

## Overview of Hypertension Guidelines for Bermuda

### CLASSIFICATION AND DIAGNOSIS OF HYPERTENSION

#### Classification of Hypertension and Recommendations for Follow-up

Category	Systolic	Diastolic	Follow-up recommended to determine diagnosis without acute end organ-damage
<b>Optimal BP</b>	<120	<80	Recheck in two years
<b>Normal BP</b>	120 – 129	80 - 84	Recheck in two years
<b>Pre-Hypertensive</b>	<b>130 – 139</b>	<b>85 – 89</b>	Recheck in one year*
<b>Stage 1 hypertension (mild)</b>	140 – 159	90 – 99	Confirm within two months If still stage 1 and no other risk factors prescribe lifestyle modification and sodium restriction for 6 months. If other risk factors present treat
<b>Stage 2 hypertension (moderate)</b>	160 – 179	100 – 109	Evaluate, treat, or refer to source of care within one month
<b>Stage 3 hypertension (severe)</b>	≥180	≥110	Evaluate and treat immediately or within one week depending on clinical situation and complications
<b>Isolated systolic hypertension 1</b>	≥140	<90	Confirm within two months
<b>Isolated systolic hypertension 2</b>	≥160	<90	Evaluate and treat immediately or within one week depending on clinical situation and complications

*Adapted: Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. 2004.*

**Pre-hypertension** is not a disease category, but identifies individuals at **high risk** of developing hypertension.

\* Provide lifestyle modification.

If systolic and diastolic categories are different, follow recommendations for the shorter time follow-up (e.g. 160/86 mm Hg should be evaluated or referred to source of care within one month).

### MANAGEMENT OF HYPERTENSION

#### Monitoring Schedule for Management of Hypertensive Patients

Blood pressure level	Monitoring interval
BP<140/90	Reassess in 3-6 months
BP 140-159/90-99 (Stage 1)	Reassess within 2 months
BP 160-179/100-109 (Stage 2)	Treat, reassess or refer within 1 month
BP>180/110 (Stage 3)	Treat, reassess or refer within 7 days as necessary
BP>220/120	Treat immediately and reassess within 1-3 days as necessary
Malignant hypertensive or emergency patients	Refer for in-hospital treatment immediately
Isolated systolic hypertension (SBP>140, DBP<90)	As for category corresponding to SBP
Isolated systolic hypertension (SBP>160, DBP<90)	As for BP>180/110

*Adapted from the following Guidelines: 1. National Heart Foundation of Australia (National Blood Pressure and Vascular Disease Advisory Committee). Guide to Management of Hypertension 2008 AND*

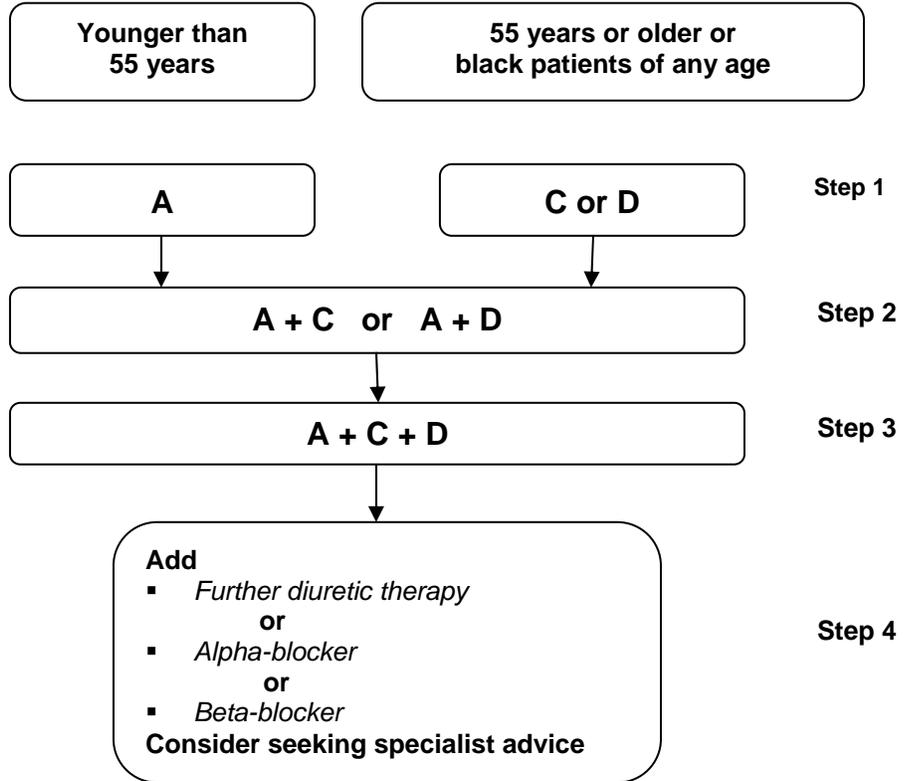
*2. US Department of Health and Human Services Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. 2004 AND*

*3. Caribbean Health Research Council: Managing Hypertension in primary care in the Caribbean. St. Augustine, Trinidad and Tobago: Caribbean Health Research Council 2007*

**ALGORITHM:  
CHOOSING DRUGS FOR PATIENTS NEWLY DIAGNOSED WITH HYPERTENSION**

**Abbreviations:**  
**A = ACE Inhibitor**  
 (consider angiotension-II receptor if ACE intolerant)  
**C = calcium-channel blocker**  
**D = thiazide-type diuretic**

**Black patients are those of African descent, and NOT mixed-race, Asian or Chinese patients**



**Beta-blockers**

- Beta-blockers are no longer preferred as a routine initial therapy for hypertension.
- But consider them for younger people, particularly:
  - Women of childbearing potential
  - Patients with evidence of increased sympathetic drive
  - Patients with intolerance of or contraindications to ACE inhibitors and angiotension-II receptor antagonists.
- If a patient taking a beta-blocker needs a second drug, add a calcium-channel blocker rather than a thiazide-type diuretic, to reduce the patient's risk of developing diabetes.
- If a patient's blood pressure is not controlled by a regime that includes a beta-blocker (that is, it is still above 140/90 mmHg), change their treatment by following the flow chart above.
- If a patient's blood pressure is well controlled (that is, 140/90 mmHg) by a regime that includes a beta-blocker, consider long-term management at their routine review. There is no absolute need to replace the beta-blocker in this case.
- When withdrawing a beta-blocker, step down the dose gradually.
- Beta-blockers should not usually be withdrawn if a patient has a compelling indication for being treated with one, such as symptomatic angina or a previous myocardial infarction.

Source: NHS, National Institute for Health and Clinical Excellence: NICE clinical guideline 34: Hypertension: The management of hypertension in adults in primary care. London: Royal College of Physicians, 2008<sup>6</sup>