Clinical Effectiveness South East London

QUAY HEALTH SOLUTIONS

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Hypertension

A guide for Southwark General Practice

Key messages

1. Lifestyle changes are key to reducing CV risk and lowering blood pressure
2. Check for complications and calculate a QRISK 2 or 3 score
3. Aim for NICE blood pressure targets (which are often stricter than QOF)
4. Check blood pressure *more frequently*

Always work within your knowledge and competency

July 2023 (review July 2024, or earlier if indicated)

Why focus on BP in Southwark?

Hypertension is a risk factor for having worse outcomes from Covid-19.

Treatment of high BP significantly reduces risk of stroke, IHD, heart failure and all cause mortality[1]

- **Risk reduction**: Every 10mmHg reduction in systolic BP reduces risk of major CV events by 20%[1]
- **Under-treated:** 45% of Southwark patients <80 years, with hypertension, have a BP >140/90mmHg[2]
- **Under-diagnosed:** 27,650 people remain undiagnosed (prevalence = 10.6% vs. expected= 19.2%)[1]

In Southwark, if we reduce the average systolic BP in people with hypertension by 10 mmHg, in one year, we could prevent[1]:

- **67** people from having a stroke
- **47** people from developing heart failure
- **49** people from developing IHD
- **178** deaths

Hypertension diagnosis and assessment, including for people with Type 2 diabetes (T2DM)

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Confirm hypertension diagnosis (using ABPM/HBPM) and stratify CV risk[3,4]

Clinic BP
<140/90mmHg

Clinic BP
Systolic 140-179mmHg
or Diastolic 90-119mmHg

Confirm diagnosis, request bloods/ACR + check for complications
Do ABPM/HBPM

ABPM/HBPM
≥ 135/85mmHg
Stage 1 Hypertension

ABPM/HBPM
≥ 150/95mmHg
Stage 2 Hypertension

Clinic BP
Systolic ≥ 180mmHg or Diastolic ≥ 120mmHg
Severe Hypertension

Urgent (same day) GP review

Target organ damage?

No

Repeat clinic BP within 7 days (or urgent ABPM/HBPM) and treat accordingly

Yes

Consider treating BP without ABPM/ HBPM result

Worrying symptoms?

999/A&E

Offer lifestyle Advice (see page 5)

Assess for complications + CV risk (QRISK 2 or 3)
(See page 4)

If <60 yrs + QRISK 2 or 3 <10%

If >80 yrs + BP >150/90 mmHg

If <80 yrs and ≥1 of: QRISK ≥10% diabetes/renal disease/ hypertensive eye disease/CKD/LVH or CVD

***'Consider'* starting BP treatment**

'Discuss' starting BP treatment*

***Start* BP Treatment**
Use clinical judgment in frailty/multi-morbidity

QRISK 2 or 3 (to assess 10-year CV risk)

≤10%
No statin

≥10%
Address modifiable risk factors first, then consider initiating or optimising statin if still >10%

BP every 5 years, or annually if near to 140/90mmHg (use clinical judgement), or if target organ damage/ T2DM (see Traffic light page within SELIMOC hypertension guidance 2021 for primary care)

Review BP (recommended at least annually, or more frequently when clinically indicated)
(BP/blood tests/ACR/lifestyle and medication review)

Hypertension diagnosis: additional information

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Diagnosing hypertension

How to measure BP when considering a diagnosis of hypertension:

- Measure blood pressure in both arms, if difference >15 mmHg, repeat measurements
- If difference remains >15 mmHg, measure subsequent blood pressures in the arm with the higher reading (note this on EMIS)

When to measure standing + sitting BP?

- In DM, postural hypotension (systolic drop ≥20mmHg from sitting to standing), or age ≥80yrs
- If significant drop/symptoms of postural hypotension, **review medication and treat to BP target based on standing BP**

- **Ambulatory BP monitoring (ABPM)**
  Ensure sufficient readings - minimum 14 readings during waking hours.
  Use daytime average BP for diagnosis

- **Home BP monitoring (HBPM)**
  Ensure a validated (and calibrated) BP machine is being used and advise to record two BP readings every morning and evening for at least 4 days (ideally 7)
  In practice, disregard the first day's readings and take an average of the remaining readings

Assessing complications

Look for complications (target organ damage – i.e. fundoscopy, urine dip, CV exam) + do a **QRISK 2 or 3**

- **Tests:** renal profile, lipids, FBC, HbA1c, TFT, ACR, urinalysis for haematuria + ECG + fundoscopy
- **Record:** smoking status, physical activity level, alcohol intake, BMI, [waist circumference], family history [use Arden's BP EMIS Template]

Assessing Cardiovascular (CV) risk: QRISK

- As of December 2021, the QRISK2 'calculator' is integrated into EMIS. this may change (responsibility for this lies with EMIS or Ardens), and QRISK 3 calculators can be found online here

- The calculated CV risk is an estimate. Clinical judgement is required to adjust for factors that the risk calculator does not take into account

QRISK 2&3

- QRISK 3 is a more advanced risk calculator than QRISK 2 as it has additional inclusions such as CKD 3-5, severe mental illness and rheumatological conditions.
- QRISK 2/3 are CVD risk estimate calculators only, and **therefore clinical judgment must be used**. For example, people considered high risk of CVD should already be on/offered lipid management treatment (such as those with type 1 diabetes, CKD 3-5, existing CVD/previous Stroke/TIA, familial hypercholesterolaemia and people aged >85 yr).

When to refer a patient?

Suspect secondary causes OR patient <40 years?

- If you suspect **secondary causes in a patient of any age** e.g. Cushing's, Conn's*
- **If <40 years + BP ≥140/90mmHg + no evidence of CVD, renal/hypertensive eye disease or diabetes.** The 10-year QRisk can underestimate the lifetime risk of CV events in this cohort.[3]
- In patients of **African or Caribbean family origin, primary hypertension can present earlier, if in doubt, consider A&G** to discuss need for referral

Refer to specialist clinic for investigation

Worrying symptoms?

- **Life-threatening symptoms -** new onset confusion, chest pain, HF, AKI
- **Accelerated hypertension** - retinal haemorrhage, papilloedema
- **Suspected phaeochromocytoma -** labile or hypotension, headache, pallor, palpitations, abdo pain, excessive sweating[17]

Immediate: 999 or A&E

*Other conditions which can cause hypertension include: Connective tissue disorders: scleroderma, systemic lupus, erythematous, polyarteritis nodosa, retroperitoneal fibrosis, obstructive sleep apnoea

Impact of life-style changes on BP[6]

Action	Recommendation	Approx. systolic BP reduction
Reduced weight	Aim for ideal body weight	5-20mmHg/10kg loss
DASH diet	Consume a diet rich in fruits, vegetables, low-fat dairy with reduced saturated and total fat	8-14mmHg
Reduced salt intake	Reduced dietary sodium intake (<1 teaspoon/day)	2-8mmHg
Increased exercise	Regular aerobic physical activity (at least 30 min/day, most days of the week)	4-9mmHg
Reduced alcohol intake	Below or equal to 14 units/week	2-4mmHg

Note: In addition, discourage consumption of excessive caffeine or caffeine-rich products.[4] Average BP reduction (systolic) from one anti-hypertensive drug= 12.5-15.5mmHg.[7] The effects of implementing lifestyle modifications are dose and time dependent, and could be greater for some individuals.[6] In the study used, stress management's impact on BP was variable.[6]

Which BP target? Aim for and maintain at NICE BP targets (or below)[4, 5, 8, 9, 18]

Which condition?	Which cohort within the condition?	NICE Clinic BP Target • Use clinical judgment in frailty/multi-morbidity • Targets for ABPM/HBPM are 5mmHg lower	QOF BP Targets • Targets for ABPM/HBPM are 5mmHg lower
Hypertension, including Type 2 Diabetes (but with no CKD)	Age <80yrs	**≤140/90mmHg (ABPM/HBPM≤135/85)**	QOF now in line with NICE
	Age ≥80yrs	**≤150/90mmHg (ABPM/HBPM≤145/85)**	QOF now in line with NICE
Diabetes and Hypertension	Type 2 Diabetes	**Same as hypertension if no CKD**	If no moderate/severe frailty: **≤140/90mmHg (ABPM/HBPM≤135/85)** But use clinical judgement in Type 1 as NICE targets much lower to QOF
	Type 1 Diabetes + no albuminuria	**≤135/85mmHg**	
	Type 1 Diabetes + albuminuria or ≥ 2 features of metabolic syndrome	**≤130/80mmHg**	
CKD and Hypertension	ACR <70mg/mmol	**<140/90mmHg (systolic range = 120-139mmHg)**	No QOF target
	ACR ≥70mg/mmol or co-existent Diabetes	**<130/80mmHg (systolic range = 120-129mmHg)**	
IHD/PAD or TIA/Stroke and Hypertension	History of IHD/PAD	**Same as hypertension, if no CKD**	No QOF target for PAD, but for rest, based on age i.e. <80yrs ≤140/90mmHg ≥80yrs ≤150/90mmHg
	History of TIA/Stroke	**Same as hypertension, if no CKD**	

Note: For people ≥80 years with hypertension and T2DM, CKD, PAD, CVD or TIA/Stroke, individual NICE guidance on these areas offers no age-specific BP targets for this cohort. However, NICE Hypertension guidelines (as mentioned above) do suggest a target of ≤150/90 mmHg for those ≥80 years with hypertension, but with frailty/multi-morbidity use clinical judgement.

Hypertension treatment[3,4]

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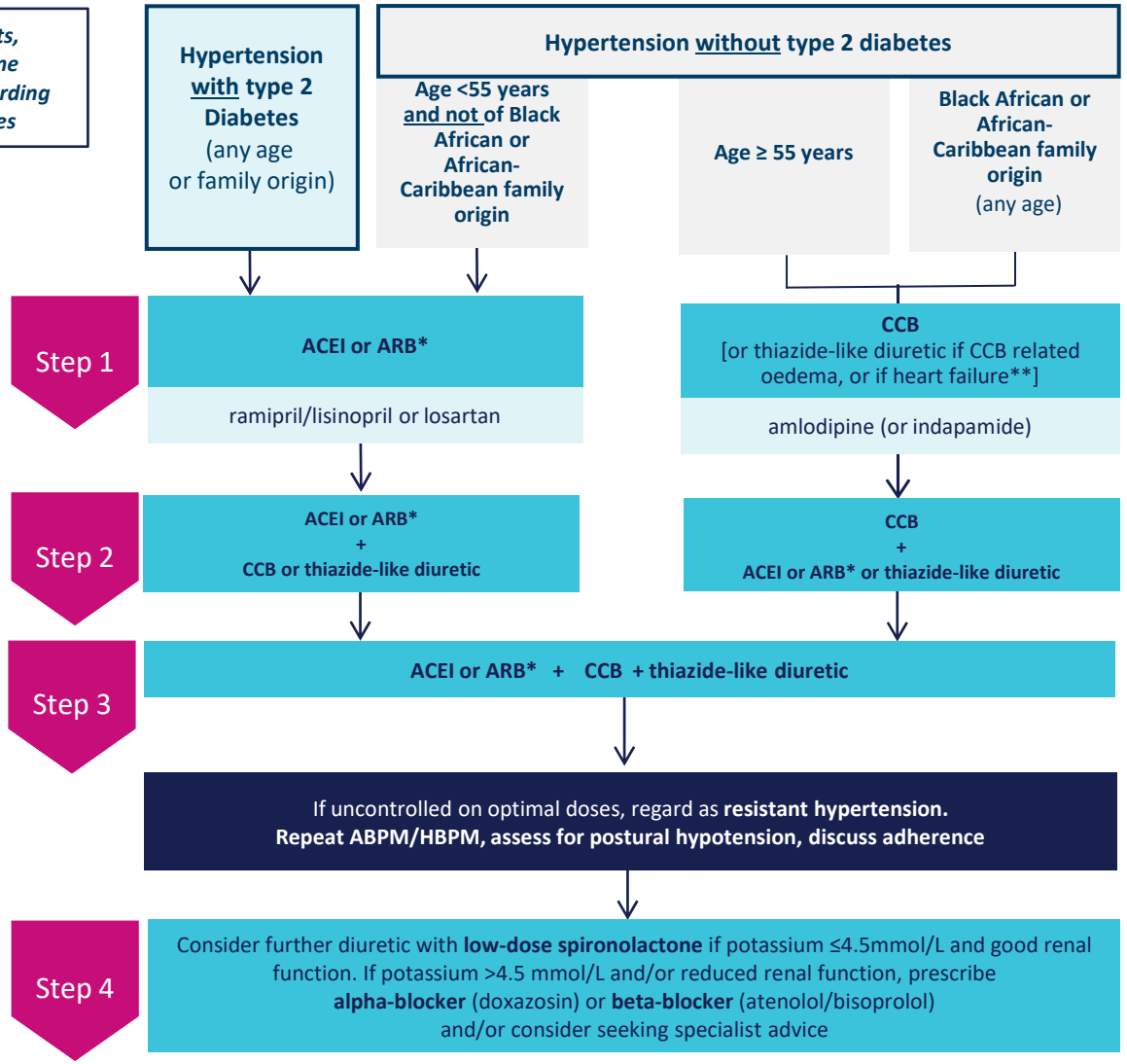
For CVD patients, consider first-line treatment according to co-morbidities

Optimise medication to most effective tolerated dose, **and check adherence** at eachstep, before stepping up



*For **people of black African or African-Caribbean family origin, consider ARB** instead of ACEI (as increased risk of angioedema with ACEI)

** If hypertension in context of heart failure, please see CES Heart Failure

Hypertension in Chronic Kidney Disease[9] (CKD stages 3-5 i.e. eGFR <60ml/min)	
ACR <30 mg/mmol	Follow BP algorithm
ACR ≥30 mg/mmol	1st line: ACEI or ARB, then follow BP algorithm

eGFR corrections

Corrected eGFR
Latest NICE CKD guidance (August 2021) **does not recommend** adjusting the estimation of glomerular filtration rate (eGFR) in people of African-Caribbean or African family background

Women with pre-existing hypertension contemplating pregnancy[10]

Refer to specialist **pre-conception counselling** (page 9)

Drugs to avoid at conception/in pregnancy include: ACEI/ARB/thiazide or thiazide-like diuretic (increased risk of congenital abnormalities)

NICE guidelines:
Stop ACEI/ARBs and change medication (preferably within 2 working days of notification of pregnancy). Offer alternatives:
- Labetalol if no CI e.g. asthma, nifedipine or methyldopa. Can also remain on amlodipine – GSTT Obstetric Medicine advice
- **Target BP ≤ 135/85 mmHg**
- **Offer aspirin 75-150mg OD from week 12 of pregnancy**

Refer to **Hypertension in Pregnancy clinic (GSTT) ASAP**

This guidance is aligned to SEL IMOC Hypertension 2021 guidance for Primary Care

Hypertension: preferred medication[3, 4, 11, 12, 13, 14]

	Drug	Starting dose	Daily Range	Notes (These are not extensive, please refer to the latest BNF for further information, especially titration increments, cautions and contraindications)
ACEIs	1st Line: Ramipril	2.5mg OD (1.25mg OD in frail/elderly patients)	2.5-10mg OD	- For people of Black African or African-Caribbean family origin**, consider ARB** instead of ACEI (as risk of angioedema with ACEI) - Check baseline renal profile (Na/K/Cr/eGFR). Hyperkalaemia may occur, therefore close monitoring of serum potassium is required - Re-check renal profile within 2 weeks of initiation, or dose increase and then at least annually - **Titrate ACEI/ARB up at 2-4 weekly intervals to achieve optimal BP control** - Initiation/Dose titrations: If serum creatinine increases by >20% (or eGFR falls by >15%) – stop ACEI and seek specialist advice. ACEI dose should only be increased if serum creatinine increases by less than 20% (or eGFR falls by less than 15%) after each dose titration, and potassium <5.5mmol - **ACEI/ARB dose should be optimised before the addition of a second agent** - Side-effects: Symptomatic hypotension can occur on first dosing – suggest to take at night. Dry cough with ACEI, consider switch to ARB - **Caution:** Do not combine an ACEI and an ARB to treat hypertension - For diabetic nephropathy ARB of choice: losartan and irbesartan
	2nd line: Lisinopril	10mg OD	10-80mg OD (usual maintenance dose 20mg OD for hypertension)	
ARBs	Losartan	50mg OD (25mg OD if >75yrs old)	50-100mg OD	
	Candesartan	8mg OD	8mg-32mg OD	
CCBs	Amlodipine	5mg OD	5-10mg OD	- Increase after 2-4 weeks to maximum dose of 10mg OD - **Caution:** Interacts with simvastatin – consider switching to atorvastatin - Step 1: If amlodipine causes ankle oedema, consider using a thiazide-like diuretic instead of a CCB - **CI:** Unstable angina, aortic stenosis - **Side effects include flushing and headaches at initiation;** swollen ankles especially at higher doses
Thiazide-like diuretics	Indapamide (IR)	2.5mg OD	2.5mg OD	- Check baseline renal profile, then after 2 weeks, then at least annually. If potassium <3.5mmol/L or eGFR <25ml/min, stop indapamide and seek specialist advice
Aldosterone antagonist	Spironolactone	25mg OD	25mg OD	- Step 4: Spironolactone is the preferred diuretic at step 4, but is an unlicensed indication in resistant hypertension (BNF) - Consider only if **potassium ≤4.5mmol/**L (caution in reduced eGFR <30ml/min, as increased risk of hyperkalaemia). Monitor Na/K/renal function within 1 month and repeat 6 monthly thereafter - If K >4.5mmol/L should be stopped
α-B	Doxazosin (IR)	1mg OD	2-16mg OD (or BD dosing when dose >8mg/day)	- Consider at Step 4 if potassium ≥ 4.5mmol/L. Initial dose of 1mg usually increased after 1-2 weeks to 2mg OD - At doses above 8mg/day, consider split dosing from OD to BD to reduce BP variation - **Caution:** Initial dose postural hypotension, avoid in elderly as orthostatic hypotension risk
β-B	Atenolol	25mg OD	25-50mg OD	- Consider at Step 4 if potassium ≥ 4.5mmol/L. - Beta blockers may be considered in younger people and in those with an intolerance/CI to ACEI or ARBs, women of childbearing potential, co-existent anxiety/tachycardia/heart failure - **Particular caution in T2DM: symptoms of hypoglycaemia may be masked** - **Caution:** Increased risk of diabetes when beta-blocker is prescribed with a thiazide diuretic. Beta-blockers can cause bradycardia if combined with certain CCBs e.g. verapamil/diltiazem - **CI:** Asthma, 2nd/3rd degree AV block, severe PAD
	Bisoprolol	5-10mg OD	5-20mg OD	
	Related Drugs			
S	Atorvastatin	20mg OD	20-80mg OD	- Please see SEL IMOC guideline on lipid management: medicines optimisation pathways (Sept 2021) - Primary prevention 20mg, secondary prevention 40- 80mg (alternative is rosuvastatin)

AKI SICK DAY RULES[16] When patients have any of the following: **Vomiting, diarrhoea, or general dehydration** due to intercurrent Illness, advice to **STOP** taking the medicines listed below (restart after feeling well/after 24-48hrs of eating and drinking normally):

- **ACE Inhibitors**, **ARBs**, **Diuretics**, Metformin, NSAIDs, Sulfonylureas, SGLT2 inhibitors (e.g. Empagliflozin)

This guidance is aligned to SEL IMOC Hypertension 2021 guidance for Primary Care)

Hypertension review (at least annual)

	Tasks/Activity	Who?	Where?	Tools/Support
Review planning at practice level	**Call/recall planning:** Use Ardens/CES searches to help determine who to invite for review first e.g. BP >160/100mmHg recorded in the last year vs. those that are well controlled.	Admin colleague with clinician support (GP nurse/GP)	In practice or remotely via EMIS	EMIS searches e.g. CES Top priority Searches/Ardens searches
Pre-patient review	**Contact patient to:** 1. **Arrange bloods (renal function, FBC, lipids, HbA1c) & urine ACR** 2. **Arrange BP measurement** (in practice/machine at home), at least annually	HCA/GP Nurse/Pharmacist	Remote or F2F In practice/at home	AccuRx text messages Consider E-consult which has a BP review page (which can be sent via AccuRx) or the Doctaly Assist Hypertension flow on WhatsApp
Patient review	1. **Concerns + screen for symptoms/complications related to:** • **Hypertension** • **Hypotension (dizziness/nausea/weakness/confusion, BP <90/60mmHg)** 2. **Review BP trend** 3. **Review investigations:** blood + urine ACR results 4. **Re-calculate QRISK 2 or 3** (if appropriate) 5. **Discuss risk-reduction + life-style**: in context of QRISK 2 or 3 (BMI, smoking, alcohol, diet,activity) & COVID 6. **Mind + Body:** consider screening for mental health conditions 7. **Medication review**: concerns, side-effects, compliance, adherence, ensure renal function satisfactory and adjust medications if needed. Note that some drugs/substances can cause hypertension*	GP/GP Nurse/GP Pharmacist	Remote or F2F	Arden's template (for correct coding, annual review, medication review & Vital 5**recording) Brief-interventions around lifestyle
	8. **Self-management**	GP/GP Nurse or Social prescribing link worker & Patient/GP pharmacist		Self-management resources - send links via AccuRx: British Heart Foundation resources • Understanding your BP • 6 tips for reducing BP • BP and COVID-19 • Online Community for patients • Online programme about BP for patients
	9. **Follow-up plans: review BP monthly until it is at target**	GP/GP Nurse/GP Pharmacist/HCA		

*Drugs/other substances that can cause hypertension, include[4]
- combined oral contraceptives, corticosteroids, NSAIDs, sympathomimetics
- venlafaxine
- cyclosporine
- liquorice (present in some herbal medicines)
- alcohol, substances of abuse including cocaine

**Vital 5: Hypertension, smoking, BMI, alcohol intake and mental health.

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Health Inequalities in Hypertension

Our population - South East London (SEL)

The Black African and Black Caribbean population in SEL has greater prevalence of hypertension than any other ethnic group[1] and these individuals have higher risk of stroke due to hypertension, associated with worse outcomes[2]. In South London, these patients are more likely to have **hypertension and diabetes and be approx. 10 years younger when presenting with acute stroke** compared to White ethnicity stroke patients[3]. The drivers for these inequalities include overcrowded housing, higher levels of deprivation, unemployment, barriers to education attainment and racism[2,4].

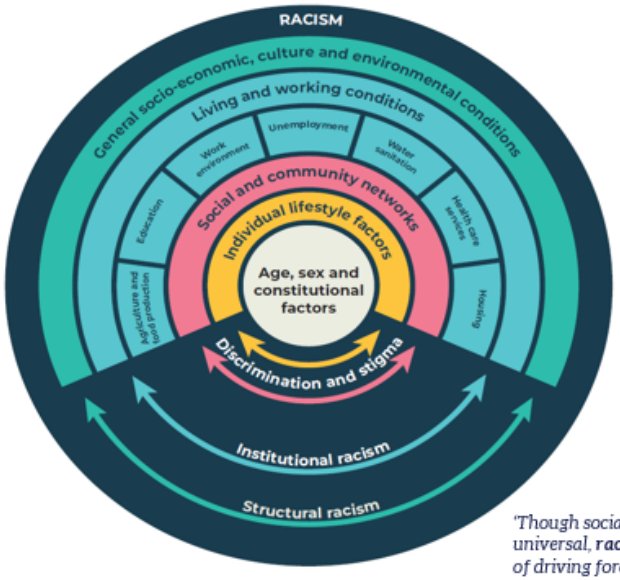
What people have told us [5]

Barriers to optimal hypertension detection and management include:

Trust – lack of trust in health services generally and not trusting individual healthcare professionals

Access – difficulties accessing services

Racism and the wider determinants of health



*'Though social determinants are universal, **racism** is one of a range of driving forces that exists in our societies and that acts on these determinants.'*[4,5]

Racism and the wider determinants of health

Individual actions

- Acknowledge that patients may have experienced racism in healthcare services.
- Re-establish trust with patient-centred consultations and shared decision making[6].

Team and system actions

- Undertake cultural humility training to acknowledge and challenge power imbalances and improve your understanding to support patients in their preferences for their hypertension care[2, 8]. There are many cultural awareness courses available, find one that has cultural humility at its core and essential components of self-reflection, understanding the impact of your own culture on others and the intent to neutralise patient-provider power imbalances.
- Access the SEL Hypertension Dashboard to better understand the ethnic mix of your hypertension patients[1].
- Ardens case-finder searches can identify those patients without their ethnicity coded in your practice, contact your CESEL facilitator for support
- Consider where you offer your service - community-based blood pressure testing and advice, including pharmacies, places of worship and community events, has high acceptability[9].
- Patents prefer face-to-face care, especially for a new diagnosis of hypertension[9].
- Encourage self-care and engagement for example home BP monitors and out of hours drop-in GP attendance for BP testing[9].

Southwark Patient Support

Patient resources

- **Practice connected social prescribing link worker**
- **Southwark free gym and swim**
- **Southwark Weight management programme**
- **Healthy weight advice and support in Southwark**
- **Southwark Sport and Leisure**
- **Southwark Wellbeing Hub Directory for community resources**
- **NHS England » The NHS Digital Weight Management Programme**
- **Southwark 'Exercise on Referral' Scheme** (see DXS)
- **British Heart Foundation: Preventing Heart Disease (resources for patients)**
- **Home BP measurements**
- **DASH diet**
- **Stop smoking services**
- **Southwark Healthy Lifestyle Hub**
- **(Active) Pharmacies providing Blood Pressure Checking Service and local SELGP Surgeries (May 2022) - Google My Maps**

See also page 8 under self-management for excellent BHF patient support

Shared resources

NICE has produced a document on shared decision making in the context of hypertension and it can be found here

Southwark Clinical Support

Urgent telephone advice- Consultant connect: Cardiology

Non-urgent 'Advice & Guidance'- Depending on the context: Hypertension clinic (GSTT), CKD clinic (GSTT), Diabetic medicine (GSTT/KCH), Obstetric medicine (GSTT), Pregnancy in Hypertension clinic (GSTT)

Virtual hypertension clinics- These are available for practices to organise via the community hypertension clinics (see below)

Community hypertension clinic- Referral criteria on form (see DXS). Can also provide hypertension drug related advice via email: gst-tr.KHPCommunityCVD@nhs.net

Specialist clinics- Refer via eRS to: Hypertension clinic (GSTT/KCH), Pre-conception counselling clinic (GSTT), Pregnancy in Hypertension clinic (GSTT), Obstetric Medicine clinic (GSTT) – for pregnant women with multiple co-morbidities, [CKD clinic (GSTT), Diabetic medicine (GSTT/KCH)]

References

Pages 2- 8

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Page 9: 'Health Inequalities in South East London' references

Thank you to the One London Hypertension Pathfinder Project and Mabadiliko for help developing this resource.

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Abbreviations

α-B – Alpha-blocker

ABPM –Ambulatory blood pressure monitoring

ACEI– Angiotensin converting enzyme inhibitor

ACR – Albumin-creatinine ratio

A&G – Advice & Guidance

AKI – Acute kidney injury

ARB- Angiotensin II receptor blocker

β-B – Beta-blocker

BD – Twice daily dosing

BMI – Body mass index

BP – Blood pressure

CCB – Calcium channel blocker

CI - Contraindication

CKD – Chronic kidney disease

Cr – Serum creatinine

CV - Cardiovascular

CVD – Cardiovascular disease

DASH diet – Dietary approaches to stop hypertension diet

DXS – Point-of-care tool for EMIS Web

ECG – Electrocardiogram (12-lead)

eGFR – Estimated glomerular filtration rate

eRS – Electronic referral system

FBC – Full blood count

GSTT – Guy's & St Thomas' NHS Trust

HF – Heart failure

K – Serum potassium

KCH – King's College Hospital NHS Trust

HbA1c – Haemoglobin A1c

HBPM – Home blood pressure monitoring

IHD – Ischaemic heart disease

IR – Immediate release

LVH – Left ventricular hypertrophy

Na – Serum sodium

NSAID – Non-steroidal anti-inflammatory drug

OD – Once daily (dosing)

PAD – Peripheral arterial disease

QOF – Quality and outcomes framework (contract)

QRISK*- refers to QRisk 2 or 3 - an algorithm that predicts 10-year CVD risk. EMIS is currently using QRISK2 (although QRISK3 was released in 2017)

Renal profile – this includes serum sodium/potassium/creatinine/eGFR

S- Statin

SELAPC – South East London Area Prescribing Committee

TFT – Thyroid function blood tests

TIA-Transient ischaemic attack

T2DM – Type-2 diabetes

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Contact CESEL at selccg.clinicaleffectiveness@nhs.net and/or visit https://selondonccg.nhs.uk/covid_19/clinical-effectiveness-sel/

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Making the right thing to do the easy thing to do.

July 2023 (review July 2024, or earlier if indicated)