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Meta-analyses of observational studies have shown that high blood pressure (BP) and hypertension are associated with an increased risk of cardiovascular disease (CDC), end-stage renal disease, subclinical atherosclerosis and mortality from all causes. The risk of hypertension depends on various genetic and environmental factors such as being overweight or obese; Diet; Alcohol consumption and fitness level. The American College of Cardiology (ACC) and the American Heart Association (AHA) have recently updated their guidelines on the prevention, detection, evaluation and treatment of high BP in adults. The ACC/AHA recommendations were based on a systematic review that examined the following questions: Is there evidence that BP's home monitoring (HBPM) and/or BP 'ABPM' exceed BP's office measurements by a health professional to prevent adverse outcomes and achieve better control over BP? What is the optimal purpose of BP for antihypertensive therapy in adults? In adults with hypertension, do different classes of antihypertensive drugs differ in their comparative advantages and harm? In adults with hypertension, is initiation of treatment of antihypertensive pharmacological monotherapy against combination therapy a comparative advantage and harm to specific health outcomes? Estimates of the prevalence of hypertension depend to a large extent on the choice of bran used to classify increased BP and hypertension, the methods used for diagnosis and the population studied. The prevalence of hypertension among U.S. adults is significantly higher when the definitions in this guide are used compared to the definitions in the seventh report of the Joint National Committee, but non-pharmacological therapy will be recommended for most patients with newly diagnosed hypertension based on current guidance. To prevent and treat hypertension, BP should first be classified as normal (less than 120 mmHg and less than 80 mmHg), increased (from 120 to 129 mmHg and less than 80 mmHg), stage 1 hypertension (from 130 to 139 mm Hg, systolic or 80 to 89 mmHg), or stage 2 of hypertension (at least 140 mmHg or at least 90 mmHg). Patients whose systolic and diastolic BPs are in different categories should be classified in the highest category (i.e. a patient with BP 128/82 mmHg should be diagnosed with stage 1 hypertension). While measuring BP in office settings is relatively easy, errors are common and can lead to misleading estimates of a true BP patient. Accurate measurements and records are essential for BP classification, install BP-related GSD risk, and guide the management of hypertension. Most systematic errors in BP measurement can be avoided by having sit quietly for five minutes before reading taken, supporting the limbs used to measure BP, BP, THE BP cuff is at heart level, using the correct cuff size, and blowing the cuff slowly. Because individual BP measurements tend to vary, one reading is insufficient for clinical decision-making. Using an average of two or three measurements taken in two or more isolated cases will minimize accidental error and provide a more accurate basis for evaluating BP measurements. Outside-office BP measurements in combination with telemedicine consultation or clinical interventions are recommended to confirm the diagnosis of hypertension and to tinge BP-reducing medications. ABPM is generally considered the best method outside the office, but HBPM is often a more practical approach. White coat hypertension is characterized by increased measurements of BP in an office setting, but normal readings on ABPM or HBPM. In contrast, hypertension in masks is characterized by normal office readings, but ABPM/HBPM readings are consistently above normal. The risk of CSE and mortality from all causes in people with disguised hypertension is similar to that of people with persistent hypertension and about twice as high as in people with normal BP. Some studies have found a slight increase in the risk of complications of THES and mortality from all causes in patients with white coat hypertension. The prevalence of white coat hypertension ranges from 13% to 35% in some populations. Adults with untreated systolic BP have more than 130 mmHg, less than 160 mm Hg, or diastolic BP over 80 mm Hg, less than 100 mm Hg. Art.com-screening for white coat hypertension using daytime ABPM or HBPM prior to diagnosis of hypertension. Masked hypertension screening with ABPM or HBPM is reasonable in adults whose untreated BP office has consistently been between 120 and 129 mmHg, 75 to 79 mm Hg. Physicians caring for patients with high levels of BP should focus on the overall health of patients, with a focus on reducing the risk of future adverse CSE outcomes. All patient risk factors should be managed in a comprehensive manner with a comprehensive set of non-pharmacological and pharmacological strategies. NONPHARMACOLOGIC INTERVENTIONSWeight loss is recommended to reduce BP in adults who are overweight or obese. A healthy diet and increased physical activity within the structured exercise program are recommended. Sodium intake should be reduced and potassium should be supplemented if contraindicated. Alcoholic beverages should be limited to two per day for men, or one per day for women. PHARMACOLOGIC TREATMENTSUse drugs to reduce BP are recommended for secondary prevention of recurrent cardiovascular events in patients with clinical ER and medium BP 130 mmHg, art or more systolic or 80 mm Hg, art or more diastolic. Medication recommended Primary prevention in adults with an estimated 10-year risk of atherosclerotic GSD 10% more and average BP BP 130 mm Hg, art or more systolic or 80 mm Hg, art or more diastolic. (Risk calculator is available at First-line agents include diuretic, calcium channel blockers and enzyme inhibitors that convert angiotensin, or angiotensin receptor blockers. The onset of BP-reduction therapy with two first-line agents of different classes (as individual agents or in a fixed dose combination) is recommended for adults with stage 2 hypertension and an average BP of more than 20/10 mmHg, above his goal. Therapy with one agent is reasonable in adults with stage 1 hypertension and target BP less than 130/80 mmHg. The dosage should be credited and additional agents added sequentially to achieve the BP goal. The simultaneous use of an enzyme inhibitor, converting angiotensin, or angiotensin receptor blocker, and/or renin inhibitor, is not recommended. Target BP is less than 130/80 mmHg. This is recommended for adults with confirmed hypertension and GCC or a 10-year atherosclerotic risk of 10% or more. The target is less than 130/80 mm Hg. Art may be reasonable for adults with confirmed hypertension, but without additional markers of increased risk of ERS. Targeted BPs for adults with hypertension and comorbidities are shown in Table 1.Adults with elevated BP or stage 1 hypertension, whose estimated 10-year risk of atherosclerotic ERHD is less than 10% should be treated with non-pharmacological interventions and re-evaluation within three to six months. Those with stage 1 hypertension, which is estimated to be 10% or more, should undergo therapy that reduces BP, combined with non-pharmacological interventions, and then undergo a re-evaluation within one month. Adults with stage 2 hypertension should be evaluated or referred to a primary care physician within one month, receive a combination of non-pharmacological interventions and drugs, reducing BP (with two agents from different classes), and undergo a re-evaluation within one month. Adults with very high BPs (systolic BP 180 mmHg or higher, or diastolic BP 110 mmHg and above) should be evaluated quickly and subject to drug therapy. Editor's note: The American Academy of Family

Physicians (AAFP) does not support the 2017 ACC/AHA Guide to Hypertension and continues to support the 2014 Evidence Guide to High Blood Pressure Management in Adults. AAFP also supports its 2017 guidance, which has been shared with the American College of Physicians: Pharmacological Treatment for Hypertension in adults age 60 or older and higher compared to lower blood pressure ( . For more information dr. Lefebvre's accompanying editorial and AAFP News ( . Leadership Source: American College College Is the heart association's assessment system used? YesSystematic literature search described? YesGuideline developed by participants without proper financial ties to the industry? NoRecommendations based on patient-oriented results? YesPublished Source: J Am Coll Cardiol. Published online on The Eve of Printing November 7, 2017 Available by: 2ERIN WESTFALL, DO, University of Minnesota Department of Family Medicine and Public Health, Mankato, Minnesota DANA BRANDENBURG, PsyD, University of Minnesota Department of Family Medicine and Public Health, Minneapolis, MinnesotaAm Fam Physician. 2018 March 15;97 (6): online. Are probiotics effective in treating symptoms of depression and anxiety? The combination of three probiotic species slightly improves symptoms in patients with severe depressive disorder. (SOR: B based on a small randomized controlled trial (RCT).) Lactobacillus casei itself does not affect depressive symptoms in patients with chronic fatigue syndrome, but it improves anxiety. (SOR: C, based on low quality small RCT.) A 2016 RCT assessed the clinical impact of probiotics on major depressive disorders.1 Forty patients between the ages of 20 and 55 who were diagnosed with a serious depressive disorder were recruited from an Iranian hospital. Treatment and control groups were well matched, with the exception of higher baseline fasting glucose levels in the probiotic group. Patients received a capsule containing three viable, freeze-dried probiotic strains (n No. 20; Lactobacillus acidophilus, 2 × 109 colonies per d; L. Casei, 2 × 109 CFU per g; and Bifidobacteria Bifidum, 2 × 109 CFU per d) or placebo (n No 20) each day for eight weeks. They were instructed not to change their normal physical activity or diet and to avoid any additional supplements or medications. There were no statistically significant differences in self-nutrition or activity. The result of the measure was the overall score on Beck Depression Inventory, a 21-point questionnaire scored 0 to 63, with scores as high as 30 indicating severe or extreme depression. Patients who received probiotic supplements had an average decline of 5.7 points compared to a decrease of 1.5 points in the placebo group (P 0.001). Differences remained after adjusting for baseline differences in fasting glucose levels. Limitations of the study included uncertainty as to which strain of the probiotic led to the effect of treatment, the duration of the study and the small sample size. 2009 RCT evaluated the effectiveness of probiotics on symptoms of depression and anxiety in 35 patients aged 18 to 65 who have been diagnosed with chronic fatigue syndrome.2 Patients completed Beck Depression inventory and Beck Anxiety inventory up before randomized L. casei at a daily dosage of 2.4 × 109 CFU per g (n No. 19) or placebo (n No. 16) for eight weeks. Patients in the probiotic group had a greater decrease after treatment anxiety scores compared to those in the placebo group (P 0.011). There was no difference in points on the Beck Depression inventory (P and .29). The limitations of the study include a small sample size, a short duration of study and a lack of reporting on numerical estimates, so the magnitude of the effect is unknown. Copyright © Family Doctors Requests Network. Used with permission. To see the full article, log in or buy access.1. Akkasheh G, Kashani-Poor S., Tajabadi-Ebrahimi M. et al. Clinical and metabolic response to probiotic administrations in patients with serious depressive disorder: a randomized, double-blind, placebo-controlled study. Power. 2016;32(3):315–320.2. Rao AV, Bested AC, BeaulneTM, et al. Randomized, Double-Blind, Placebo-Controlled Experimental Probiotic Study for Emotional Symptoms of Chronic Fatigue Syndrome. Gut Patog. 2009;1(1):6.Help Desk Answers provides answers to questions submitted by family practitioners in the Family Physicians Network (FPIN). Network members select questions based on their importance to family medicine. The responses are taken from an approved set of evidence-based resources and are peer-reviewed. The strength of the recommendations and the level of evidence for individual studies are assessed using criteria developed by the Evidence-Based Medical Working Group ( ). The complete database of questions and answers based on evidence is protected by the copyright of FPIN. If interested in submitting questions or writing answers for this series, go to or email: questions@fpin.org.This series is coordinated by John E. Delzell Jr., MD, MSPH, Deputy Medical Editor. A collection of FPIN's Support Responses published in AFP is available on 3UU.S. Preventive Care Trust ForceAm Fam Doctor. 2018 March 15;97 (6): online. As published in the U.S. Preventive Services Task Force.Related Putting Prevention in Practice: Screening for Thyroid Cancer USPSTF recommends against screening for thyroid cancer in imptomatic adults (table 1). Recommendation D. In 2013, the incidence of thyroid cancer in the United States was 15.3 cases per 100,000 people, which is a significant increase compared to 1975, when the incidence was 4.9 cases per 100,000 people.1 Growth was 6.7% per year from 1997 to 2009, but the rate of growth has slowed to 2.1% per year in recent years (2009-2013).1 Meanwhile, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Meanwhile, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Mean to, the change in mortality rate has only increased to 2.1% per year in recent years (2009-2013).1 Most thyroid cancer cases have a good prognosis.2 5-year survival rate for thyroid cancer overall is 98.1% and ranges from 99.9% for localized diseases to 55.3% 55.3% 3DETECTIONThe USPSTF found insufficient evidence to assess the accuracy of neck palpation or ultrasound as a screening test for thyroid cancer in amptomtic individuals. However, the USPSTF determined that the benefit amount could be limited as little as a small, relative rarity of thyroid cancer, the apparent lack of difference in outcomes between patients who are treated against only controlled (i.e. for the most common types of tumors), and observational evidence demonstrating no change in mortality over time after the introduction of the population screening program. HARMS OF EARLY DETECTION AND TREATMENTThe USPSTF has found insufficient direct evidence to assess the harm from screening for thyroid cancer in amptomtic individuals. USPSTF has found adequate evidence to link the magnitude of the overall harm from screening and treatment as at least moderate, based on adequate evidence of serious harm from thyroid cancer treatment and evidence that overdiagnosis and overdiagnosis are likely the consequences of screening. USPSTF ASSESSMENTThe USPSTF moderately concludes that screening for thyroid cancer in azimptomic individuals leads to harm that outweighs the benefits. This recommendation applies to screening in adults who are promptomatic. This does not apply to individuals who experience hriemping, pain, difficulty swallowing, or other symptoms of throat or persons who have lumps, swelling, neck asymmetry, or other reasons for neck examination. It also does not apply to people at increased risk of thyroid cancer due to a history of exposure to ionizing radiation (e.g. medical treatment or radiation fallout), especially those with low iodine content, hereditary genetic syndrome associated with thyroid cancer (e.g., family adenomatous polyposis), or a first-degree relative with a history of thyroid cancer.4.5ASSESSMENT OF RISKKaco USPSTF recommends against screening in the general asceptoma adult population Several factors significantly increase the risk of thyroid cancer, including a history of radiation exposure to the head and neck in childhood, exposure to radioactive fallout, a family history of thyroid cancer in a relative of the first degree, as well as some genetic diseases such as familial medullary thyroid cancer or multiple endocrine neoplasia syndrome (type 2A or 2B).4SCREENING TestsAlthough The USPSTF recommends anti-screening in the general amptomtic adult population. TREATMENT AND INTERVENTIONSSurgery (i.e. a full or partial thyroidectomy, with or without lymphadenectomy) primary treatment for thyroid cancer. Additional treatment, including radioactive iodine therapy, may be indicated, depending on the postoperative condition of the disease, the stage of the tumor and the type of thyroid cancer. External radiation therapy and chemotherapy are not usually used to treat early-stage differentiated thyroid cancer. To see the full article, log in or buy access. This recommendation statement was first published in JAMA. USPSTF recommendations are independent of the U.S. government. They do not reflect the views of the Agency for Health Research and quality, the U.S. Department of Health and Human Services, or the U.S. Public Health Service. Howlader N, Noone AM, Krapcho M et al, eds. SEER Cancer Statistics Review, 1975-2013. Bethesda, md.: National Cancer Insitute; 2016. . Access March 9, 2017.... 2. Cooper DS, Doherty GM, Haugen BR, etc.; American Thyroid Association (ATA) Guidelines Task Force on Thyroid Nodules and Differentiated Thyroid Cancer. Revised management guidelines for patiens with thyroid nodules and differentiated thyroid cancer published corrections appear in the thyroid gland. 2010;20 (6):674-675 and thyroid. 2010;20(8):942». Thyroid. 2009;19(11):1167–214.3. National Cancer Insitute. Cancer statistics: thyroid cancer. . Access March 9, 2017.4. American Cancer Society. Risk factors for thyroid cancer. . Accessed March 9, 2017.5. Lin JS, Aiello Bowles EJ, Williams SB, Morrison CC. Thyroid Cancer Screening: An Updated Evidence Report and a Systematic Review for the U.S. Preventive Services Task Force. Jama. 2017;317 (18):1888-1903 This summary is one of a series of excerpts from the UsPSTF Statement Recommendation. These statements relate to preventive health services for use in the clinical context of primary health care, including screening tests, consultations and preventive drugs. The full version of this statement, including supporting scientific evidence, evidence tables, classification system, USPSTF members at the time of completion of this recommendation, and links, is available on the USPSTF website for series coordinated by Sumi Sexton, MD, Editor-in-Chief of the USPSTF Recommendation Statement published by AFP available in . . aha/acc hypertension guidelines 2017. aha/acc hypertension guidelines 2020. aha/acc hypertension guidelines pdf. aha/acc hypertension guidelines 2019. aha/acc hypertension guidelines 2018. aha acc hypertension guidelines 2019. aha acc hypertension guidelines 2018. aha acc hypertension guidelines 2017 pdf

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