	Survival and Ventricular Enlargement Study
SOLVD	Studies of Left Ventricular Dysfunction
TRACE	Trandolapril Cardiac Evaluation Study
UKPDS	United Kingdom Prospective Diabetes Study
ValHEFT	Valsartan Heart Failure Trial

REFERENCE LIST

1. National High Blood Pressure Education Program. The sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Arch Intern Med.* 1997;157:2413-46. **PR**
2. U.S. Department of Health and Human Services, National Heart, Lung, and Blood Institute. National High Blood Pressure Education Program. Available at: <http://www.nhlbi.nih.gov/about/nhbpep/index.htm>. Accessed March 5, 2003.
3. Sheps SG, Roccella EJ. Reflections on the sixth report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Curr Hypertens Rep.* 1999;1:342-5. **PR**
4. Roccella EJ, Kaplan NM. Interpretation and evaluation of clinical guidelines. In: Izzo JL Jr, Black HR, eds. *Hypertension Primer*. Dallas, TX: American Heart Association, 2003;126:126-7. **PR**
5. Last JM, Abramson JH, eds. *A dictionary of epidemiology*. 3rd ed. New York, NY: Oxford University Press, 1995.
6. Vasan RS, Larson MG, Leip EP, et al. Assessment of frequency of progression to hypertension in nonhypertensive participants in the Framingham Heart Study: A cohort study. *Lancet.* 2001;358:1682-6. **F**
7. Vasan RS, Beiser A, Seshadri S, et al. Residual lifetime risk for developing hypertension in middle-aged women and men: The Framingham Heart Study. *JAMA.* 2002;287:1003-10. **F**
8. Lewington S, Clarke R, Qizilbash N, et al. Age-specific relevance of usual blood pressure to vascular mortality: A meta-analysis of individual data for one million adults in 61 prospective studies. *Lancet.* 2002;360:1903-13. **M**
9. Whelton PK, He J, Appel LJ, et al. Primary prevention of hypertension: Clinical and public health advisory from The National High Blood Pressure Education Program. *JAMA.* 2002;288:1882-8. **PR**
10. Neal B, MacMahon S, Chapman N. Effects of ACE inhibitors, calcium antagonists, and other blood-pressure-lowering drugs: Results of prospectively designed overviews of randomised trials. Blood Pressure Lowering Treatment Trialists' Collaboration. *Lancet.* 2000;356:1955-64. **M**

11. Ogden LG, He J, Lydick E, Whelton PK. Long-term absolute benefit of lowering blood pressure in hypertensive patients according to the JNC VI risk stratification. *Hypertension*. 2000;35:539-43. **X**
12. Cherry DK, Woodwell DA. National Ambulatory Medical Care Survey: 2000 Summary. *Advance Data*. 2002;328. **PR**
13. Izzo JL Jr, Levy D, Black HR. Clinical Advisory Statement. Importance of systolic blood pressure in older Americans. *Hypertension*. 2000;35:1021-4. **PR**
14. Cushman WC, Ford CE, Cutler JA, et al. Success and predictors of blood pressure control in diverse North American settings: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). *J Clin Hypertens (Greenwich)*. 2002;4:393-404. **RA**
15. Black HR, Elliott WJ, Neaton JD, et al. Baseline characteristics and elderly blood pressure control in the CONVINCE trial. *Hypertension*. 2001;37:12-8. **RA**
16. World Hypertension League. Measuring your blood pressure. Available at: <http://www.mco.edu/org/whl/bloodpre.html>. Accessed April 1, 2003.
17. Pickering T. Recommendations for the use of home (self) and ambulatory blood pressure monitoring. American Society of Hypertension Ad Hoc Panel. *Am J Hypertens*. 1996;9:1-11. **PR**
18. Verdecchia P. Prognostic value of ambulatory blood pressure: current evidence and clinical implications. *Hypertension*. 2000;35:844-51. **PR**
19. American Heart Association. Home monitoring of high blood pressure. Available at: <http://www.americanheart.org/presenter.jhtml?identifier=576>. Accessed April 1, 2003.
20. GFR / 1.73 M^2 by MDRD ($\pm$ SUN and SALb) Calculator. Available at: <http://www.hdcn.com/calcf/gfr.htm>. Accessed April 1, 2003.
21. American Diabetes Association. Treatment of hypertension in adults with diabetes. *Diabetes Care*. 2003;26(suppl 1):S80-S82. **PR**
22. National Kidney Foundation Guideline. K/DOQI clinical practice guidelines for chronic kidney disease: Evaluation, classification, and stratification. Kidney Disease Outcome Quality Initiative. *Am J Kidney Dis*. 2002;39(suppl 2):S1-S246. **PR**

23. The Trials of Hypertension Prevention Collaborative Research Group. Effects of weight loss and sodium reduction intervention on blood pressure and hypertension incidence in overweight people with high-normal blood pressure. The Trials of Hypertension Prevention, phase II. *Arch Intern Med.* 1997;157:657-67. **RA**
24. He J, Whelton PK, Appel LJ, Charleston J, Klag MJ. Long-term effects of weight loss and dietary sodium reduction on incidence of hypertension. *Hypertension.* 2000;35:544-9. **F**
25. Sacks FM, Svetkey LP, Vollmer WM, et al. Effects on blood pressure of reduced dietary sodium and the Dietary Approaches to Stop Hypertension (DASH) diet. DASH-Sodium Collaborative Research Group. *N Engl J Med.* 2001;344:3-10. **RA**
26. Vollmer WM, Sacks FM, Ard J, et al. Effects of diet and sodium intake on blood pressure: Subgroup analysis of the DASH-sodium trial. *Ann Intern Med.* 2001;135:1019-28. **RA**
27. Chobanian AV, Hill M. National Heart, Lung, and Blood Institute Workshop on Sodium and Blood Pressure: A critical review of current scientific evidence. *Hypertension.* 2000;35:858-63. **PR**
28. Kelley GA, Kelley KS. Progressive resistance exercise and resting blood pressure: A meta-analysis of randomized controlled trials. *Hypertension.* 2000;35:838-43. **M**
29. Whelton SP, Chin A, Xin X, He J. Effect of aerobic exercise on blood pressure: A meta-analysis of randomized, controlled trials. *Ann Intern Med.* 2002;136:493-503. **M**
30. Xin X, He J, Frontini MG, et al. Effects of alcohol reduction on blood pressure: A meta-analysis of randomized controlled trials. *Hypertension.* 2001;38:1112-7. **M**
31. Black HR, Elliott WJ, Grandits G, et al. Principal results of the Controlled ONset Verapamil INvestigation of Cardiovascular Endpoints (CONVINCE) trial. *JAMA.* 2003;289:2073-82. **RA**
32. Dahlof B, Devereux RB, Kjeldsen SE, et al. Cardiovascular morbidity and mortality in the Losartan Intervention For Endpoint reduction in hypertension study (LIFE): A randomised trial against atenolol. *Lancet.* 2002;359:995-1003. **RA**
33. The ALLHAT Officers and Coordinators for the ALLHAT Collaborative Research Group. Major outcomes in high-risk hypertensive patients randomized to angiotensin-converting enzyme inhibitor or calcium channel blocker vs diuretic: The Antihypertensive and Lipid-Lowering Treatment to Prevent Heart Attack Trial (ALLHAT). *JAMA.* 2002;288:2981-97. **RA**

34. The Heart Outcomes Prevention Evaluation Study Investigators. Effects of an angiotensin-converting-enzyme inhibitor, ramipril, on cardiovascular events in high-risk patients. *N Engl J Med.* 2000;342:145-53. **RA**
35. PROGRESS Collaborative Group. Randomised trial of a perindopril-based blood-pressure-lowering regimen among 6,105 individuals with previous stroke or transient ischaemic attack. *Lancet.* 2001;358:1033-41. **RA**
36. Wing LMH, Reid CM, Ryan P, et al. A comparison of outcomes with angiotensin-converting-enzyme inhibitors and diuretics for hypertension in the elderly. *N Engl J Med.* 2003;348:583-92. **RA**
37. Psaty BM, Smith NL, Siscovick DS, et al. Health outcomes associated with antihypertensive therapies used as first-line agents. A systematic review and meta-analysis. *JAMA.* 1997;277:739-45. **M**
38. *Physicians' Desk Reference.* 57 ed. Oradell, NJ: Medical Economics, 2003.
39. Psaty BM, Manolio TA, Smith NL, et al. Time trends in high blood pressure control and the use of antihypertensive medications in older adults: The Cardiovascular Health Study. *Arch Intern Med.* 2002;162:2325-32. **X**
40. Hunt SA, Baker DW, Chin MH, et al. ACC/AHA guidelines for the evaluation and management of chronic heart failure in the adult: Executive summary. A report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines (Committee to revise the 1995 Guidelines for the Evaluation and Management of Heart Failure). *J Am Coll Cardiol.* 2001;38:2101-13. **PR**
41. Tepper D. Frontiers in congestive heart failure: Effect of Metoprolol CR/XL in chronic heart failure: Metoprolol CR/XL Randomised Intervention Trial in Congestive Heart Failure (MERIT-HF). *Congest Heart Fail.* 1999;5:184-5. **RA**
42. Packer M, Coats AJ, Fowler MB, et al. Effect of carvedilol on survival in severe chronic heart failure. *N Engl J Med.* 2001;344:1651-8. **RA**
43. CIBIS Investigators and Committees. A randomized trial of beta-blockade in heart failure. The Cardiac Insufficiency Bisoprolol Study (CIBIS). *Circulation.* 1994;90:1765-73. **RA**
44. The SOLVD Investigators. Effect of enalapril on survival in patients with reduced left ventricular ejection fractions and congestive heart failure. *N Engl J Med.* 1991;325:293-302. **RA**

45. The Acute Infarction Ramipril Efficacy (AIRE) Study Investigators. Effect of ramipril on mortality and morbidity of survivors of acute myocardial infarction with clinical evidence of heart failure. *Lancet*. 1993;342:821-8. **RA**
46. Kober L, Torp-Pedersen C, Carlsen JE, et al. A clinical trial of the angiotensin-converting-enzyme inhibitor trandolapril in patients with left ventricular dysfunction after myocardial infarction. Trandolapril Cardiac Evaluation (TRACE) Study Group. *N Engl J Med*. 1995;333:1670-6. **RA**
47. Cohn JN, Tognoni G. A randomized trial of the angiotensin-receptor blocker valsartan in chronic heart failure. *N Engl J Med*. 2001;345:1667-75. **RA**
48. Pitt B, Zannad F, Remme WJ, et al. The effect of spironolactone on morbidity and mortality in patients with severe heart failure. Randomized Aldactone Evaluation Study Investigators. *N Engl J Med*. 1999;341:709-17. **RA**
49. Braunwald E, Antman EM, Beasley JW, et al. ACC/AHA 2002 guideline update for the management of patients with unstable angina and non-ST-segment elevation myocardial infarction—summary article: A report of the American College of Cardiology/American Heart Association task force on practice guidelines (Committee on the Management of Patients With Unstable Angina). *J Am Coll Cardiol*. 2002;40:1366-74. **PR**
50. β -Blocker Heart Attack Trial Research Group. A randomized trial of propranolol in patients with acute myocardial infarction. I. Mortality results. *JAMA*. 1982;247:1707-14. **RA**
51. Hager WD, Davis BR, Riba A, et al. Absence of a deleterious effect of calcium channel blockers in patients with left ventricular dysfunction after myocardial infarction: The SAVE Study Experience. SAVE Investigators. Survival and Ventricular Enlargement. *Am Heart J*. 1998;135:406-13. **RA**
52. The Capricorn Investigators. Effect of carvedilol on outcome after myocardial infarction in patients with left-ventricular dysfunction: The CAPRICORN randomised trial. *Lancet*. 2001;357:1385-90. **RA**
53. Pitt B, Remme W, Zannad F, et al. Eplerenone, a selective aldosterone blocker, in patients with left ventricular dysfunction after myocardial infarction. *N Engl J Med*. 2003;348:1309-21. **RA**
54. UK Prospective Diabetes Study Group. Efficacy of atenolol and captopril in reducing risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 39. *BMJ*. 1998;317:713-20. **RA**

55. Lewis EJ, Hunsicker LG, Bain RP, Rohde RD. The effect of angiotensin-converting-enzyme inhibition on diabetic nephropathy. The Collaborative Study Group. *N Engl J Med.* 1993;329:1456-62. **RA**
56. Brenner BM, Cooper ME, de Zeeuw D, et al. Effects of losartan on renal and cardiovascular outcomes in patients with type 2 diabetes and nephropathy. *N Engl J Med.* 2001;345:861-9. **RA**
57. Lewis EJ, Hunsicker LG, Clarke WR, et al. Renoprotective effect of the angiotensin-receptor antagonist irbesartan in patients with nephropathy due to type 2 diabetes. *N Engl J Med.* 2001;345:851-60. **RA**
58. The GISEN Group (Gruppo Italiano di Studi Epidemiologici in Nefrologia). Randomised placebo-controlled trial of effect of ramipril on decline in glomerular filtration rate and risk of terminal renal failure in proteinuric, non-diabetic nephropathy. *Lancet.* 1997;349:1857-63. **RA**
59. Wright JT Jr, Agodoa L, Contreras G, et al. Successful blood pressure control in the African American Study of Kidney Disease and Hypertension. *Arch Intern Med.* 2002;162:1636-43. **RA**
60. Bakris GL, Weir MR, on behalf of the Study of Hypertension and Efficacy of Lotrel in Diabetes (SHIELD) Investigators. Achieving goal blood pressure in patients with type 2 diabetes: Conventional versus fixed-dose combination approaches. *J Clin Hypertens.* 2003;5:201-10. **RA**
61. Antithrombotic Trialist Collaboration. Collaborative meta-analysis of randomised trials of antiplatelet therapy for prevention of death, myocardial infarction, and stroke in high risk patients. *BMJ.* 2002;324:71-86. **M**
62. Pfeffer MA, Braunwald E, Moye LA, et al. Effect of captopril on mortality and morbidity in patients with left ventricular dysfunction after myocardial infarction. Results of the Survival And Ventricular Enlargement trial. The SAVE Investigators. *N Engl J Med.* 1992;327:669-77. **RA**
63. Lindholm LH, Ibsen H, Dahlof B, et al. Cardiovascular morbidity and mortality in patients with diabetes in the Losartan Intervention For Endpoint reduction in hypertension study (LIFE): a randomised trial against atenolol. *Lancet.* 2002;359:1004-10. **RA**
64. Bakris GL, Williams M, Dworkin L, et al. Preserving renal function in adults with hypertension and diabetes: A consensus approach. National Kidney Foundation Hypertension and Diabetes Executive Committees Working Group. *Am J Kidney Dis.* 2000;36:646-61. **PR**

65. Bakris GL, Weir MR. Angiotensin-converting enzyme inhibitor-associated elevations in serum creatinine: Is this a cause for concern? *Arch Intern Med.* 2000;160:685-93. **M**
66. National Cholesterol Education Program. Third Report of the National Cholesterol Education Program (NCEP) Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel III) final report. *Circulation.* 2002;106:3143-421. **PR**
67. Kjeldsen SE, Dahlof B, Devereux RB, et al. Effects of losartan on cardiovascular morbidity and mortality in patients with isolated systolic hypertension and left ventricular hypertrophy: a Losartan Intervention for Endpoint Reduction (LIFE) substudy. *JAMA.* 2002;288:1491-8. **RA**
68. Hyman DJ, Pavlik VN. Characteristics of patients with uncontrolled hypertension in the United States. *N Engl J Med.* 2001;345:479-86. **X**
69. Staessen JA, Wang J. Blood-pressure lowering for the secondary prevention of stroke. [Commentary]. *Lancet.* 2001;358:1026-7.
70. Di Bari M, Pahor M, Franse LV, et al. Dementia and disability outcomes in large hypertension trials: lessons learned from the systolic hypertension in the elderly program (SHEP) trial. *Am J Epidemiol.* 2001;153:72-8. **RA**
71. Writing Group for the Women's Health Initiative Investigators. Risks and benefits of estrogen plus progestin in healthy postmenopausal women: Principal results from the Women's Health Initiative randomized controlled trial. *JAMA.* 2002;288:321-33. **RA**
72. National High Blood Pressure Education Program. Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. *Am J Obstet Gynecol.* 2000;183:S1-S22. **PR**
73. National High Blood Pressure Education Program. Update on the 1987 Task Force Report on High Blood Pressure in Children and Adolescents: A working group report from the National High Blood Pressure Education Program. National High Blood Pressure Education Program Working Group on Hypertension Control in Children and Adolescents. *Pediatrics.* 1996;98(pt 1):649-58. **PR**
74. Barlow SE, Dietz WH. Obesity evaluation and treatment: Expert Committee recommendations. The Maternal and Child Health Bureau, Health Resources and Services Administration and the Department of Health and Human Services. *Pediatrics.* 1998;102:E29. **PR**

75. Barrier PA, Li JT, Jensen NM. Two words to improve physician-patient communication: What else? *Mayo Clin Proc.* 2003;78:211-4. **PR**
76. Betancourt JR, Carrillo JE, Green AR. Hypertension in multicultural and minority populations: Linking communication to compliance. *Curr Hypertens Rep.* 1999;1:482-8.
77. Phillips LS, Branch WT, Cook CB, et al. Clinical inertia. *Ann Intern Med.* 2001;135:825-34.
78. Balas EA, Weingarten S, Garb CT, et al. Improving preventive care by prompting physicians. *Arch Intern Med.* 2000;160:301-8. **C**
79. Boulware LE, Daumit GL, Frick KD, et al. An evidence-based review of patient-centered behavioral interventions for hypertension. *Am J Prev Med.* 2001;21:221-32. **PR, M**
80. Hill MN, Miller NH. Compliance enhancement. A call for multidisciplinary team approaches. *Circulation.* 1996;93:4-6.
81. Flegal KM, Carroll MD, Ogden CL, Johnson CL. Prevalence and trends in obesity among US adults, 1999-2000. *JAMA.* 2002;288:1723-7. **X**

Discrimination Prohibited: Under provisions of applicable public laws enacted by Congress since 1964, no person in the United States shall, on the grounds of race, color, national origin, handicap, or age, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity (or, on the basis of sex, with respect to any education program or activity) receiving Federal financial assistance. In addition, Executive Order 11141 prohibits discrimination on the basis of age by contractors and subcontractors in the performance of Federal contracts, and Executive Order 11246 states that no federally funded contractor may discriminate against any employee or applicant for employment because of race, color, religion, sex, or national origin. Therefore, the National Heart, Lung, and Blood Institute must be operated in compliance with these laws and Executive Orders.

For More Information

The NHLBI Health Information Center is a service of the National Heart, Lung, and Blood Institute (NHLBI) of the National Institutes of Health. The NHLBI Health Information Center provides information to health professionals, patients, and the public about the treatment, diagnosis, and prevention of heart, lung, and blood diseases. For more information, contact:

NHLBI Health Information Center
P.O. Box 30105
Bethesda, MD 20824-0105
Phone: 301-592-8573
TTY: 240-629-3255
Fax: 301-592-8563
Web site: <http://www.nhlbi.nih.gov>



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
National Institutes of Health
National Heart, Lung, and Blood Institute
National High Blood Pressure Education Program

NIH Publication No. 03-5233
May 2003