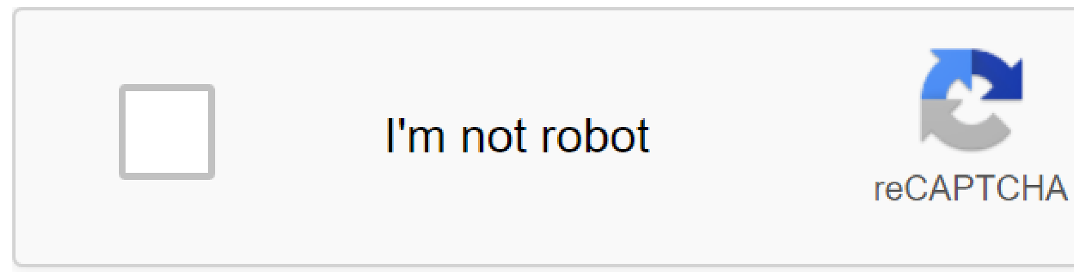
Jnc hypertension guidelines 2020 pdf



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CHICAGO, Illinois -- The long-awaited update of the guidelines for the treatment of hypertension, the eighth report of the Joint National Committee on the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC-8), will be published in late 2012. Previous guidelines (JNC-7) were last published in 2003. Suzanne Oparil, MD, Professor, Department of Medicine, Division of Cardiovascular Diseases, University of Alabama, Birmingham, and co-chair of the panel that developed these guidelines, discussed the process that contributed to the long delay in the publication of the JNC-8 guidelines at the 2012 American College of Cardiology (ACC) meeting. The new JNC-8 hypertension guidelines will answer 3 clinical questions: When to initiate drug treatment? How should low blood pressure (BP) be lowered? How do you get there? These questions have been identified to answer whether health outcomes in patients with hypertension are improved by initiating antihypertensive pharmacological therapy at specific BP thresholds, by achieving specific BP targets, as well as using various antihypertensive drugs or classes of drugs that differ in comparative benefits and harm. Dr. Oparil gave no indication of what specific recommendations would be. The development of JNC-8 clinical practice guidelines is part of an ongoing cardiovascular disease prevention program (CDC) sponsored by the National Heart, Lung and Blood Institute (NHLBI). Guidelines of the Adult Treatment Group for the treatment of elevated blood cholesterol and guidelines on overweight and obesity are developed simultaneously. Ultimately, these three guidelines will be integrated into one guiding principle to reduce the risk of GCC. Ensuring that the JNC-8 guidelines are firmly based on evidence is the reason that they have so much time to write, Dr. Oparil said. This increase in attention is a direct result of a 2001 report by the Institute of Medicine (IOM) on the qualitative divide, which notes that clinical decision-making is based on learning and experience. The report also promotes patient care based on the best scientific knowledge and the elimination of variability in health care. Dr. Oparil noted that only 3 of the ACC/American Heart Association guidelines have a high level of evidence (level A) for qgt;20% of the recommendations in the guide; the rest range from 15% to 55%. New adult guidelines sponsored by NHLBI, including JNC-8, will not look like previous guidelines, noted Dr. Oparil. They will be based solely on evidence, have more depth and rigor, be more and use evidence-based strategies to implement them, she explained. The practice guidelines will include a summary of the evidence on each clinical issue, graded evidence, graded recommendations and references. Increased attention to the level of evidence was created to ensure rigor and minimize bias, said Dr. Oparil, and it uses methods to meet many of the IOM's new standards for systematic reviews. Strict criteria for systematic literature search, assessment of the quality of research using tools for various studies, as well as data abstraction and the development of evidence tables were established. The quality of evidence is rated as low, moderate and high. The strength of the recommendations will range from A to conclusive evidence, B to moderate, C to weak, D vs. E to expert opinion, and N without any recommendations. The JNC-8 expert group is well represented, ranging from hypertension, primary health care, cardiology, nephrology, research methodology, evidence-based medicine, epidemiology and the development and implementation of guidelines and others. The rationale behind the clinical issues underlying the JNC-8 guidelines is to assess the evidence for THE 140/90 mm BP. Art. as the goal of treatment; determine whether this treatment threshold should be adjusted for specific diseases, comorbidities, characteristics or age; and determine whether there is evidence of improvement in results by reducing BP with a specific drug or class drug. The JNC-8 guidelines will provide practical guidance for patients aged ≥18 in a number of foreseeable subgroups such as diabetes, chronic kidney disease, GCC, elderly, gender, racial and ethnic groups, and smokers. Guidelines for Hypertension Screening have been issued by the following organizations: Joint National Committee (JNC) Joint National Committee (JNC) of the American College of Obstetricians and Gynecologists (ACOG) Department of Veterans Affairs (VA)/Ministry of Defense (DOD) European Society of Hypertension (2) ESH/European Society of Cardiology (ESC) Joint European Society of Hypertension (ESH) 2013 and guidelines of the European Society of Cardiology (ESC) recommend the inclusion of outpatient blood pressure monitoring (ABPM) in the assessment of cardiovascular risk and hypertension factors. A comparison of blood pressure screening recommendations is shown in Table 4 below. Table 4. Guidelines for Adult Blood Pressure Screening (Open Table in the New Window) Issue of the Organization's Year Screening Population Screening Interval European Society of Cardiology /European Society of Hypertension (ESC/ESH) 2018 All Adult Office Measurements at regular intervals based on blood pressure levels: Healthy people with optimal office blood pressure (120/80 mmHg). remeasure, if seen before. Patients with normal blood pressure (120-129/80-84 mm Article): At least every 3 years. Patients with high normal blood pressure (130-139/85-89 mmHg): annually. U.S. Preventive Services Task Force (USPSTF) (USPSTF) (127) 2015 Adults ≥18 ≥18 without known measurements of hypertension outside the clinical setting should be obtained for diagnostic confirmation before treatment begins. No evidence of a single gold standard protocol for HBPM or ABPM has been found. However, both can be used in conjunction with a proper office measurement to make diagnosis and management management and treatment options. Each year, adults aged ≥40 and those at high risk of high blood pressure, including those with high normal blood pressure (130-139/85-89 mmHg), are overweight or obese, or Afro-American. Adults aged between ≥18 and 40 years old with normal blood pressure (≤130/85mm Hg) without known risk factors should be tested every 3-5 years of the Seventh Prevention Report, Detection, Evaluation, and Treatment of the Joint National Committee on High Blood Pressure (JNC 7) 2003 Adults aged ≥18 years Diagnosis based on an average of 2 or more sitting blood pressure readings on each of two or more office visits At least once every 2 years in adults with blood pressure of less than 120/80 mmhg. and every year in those with levels of 120-139/80-89 mm Hg. Art. American College of Obstetricians and Gynecologists (ACOG) 2013 All women aged ≥13 years Office measure annually as part of the routine of the well female care Department of Veterans Affairs / Department of Defense (VA/DoD) 2014 All adult office measurements; Diagnosis based on 2 readings at 2 separate visits; For patients where the diagnosis remains uncertain, monitoring of blood pressure at home (2-3 times a day for 7 days) or 24-hour outpatient monitoring to confirm the diagnosis is periodic, preferably annually, during regular preventive care or health assessment; European Society of Hypertension /European Society of Cardiology (ESH/ESC) (126) 2013 All adult office measurements; Diagnosis based on at least 2 indications with 2 separate visits; Consider home blood pressure monitoring or 24-hour outpatient monitoring to confirm a diagnosis during regular preventive care or health evaluation in the United States, the most widely used blood pressure classification for adults 18 years of age and older from the 2003 Seventh Report of the Joint National Committee for the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7), as follows: Normal: Systolic Below 120th. 1, diastolic below 80 mm Hg. Diastolic 80-89 mm Hg Stage 1: Systolic 140-159 mm Hg. art., diastolic 90-99 mm Hg. Stage 2: Systolic 160 mm Hg. art or more, diastolic 100 mm Hg. However, in 2017, the American College of Cardiology/American Heart Association (ACC/AHA) updated its principles for prevention, detection, evaluation and management of high blood pressure in adults, eliminating the classification of prehypertension and dividing it into two levels: High blood pressure with systolic systolic between 120 and 129 mm Hg. and diastolic pressure of less than 80 mm Hg. Hypertension, with systolic pressure from 130 to 139 mm Hg. 80 to 89 mm Hg. In 2013 and 2018, the ESH/ESC guidelines use the following classification system, which was first introduced in the 2002 guidelines No. 9, 126 : Optimal: Systolic below 120 mmHg. art and diastolic below 80 mm Hg. Normal: Systolic 120-129 mm Hg. Art and/or diastolic 80-84 mm Hg. High normal: Systolic 130-139 mm Hg. Art and/or diastolic 80-84 mm Hg. Art.85-89 mm Hg. Article 1: systolic 140-159 mm Hg. Art and/or diastolic 90-99 mm Hg. Art 2: systolic 160-179 mm Hg. Art or more and/or diastolic 100-109 mm Hg. Art: Systolic 180 mm Hg. art or more and/or diastolic 110 mm Hg. Art or more isolated systolic hypertension: 140 mm Hg. art or more and diastolic below 90 mm Hg. Both of the above classifications are based on an average of two or more indications taken during each of the two or more visits after initial screening. The Blood Pressure Trust was provided in guidelines from the following organizations: Joint National Committee (JNC) European Society of Hypertension (ESH)/European Society of Cardiology (ESC) American Heart Association/American College of Cardiology/American Society of Hypertension (AHA/ACC/ASH) American Heart Association/American College of Cardiology (ACC/ASH) On Disease Control and Prevention (AHA/ACC/CDC)) The American Society of Hypertension /International Society of Hypertension (ASH/ISH) Department of Veterans Affairs (VA)/Department of Defense (DOD) American Diabetes Association (ADA) American College of Cardiology /American Heart Association (ACC/AHA) Group has been empaneled to write the eighth United National Committee (JNC8) but this work was terminated by the National Heart, the Lung and Blood Institute (NHLBI). In 2014, the Journal of the American Medical Association published an article commonly referred to as JNC 8, but there are no official JNC 8 guidelines authorized by NHLBI, and JNC 8 has not been approved by the AHA, ACC or many other organizations that approved JNC7. A comparison of the recommendations for targeted blood pressure for guidelines issued by different organizations is shown in Table 5 below. Table 5. Recommendations for Targeted Blood Pressure (Open Table in the New Window) Issue of the Organization's Year Blood Pressure Trust Seventh Report of the Joint National Committee for the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) 2003 All adults except for people with diabetes or chronic kidney diseaseAdults with diabetes or chronic kidney disease qlt; 140/90 mmHg. 130/80 mm Hg. Article 8th Report of the Joint National Committee for the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 8) 2014 Adults aged 60 years and those with diabetes or chronic kidney diseaseAdults age ≥60 ≥60 140/90 mm Hg. 150/90 mm Hg. Art. European Society of Hypertension/European Society of Cardiology (ESH/ESC) 2013 All adults except people with diabetesAdults with diabetes 140-150 mm Hg. Art. consider 140 mm Hg. If the patient is healthy and healthy; For ages ≥80 years, the patient's mental capacity and physical health should also be considered if the orientation is on the zlt; 140 mm Hg; 85 mmHg. Art. Diastolic BP American Heart Association/American College of Cardiology/American Society of Hypertension (AHA/ACC/ASH)) TIA, carotid artery disease, peripheral artery disease or abdominal aortic aneurysm of the aorta; 150/90 mmHg. 140/90 mm Hg. 130/90 mm Hg. 80 mm Hg. Art. American Heart Association/American College of Cardiology (ACC)/Centers for Disease Control and Prevention (AHA/ACC/CDC) American College of Cardiology/American Heart Association (ACC/AHA) 2017 All adults Art. American Society of Hypertension/International Society for Hypertension (ASH/ISH) 2014 Adults aged 18-79 yearsDo the age of ≥80 years of zlt; 140/90 mmHg. Art. The 130/80 mm hg BP target can be considered in young people's 150/90 mm Hg Department of Veterans Affairs /Ministry of Defense (VA/ DoD) with diabetes qlt; 150/90 mmHg. 150/85 mm Hg. Article American Diabetes Association (ADA) 2016 Adults with diabetes; 140/90 mmHg. Art. 130/80 mm Hg. Article Target May Be Appropriate in Young People of the American Diabetes Association (ADA) 2017 Adults with Diabetes 140/90 mmHg. Art. 130/80 mm Hg. Art may be suitable for those at high risk of cardiovascular disease (if achievable without undue burden of treatment) CAD and coronary heart disease; MYMD MYOCARD; TIA is a transient ischemic attack. SPRINT Trial should note that, in addition to the ADA guidelines, existing guidelines on BP's target years were developed prior to the Systolic Blood Pressure Intervention (SPRINT) study, which was sponsored by nihsit studies that demonstrated a 25% reduction in cardiovascular events or death with a systolic BP orientation of less than 120 mmHg. Art. vs. 140 mm Hg. Art. in patients with an increased risk of cardiovascular disease. These intriguing results show the benefits of more intensive BP targets than recommended in the existing guidelines. However, the generalization of sprint results remains unclear. It is important to note that the SPRINT trial excluded patients with diabetes or prior to cerebrovascular accident. These populations were studied earlier in accord and SPS3, respectively, which failed to demonstrate significant benefits for strict BP targets below 120-130 mmHg. (90, 134) It is also important to recognize that the SPRINT test used OSCillometric method of BP without the human involvement, which usually gives systolic BP, which mm Hg. this is lower than the standard office BP used in most studies. This suggests that BP's lower systolic target in the SPRINT test may be closer to more moderate targets in other studies, and that the strict systolic BP targeting is 120 mmHg. Art in standard clinical practice can increase the rate of adverse events such as hypotension, electrolyte abnormalities, and acute kidney injuries. A large meta-analysis of hypertension studies that tested BP's systolic targets (including the SPRINT test) demonstrated a reduction in cardiovascular outcomes and overall mortality with a systolic BP target below 130 mmHg. , although the value of the benefit decreased with BP targets gradually below 150 mmHg. Future guidelines are likely to include sprint test results in BP's targeted recommendations, which may reduce targeted BPs, at least for patients with high cardiovascular risk, but without diabetes or previous cerebrovascular accidents. There are many guidelines for managing hypertension. The two most widely used recommendations are the seventh report of the Joint National Committee for the Prevention, Detection, Evaluation and Treatment of High Blood Pressure (JNC 7) for 2003 and the annual updated guidelines of the American Diabetes Association (ADA). In 2013, both JNC 8 and updated joint guidelines from the European Society of Hypertension/European Society of Cardiology (ESH/ESC) were issued. In 2014 and 2015, the guidelines were issued by the following organizations: American Heart Association/American College of Cardiology/American Society of Hypertension (AHA/ACC/ASH) (AHA/ACC/ASH) (130) American Hypertension Society/International Hypertension Society (ASH/ISH) (132) Department of Veterans Affairs/Department of Defense (VA/DOD) ACC/AHA, as well as the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) have issued guidelines for the prevention, detection, evaluation and management of high blood pressure in adults and the elderly, respectively. The main messages of JNC 7 were as follows: The goals of antihypertensive therapy is to reduce cardiovascular and renal morbidity and mortality, with a focus on controlling systolic BP, since most patients will achieve diastolic CONTROL of BP when systolic BP is achieved prehypertension (systolic 120-139 mmHg). Art., Diastolic 80-89 mmHg) requires healthy lifestyle changes to prevent progressive growth of BP and cardiovascular disease In uncomplicated hypertension, thiazide diuretics, either alone or in combination with drugs from other classes, should be used for pharmacological treatment in most specific conditions of high There are strong signs for the use of other antihypertensive drug classes (e.g., angiotensin conversion enzyme ACE inhibitors, ACE, receptor blockers ,ARBs), beta blockers, calcium channel blockers) Two or more antihypertensive drugs will be required to achieve the BP target (LT; 140/90 mmHg, or 130/80 mmHg) for patients with diabetes and chronic kidney disease For patients whose BP is more than 20 mmHg. art above the systolic target of BP or more than 10 mm Hg. above BP's diastolic goal, initiating therapy using 2 agents, One of which, usually to be a thiazid diuretic, should be considered regardless of therapy or care, hypertension will be monitored only if patients are motivated to stay on their treatment plan In 2016 Standards of Care for Diabetes, ADA makes the following recommendations for high blood pressure control : The onset of pharmacotherapy is recommended for all diabetic patients with confirmed office blood pressure. Art. Treatment with a regime that includes either ACEI or ARB; If one class is not allowed, the other may be replaced by several therapy medications (including thiazid diuretic and ACEI/ARB, in maximum doses) is generally required to achieve the blood pressure goals of serum creatinine/estimated rate of glomerular filtration (eGFR) and serum potassium levels should be monitored in patients receiving ACEIs, ARBs, or diuretics ADA has issued updated guidelines for patients with hypertension and diabetes in 2017, namely: Blood pressure should be measured at each routine clinical visit. Patients diagnosed with high blood pressure (≥140/90 mmHg) should have blood pressure, confirmed by several indications, including measurements on a separate day, to diagnose hypertension. All hypertensive patients with diabetes should have home blood pressure monitored to detect white coat hypertension. Orthostatic blood pressure measurements should be performed during the initial assessment of hypertension and periodically on subsequent, or when symptoms of orthostatic hypotension are present, and regularly if orthostatic hypotension has been diagnosed. Most patients with diabetes and hypertension should be treated to a systolic blood pressure goal of the zlt; 140 mm Hg and Diastolic Blood Pressure Target 90 mm Hg. Lower systolic and diastolic blood pressure targets, such as 130/80 mm Hg, can be appropriate for individuals at high risk of cardiovascular disease if they can be achieved without undue burden of treatment. For patients with systolic artery pressure, 120 mmHg. art or diastolic blood pressure of 80 mm Hg. By example, lifestyle intervention consists of weight loss when overweight or obese; Dietary approaches to stop (DASH) in the style of the dietary model, including reduced sodium content and increased potassium intake; Increased consumption of fruits and vegetables; Moderation in alcohol consumption and increased physical activity. Patients with confirmed office blood pressure ≥140/90 mm Hg. art should, in addition to the lifestyle of life timely titing of pharmacological therapy to achieve blood pressure goals. Patients with confirmed office blood pressure ≥160/100 mmHg. Art. should, in addition to lifestyle therapy, have an operational onset and timely arousal of 2 drugs or a single-accurate combination of drugs, demonstrated to reduce cardiovascular events in diabetic patients. Treatment of hypertension should include medical classes demonstrated to reduce cardiovascular events in patients with diabetes: ACEI, ARB, thiazid-like diuretics, or dihydropyridin calcium channel blockers. Multi-drug therapy is usually required to achieve blood pressure goals (but not a combination of ACEIs and ARBs). ACEI or ARB, at the maximum allowable dose specified for the treatment of blood pressure, is the recommended first line of treatment for hypertension in patients with diabetes and urine albumin-creatinine ratio of ≥300 mg/ g of creatinine or 30-299 mg/getty in cretinin. If one class is not allowed, the other should be replaced. For patients treated with ACEI, ARB, or diuretic, serum creatinine/estimated speed of glomerular filtration and serum potassium levels should be monitored. Pregnant women with diabetes and pre-existing hypertension or mild gestion hypertension with systolic blood pressure of 160 mmhg. Art, diastolic blood pressure; 105 mmHg. art., and no evidence of damage to the final organ should be treated with pharmacological antihypertensive therapy. Pregnant patients with diabetes and pre-existing hypertension who are treated with antihypertensive therapy, systolic or diastolic blood pressure targets are 120-160/80-105 mmHg. it is proposed to optimize long-term maternal health and fetal growth. The ACC/AHA 2017 guidelines exclude the classification of prehypertension and divide it into two levels no.1, 2 : (1) increased BP, with systolic pressure (SBP) between 120 and 129 mmHg. (DBP) less than 80 mmHg. (2) stage 1 hypertension, with SBP from 130 to 139 mm Hg. 80 to 89 mm Hg. In adults with an increased risk of heart failure (HF), optimal BP in people with hypertension should be less than 130/80 mmHg. Adults with HFrEF (HF with reduced emission fraction) and hypertension should be prescribed GDMT (directional management and therapy guidance) to achieve BP less than 130/80 mmHg. Art. Nondihydropyridine calcium channel blockers (CCBs) are not recommended in the treatment of hypertension in adults with HFrEF. Adults with hypertension and chronic kidney disease (CKD) should be treated before the BP target of less than 130/80 mmHg. After a kidney transplant, it is prudent to treat patients with hypertension to the BP target of less than 130/80 mmHg. Art. After a kidney transplant, it's reasonable patients with calcium antagonist hypertension based on improved global filtration rate (GFR) and Survival. Immediate reduction of SBP to less than 140 mm Hg. Art. in adults with spontaneous intracerebral hemorrhage (ICH), who are present for 6 hours after the acute event and have SBP between 150 mmHg. Art. and 220 mm Hg. do not benefit to reduce mortality or severe disability and can be potentially harmful. Adults with acute ischemic stroke and elevated BP who are eligible for intravenous (IV) tissue activator (tPA) should have their BP slowly dropping to below 185/110 mmHg. before the start of thrombolytic therapy. In adults with acute ischemic stroke, BP should be less than 185/110 mmHg. until the introduction of the IV tPA and should be maintained below 180/105 mm Hg. at least the first 24 hours after the start of drug therapy. For adults who experience stroke or transient ischemic attack (TIA), treatment with thiazide diuretic, ACEI, or angiotensin receptor blocker (ARB), or a combination treatment consisting of thi diuretic plus ACEI, is helpful. Adults with untreated SBP have more than 130 mmHg. less than 160 mm Hg. DBP more than 80 mm Hg. less than 100 mm Hg. Art., reasonably screened for white coat hypertension using either daytime ABPM (ambulatory BP monitoring) or HBPM (home BPM) prior to diagnosis of hypertension. In adults with untreated office BPs that are constantly between 120mm Hg and 129 mm Hg for SBP or between 75mm Hg and 79mm Hg for DBP, screening for camouflaged hypertension with homemade BPM (or ABPM) is reasonable. In adults with hypertension screening for primary aldosteron is recommended in the presence of any of the following concomitant conditions: resistant hypertension, hypokalemia (spontaneous or substantial, if induced diuretic induced), randomly detected adrenal mass, family history of early onset of hypertension or stroke at a young age (lt; 40 years). Adult men and women with increased BP or hypertension, who currently drink alcohol, should be advised to drink no more than two and one standard drink per day, respectively. Two or more antihypertensive drugs are recommended to achieve the BP target of less than 130/80 mmHg. Art. in most adults with hypertension, especially in black adults with hypertension. Pregnant women with hypertension should not be treated with ACE, ARB or direct renin inhibitors. The use of drugs, reducing BP, is recommended for secondary prevention of recurrent cardiovascular disease (CCC) in patients with clinical CDC and an average SBP of 130 mmHg. or above or on average DBP 80 mm Hg. Art. and above, and for primary prevention in adults with an estimated 10-year atherosclerotic cardiovascular disease (ASCVD) risk of 10% or higher and an average SBP of 130 mmHg. or above or above or average DBP 80 mm Hg. Or higher. The use of BP-reducing medication is recommended for primary prevention of GSS in adults without a history of GSD and and it is estimated that the 10-year risk of ASCVD is below 10% and SBP is 140 mmHg. or above or DBP 90 mm Hg. art or above. Adults with elevated BP or stage 1 hypertension who have an estimated 10-year risk of ASCVD below 10% should be administered with non-pharmacological therapy and re-evaluated BP within 3 to 6 months. Adults with stage 1 hypertension, who are estimated to have a 10-year risk of ASCVD 10% or higher, should be administered initially with a combination of non-pharmacetic and antihypertensive drug therapy and have a re-evaluation of BP in 1 month. For adults with very high average BP (e.g. SBP ≥180 mmHg or DBP ≥110 mmHg), an assessment followed by prompt antihypertensive medication is recommended. The simultaneous use of the ACE inhibitor, ARB and/or renin is potentially harmful and is not recommended for the treatment of adults with hypertension. The American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) have issued their guidelines for hypertension in adults age 60, including the following 72 : Clinics should start treatment in patients age 60 and older who have persistent SBP at or above 150 mmHg. to achieve the goal of less than 150 mm Hg. to reduce the risk of stroke, heart events and death. If patients aged 60 and over have a history of stroke or transient ischemic attack or have a high cardiovascular risk, doctors should consider starting or increasing drug therapy to achieve SBP of less than 140 mmHg. to reduce the risk of stroke and heart events. Consider initiating or stepping up pharmacological treatment in some adults age 60 and older with a high cardiovascular risk based on a case-by-case assessment, to achieve a target SBP of less than 140 mmHg. to reduce the risk of stroke and heart events. Factors include comorbidities, drug burdens, risk of adverse events and cost. Typically, an increased risk of cardiovascular disease includes known cardiovascular disease, diabetes or chronic kidney disease with a glomerular filtration rate of less than 45 ml/min/1.73 m 2. The Scientific Recommendations for The Treatment of Hypertension, issued in November 2013 as part of a joint effort by the American Heart Association (AHA), the American College of Cardiology (ACC) and the Centers for Disease Control and Prevention (CDC), describe the criteria for successful hypertension management algorithms and advocate for algorithms that can be incorporated into the systemic approach to high BP, as well as modified to accommodate different conditions and patients. The AHA/ACC/CDC Joint Algorithm in the report includes the following recommendations No.131, 137 : BP: The recommended target of 139/89 mmHg. art or less hypertension stage 1 BP 140-159 mm Hg. or DIAstolic BP 90-99 mm Hg. Art.): It can be treated with lifestyle modifications and, if necessary, thiazid diuretic stage 2 2 (systolic BP zgt;160 mmHg or diastolic BP zgt;100 mm Hg): It can be treated with a combination of diuretic and ACEI tiazide, angiotensin receptor blocker or calcium channel blocker, which do not meet the goals of BP: Doses of drugs can be increased and/or a drug from another class can be added to treatment in June 2013, the European Society of Hypertension (ESH) and the European Society of Cardiology (ESC) have issued new guidelines for managing hypertension, recommending that all patients, except special population groups such as patients with diabetes and the elderly, be treated below 140 mmHg. The recommendations of the new ESH and ESC guidelines include 125, 126 : In patients under 80 years of age, BP's systolic target should be between 140 and 150 mmHg. but doctors can go below 140 mmHg. If the patient is healthy and healthy; The same advice applies to the octogenarian, however, the patient's mental capacity and physical health should also be considered if the orientation is less than 140 mmHg. Patients with diabetes should be treated below 85 mmHg. Diastolic salt intake of BP should be limited to approximately 5 to 6 grams per day body mass index (BMI) should be reduced to 25 kg/m2 and waist circumference should be reduced to less than 102 cm in men and less than 88 cm in women outpatient monitoring OF BP (ABPM) should be included in the risk assessment Effective combination therapy includes thiside medication with ARB, calcium channel antagonists, or ACEIs; or, calcium channel antagonists with ARBs or ACEIs Double blockade of the renin-angiotensin system (i.e., ARBs, ACEIs, and direct renin inhibitors) are not recommended due to risks of hyperkalemia, low BP and kidney failure Joint Guidelines were issued in 2013 by the American Society of Hypertension and the International Society of Hypertension (ASH/ISH) with the aim of providing international priming with general information, especially for communities and low-resource countries. On its website, ash warns that these guidelines should be viewed more as an expert opinion, given that they are not systematically evidence-based and have not been developed using the guidelines development protocol provided by the Institute of Medicine (IOM). Recommendations for treatment for hypertensive patients with or without another serious disease are presented in Table 6, below. Table 6. American Society of Hypertension / International Society for the Treatment of Hypertension Recommendations (Open Table in the New Window) Patients without other basic medical conditions of the first line of drugs Added 2nd drug (if necessary to achieve the goal of BP) Added 3rd drug (if necessary to achieve the goal of BP) African African) CCB or thiazid diuretic ARB or ACEI Combination CCB plus ACEI or ARB plus thiazid diuretic white and other non-African-born ages of zlt; 60 years ARB or ACEI CCB or thiazid diuretic combination CCB plus ACEI or ARB plus thiazid diuretic white and other non-African ages ≥60 years of CCB or tiazida; ARB or ACEI are also effective ARB or ACEI; CCB or thiazid diuretic, if ARB or ACEI used the first combination of CCB plus ACEI or ARB plus thiazid diuretic underlying disease Diabetes (white and other non-African origin) ARB or ACEI CCB or thiazid diuretic alternative 2nd drug (CCB or tee Diabetes (African origin) CCB or thiazid diuretic ARB or ACEI Alternative 1st drug (CCB or thiazid diuretic) Chronic kidney disease ARB or ACEI CCB or thiazid urine Alternative to the 2nd drug (CCB or thiazid diuretic) coronary heart disease beta-blocker plus ARB or ACEI CCB or thiazid diuretic Alternative 2nd drug (CCB or thiazid diuretic) Stroke ACE I or ARB CCB or thiazid diuretic alternative 2nd drug (CCB or thiazid diuretic) symptomatic heart failure beta-blocker plus ARB or ACEI plus diuretic plus spironolacton regardless of BP; CCB can be added if necessary to control BP ACEI and an enzyme inhibitor that converts angiotensin; ARB and angiotensin receptor blocker; BP and blood pressure; CCB is a calcium channel blocker. In 2014, the Department of Veterans Affairs/Department of Defense (VA/DoD) released an update on its 2004 guidelines for diagnosing and managing hypertension in primary care facilities. Initiation of pharmacotherapy is recommended for all adults with systolic BP ≥160 mm Hg. art or diastolic BP ≥90 mm Hg. art, as well as adults with a history of stroke, transient ischemic attack, or askiptomatic carotid artery disease and systolic BP ≥140 mmHg. Treatment can also be considered for adults aged ≥60 years with systolic BP zlt; 160 mmHg. Art. Combination therapy should be started for adults with systolic BP zgt;20 mm Hg. art or diastolic BP zgt;10 mm Hg. above the target. Additional recommendations include the following 129 : Thiazide type diuretic as first-line therapy either as monotherapy or in combination with other chlortalidon or indapamide drugs is preferable to hydrochlorothiazide For patients, who cannot tolerate thiazide-type diuretics, or as an additional therapy for patients who do not reach their hypertensive target with diuretic-type thiazide, or for those who start combination therapy: ACEIs or ARBs (but not both together); long-acting dihydropiridine calcium blockers For patients with chronic kidney disease, ACEIs or ARBs to improve kidney outcomes in African Americans, recommend against ACEIs or ARBs as monotherapy in African Americans with stage 1-3 chronic kidney disease, a combination of thiazide-type diuretic (for cardiovascular protection) either with ACEI or or or (to protect the kidneys) JNC 7 and AHA-ASA Lifestyle Change Recommendations Seventh Report of the Joint National Committee for Prevention, Detection, evaluation and treatment of high blood pressure (JNC 7) recommendations to reduce blood pressure (BP) and reduce the risk of cardiovascular disease include the following, with great results achieved when 2 or more lifestyle changes are combined : Weight loss helps prevent hypertension (range of approximate systolic reduction of BP (SBP), 5-20 mmHg per 10 kg); Recommendations include the DASH (Dietary Approaches to Stopping Hypertension) Diet (range of approximate reduction of SBP, 8-14 mmHg), which is rich in fruits and vegetables and encourages the use of skimmed or skimmed milk and dairy products Limiting alcohol consumption by no more than 1 ounce (30 ml) of ethanol per day for men (i.e. 24 ounces of beer, 10 ounces of wine, 2 ounces of 100-proof whiskey or 0.5 ounces (15 ml) of ethanol per day for women and people with lighter weight (range of approximate reduction of SBP, 2-4 mmHg) Reduced sodium intake to no more than 100 mmol/d (2.4 g sodium or 6 gides of sodium chloride; range approximately SBP reduction , 2-8 mmHg) Maintain adequate dietary potassium intake (approximately 90 mmol/d) Maintain adequate dietary calcium and magnesium intake for general health Stop smoking and reduce the intake of saturated fat and cholesterol for general cardiovascular health Participation in aerobic exercise for at least 30 minutes daily for most days (approximately the range of reduction SBP, 4-9 mm Hg. Art.) 2010 American Heart Association-American Stroke Association (AHA-ASA) guidelines for primary stroke prevention makes the following recommendations: Hypertension: AHA-ASA guidelines recommend regular blood pressure screening, lifestyle changes, and medication therapy; a lower risk of stroke and cardiovascular events is observed when systolic blood pressure levels are below 140 mmHg. and diastolic blood pressure is less than 90 mmHg. In patients with hypertension with diabetes or renal disease, the goal of BP is below 130/80 mmHg. Diet and nutrition: a diet low in sodium and high in potassium is recommended to reduce BP; diets that promote the consumption of fruits, vegetables and low-fat dairy products, such as the DASH-style diet, help reduce BP and may reduce the risk of physical activity in stroke: increased physical activity is associated with a reduced risk of stroke; The goal is to participate in 30 minutes or more moderate-intensity activities on a daily basis Obesity and the distribution of body fat: weight loss in overweight and recommended to reduce BP and stroke risk In 2013, the American College of Emergency Physicians (ACEP) released an update to its 2006 guidelines for hypertension in the emergency department (ED), which focused treatment of hypertensive urgency. Recommendations include: Patients with ED with aymptomatic markedly high blood pressure, regular screening for acute trauma of the target organ (e.g., serum creatinine, urinalis, electrocardiogram (ECG) are not required. in patients with poor follow-up), screening for elevated serum creatinine levels can determine kidney injury, which affects the location (e.g., hospitalization) in patients with asymptomatic markedly elevated blood pressure, regular ED medical intervention is not required in certain patient populations (e.g., poor observation is available), emergency physicians can treat noticeably elevated blood pressure in ED and/ or initiate therapy Long-term monitoring (Consensus recommendation) Patients with asymptomatic markedly elevated blood pressure should be directed to outpatient follow-up (Consensus recommendations) 2017 American College of Cardiology/American Heart Association (ACC/AHA) guidelines for hypertension and emergencies include the following : Take adults with a hypertensive emergency in the intensive care unit for continuous MONITORING monitoring and damage to targeted organs, as well as for parenteral administration of appropriate medication. For adults with a persuasive condition (e.g., aortic dissection, severe pre-eclampsia or eclampsia, or feochromocytomy crisis), below SBP below 140 mmHg. art for the first hour and below 120 mm Hg. Art in the dissection of the aorta. For adults without compelling conditions, reduce SBP to a maximum of 25% within the first hour; then, if the patient is clinically stable, lower the BP to 160/100-110 mmHg. for the next 2-6 hours, then gently normal for the next 24-48 hours. Hypertensive disorders during pregnancy are classified into four following categories, as recommended in 2000 by the National High Blood Pressure Education Group on High Blood Pressure During Pregnancy (Preeclampsia is imposed on chronic hypertension of gestion hypertension (transitional pregnancy hypertension or chronic hypertension identified in the second half of pregnancy); this terminology is preferable to the old but widely used term pregnancy-induced hypertension (PIH) because it is more accurate. However, JNC 7 classifies hypertensive disorder during pregnancy as follows (see table 7, below) : Chronic hypertension pre-eclampsia Chronic hypertension with imposed pre-eclampsia Gestension Transitional Hypertension 2013 American College of Obstetricians and Gynecologists (ACOG) uses a classification system similar to JNC 7. Obstetricians and Gynecologists of Canada (SOGC) has released revised guidelines that classify hypertension during pregnancy as follows: Preexisting Hypertension Gestational Hypertension Preeclampsia Other Others Effects (transitional hypertensive effect, hypertensive white coat effect, masked hypertensive effect) Table 7. JNC 7 Classification of Hypertensive Disorder During Pregnancy (Open Table in the New Window) Classification Characteristics Chronic Hypertension SBP ≥140 mm Hg. or DBP ≥90 mm Hg. Art, currently pre-pregnancy or up to 20 weeks of gestation and the persistence of 12 weeks of postpartum pre-eclampsia SBP ≥140 mm Hg. or DBP ≥90 mm Hg. art with proteinuria (300 mg/24 h), which develops at 20 weeks of gestation; Can progress to eclampsiaSha occurs in pregnant women, multiple pregnancies, women with hypertension ≥4 years, family history of pre-eclampsia, previous hypertension during pregnancy, and renal disease Chronic hypertension with imposed pre-eclampsia New-onset proteinuria after 20 weeks of pregnancy in a hypertensive woman or in a woman with hypertension and Proteinuria up to 20 weeks of pregnancy: After 20 weeks of pregnancyMay be preprotein phase preeclampsia or recurrence of

chronic hypertension, which subsided in the middle of pregnancyMay lead to pre-eclampsiaNorther cases may cause higher rates of preterm birth and slowing growth in relation to mild pre-eclampsia Transition Hypertension Diagnosis made retrospectively returned to normal at 12 weeks after giving birthMay recur in subsequent pregnanciesProcation of the future of the ACT - aspartate aminetransferase; BP and blood pressure; DBP - diastolic BP; SBP systolic BP Specific Guidelines for Managing Hypertension During Pregnancy have been issued by the American College of Obstetricians and Gynecologists (ACOG), Society of Obstetricians and Gynecologists of Canada (SOGC). In addition, recommendations for managing hypertension during pregnancy are included in broader guidelines for the management of hypertension from the following organizations: the Joint National Committee (JNC) European Society of Hypertension (ESH)/European Society of Cardiology (ESC) American Diabetes Association (ADA) JNC 7 recommends treatment of women with chronic (already existing) hypertension and no evidence of end-of-body damage, the blood pressure of which is 150-160. ≥ art or 100-110 mm Hg. or in women with BP ≥140/90 mm Hg. art. which have gestational hypertension, subclincal organ damage, or symptoms. AcOG 2013 guidelines recommend that pregnant women with chronic hypertension be treated with antihypertensive drugs, levels of BP should be maintained between 120/80 mmHg. 160/105 mm Hg. Art. During pregnancy, fetal safety largely directs the choice of antihypertensive agent. Methyldopa is usually the preferred first line agent because of its security profile. Other drugs that can be considered include labatole, beta-blockers, and diuretics. ACOG does not recommend the use of any of the following 142 : ACE REBs Renin inhibitors of mineralocorticoid receptors antagonists Severe hypertension There is a consensus between the guidelines (JNC 7, ESH/ESC, ACOG, SOGC) for the need to acutely manage severe hypertension, defined as systolic BP ≥160 mmHg. art or diastolic BP ≥110 mm Hg. art or both, in order to prevent maternal stroke and avoid intrauterine growth restriction (IUGR). In 2015, the Committee on Obstetric Practice of the American College of Obstetricians and Gynecologists published updated guidelines Regarding emergency treatment of acute severe hypertension during pregnancy, including the following: Acute onset, severe hypertension, which is accurately measured using standard methods and is persistent for 15 minutes or longer is considered a hypertensive intravenous emergency (IV) labetalal and hydralasin has long been considered the first line of medication to manage acute onset, severe hypertension in pregnant and postnapartmental women; Available evidence suggests that oral nifedipine can also be considered as a first-line therapy parenteral laboratory should be avoided in women with asthma, heart disease, or congestive heart failure When urgent treatment is needed before IV access is established, oral nifedipine algorithm can be initiated as IV access is currently obtained, or 200-mg doses of labatalal can be administered orally; The latter can be repeated within 30 minutes if the corresponding improvement is not observed with magnesium sulfate not recommended as an antihypertensive agent, but it remains the drug of choice to prevent seizure in severe pre-eclampsia and to control seizures in eclampsia sodium nipropusid should be reserved for extreme emergencies and used for the shortest amount of time possible due to concerns about cyanide and thiocyanate and increased intracranial pressure with the potential deterioration of brain swelling in the mother's adoption standardized, Evidence-based clinical guidelines for the treatment of patients with pre-eclampsia are necessary; individuals and institutions should have mechanisms in place for the operational onset of medication when the patient poses with hypertensive hypertension and diabetes in pregnancy In pregnant patients with diabetes and chronic hypertension, ADA 2016 Medical Service in Diabetes recommends blood pressure targets of 110-129/65-79 mmHg. to optimize long-term maternal health and minimize fetal growth impairment. ACEIs and ARB are during pregnancy. The 2017 ADA statement on diabetes and hypertension states that antihypertensive pharmacotherapy is not needed for pregnant women with diabetes and pre-existing hypertension or mild hestation hypertension with SBP below 160 mmHg. DBP below 105 mmHg. art. and no evidence of damage to the final organ. For pregnant women with diabetes and pre-existing hypertension on antihypertensive therapy, the proposed BP targets SBP 120-160 mm Hg. DBP target 80-105 mm hg. jnc 8 hypertension guidelines 2020. jnc 9 hypertension guidelines 2020. jnc hypertension guidelines 2020 pdf. jnc hypertension guidelines 2020 algorithm

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