



HYPERTENSION

What is blood pressure?

Blood pressure is the force required to circulate blood throughout the body. As the heart contracts, the pressure within the blood vessels rises to a maximum or top blood pressure. This is called the systolic blood pressure. When the heart relaxes the blood pressure falls to a minimum or bottom blood pressure. This is called the diastolic blood pressure. The normal systolic blood pressure is about 120 mm Hg (millimeters of mercury) and the average diastolic blood pressure is about 80 mm Hg. This is reported as 120/80 or 120 over 80 mm Hg. Elevation of blood pressure is present when the systolic blood pressure is above 140 mm Hg or the diastolic blood pressure is above 90 mm Hg. The condition of having elevated blood pressure is called hypertension. In the majority of patients with hypertension the cause cannot be found. Genetics and heredity may play a role. In 5 to 10 % of patients a reversible cause for hypertension may be identified. Environmental factors such, as excess salt intake will raise someone's blood pressure. Other modifiable causes of hypertension include excessive calorie intake, obesity, inactivity, excessive alcohol consumption, low potassium intake, smoking and stress. In fact eliminating fast food from the diet will lower your blood pressure significantly.

Hypertension is common and present in about 10% of the adult population or about 2 million people in Canada. For the most part patients with hypertension are under diagnosed and under treated. The Canadian Heart Health Survey has shown that only 42% of patients are aware that they have hypertension, 19% are not treated and not controlled, 23% are treated and not controlled and only 16% of hypertensive patients are treated and controlled.

What are the risks of high blood pressure?

Excessive elevation of blood pressure can have long term effects. High blood pressure will lead to thickening of the heart's muscle. This condition is called hypertrophy and is a risk factor for a heart attack. Elevated blood pressure can also lead to stroke, vascular damage, and kidney failure. For the most part high blood pressure has no associated symptoms unless complications develop. Hypertension has been called the silent killer.

If blood pressure is quite high patients may experience headaches, fatigue, and shortness of breath or dizziness. High blood pressure is particularly dangerous in those patients with other cardiac conditions such as coronary artery disease or leaking heart valves. In conditions such as diabetes it is especially important to normalize blood pressure to prevent progressive kidney and organ damage. Elevated systolic blood pressure in the elderly population is one of the major risk factors for stroke.

Can high blood pressure be treated?

Yes. In addition to modifying diet, exercise and lifestyle there are many medications that can be used to control blood pressure. Often small doses of a diuretic or another medication are sufficient. In some patients combination therapy is required and in other patients certain agents are used for special or specific reasons such as angiotensin converting enzyme (ACE) inhibitors or angiotensin receptor blockers (ARB's) in diabetic patients with protein in their urine (evidence of kidney damage), and calcium channel blocking agents in the elderly with systolic hypertension. Medical evidence shows that aggressive treatment of blood pressure will reduce the risk of stroke and cardiovascular events considerably.

For more details regarding specific medications that control blood pressure, see our medication information sheets on www.cvtoolbox.com. If you have further questions please discuss them with your physician.

HOP TO ITT BLOOD PRESSURE CALENDAR

HOP to ITT BP Calendar may be downloaded as a PDF or interactive EXCEL spreadsheet from www.cvtoolbox.com

1. Monitor BP in AM before arising and 2-3 times a day after 5 minute rest.
2. Average daily and weekly systolic and diastolic readings.
3. Normal BP is Systolic ≤ 135 /Diastolic ≤ 85 for home BP monitoring. *

Condition	BP Treatment Targets
Treatment target & initiation threshold for elderly (Age ≥ 80 - CHEP 2013 or ≥ 60 - JNC-8)	150/90
Treatment target & initiation threshold for office BP measurements	< 140/90
Treatment target for Ambulatory BP or Home BP measurement	Awake <135/85 or 24h mean <130/80
Treatment target for T2DM +/- nephropathy	< 130/80
Normal BP (LV Dysfunction <120/80 - AHA 2007)	< 120/70

VALIDATED HOME BP DEVICES: OMRON: HEM-705CP, HEM-711AC, HEM-712C, HEM-739AC, HEM 757-CAN, HEM 780
AND LIFESOURCE: (AND) UA-767 CN, UA-767 Plus, UA-774 AC, UA-779, UA 787 AC

Sys/Dias	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
WEEK 1	Monitor BP 4 times daily, every day for the first week.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 2	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 3	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 4	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/

WEEK 5	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 6	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 7	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 8	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 9	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 10	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/

Sys/Dias	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
WEEK 11	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 12	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 13	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 14	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 15	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/
WEEK 16	Monitor BP 4 times daily, two days/week—choosing one weekday and one weekend day.						
AM	/	/	/	/	/	/	/
NOON	/	/	/	/	/	/	/
PM	/	/	/	/	/	/	/
BED	/	/	/	/	/	/	/
Average	/	/	/	/	/	/	/

* Reference Values For Self Recorded Blood Pressure - A Meta-analysis of Summary Data. Thijs et al. Arch Int Med. 1998; 158:481-488

GUIDE FOR COMPREHENSIVE RISK REDUCTION

Rx ✓	Intervention	Recommendations															
	Smoking: Goal -Complete cessation	Strongly encourage patient and family to stop smoking. Provide counselling, nicotine replacement, and formal cessation programs as appropriate.															
	Lipid Management: Primary goal * LDL < 2.0 (1.8) mmol/L	Start hypolipidemic diet in all patients: ≤ 30% fat, < 7% saturated fat, < 200mg/day cholesterol. 10% LDL ↓ achievable with diet. Assess fasting lipid profile. Baseline lipid profile < 24 hrs. after acute event. In post-MI patients, lipid profile may take 4 to 6 weeks to stabilize. Add drug therapy according to the following guide:															
	Secondary goal * Non-HDL Chol ≤ 2.6 mmol/L; Apo-B < 0.8 g/L Tertiary goal * Metabolic Syndrome TC/HDL < 4.0mmol/l HDL > 1.0mmol/l (men)/ > 1.3mmol/l (women) <i>2012 Update-CCS GUIDELINES for the Dx and Tx of Dyslipidemia for the Prevention of CVD</i>	<table border="1" data-bbox="419 541 1381 758"> <thead> <tr> <th>Lipid Profile</th> <th>1st Line Therapy</th> <th>2nd Line Therapy</th> </tr> </thead> <tbody> <tr> <td>LDL ↑</td> <td>Statin</td> <td>Ezetimibe</td> </tr> <tr> <td>LDL ↑↑ & TG</td> <td>Statin</td> <td>Comb. Therapy Ezetimibe, Niaspan or Fibrate</td> </tr> <tr> <td>LDL ↑ & TG ↑↑</td> <td>Fibrate or Niacin/Niaspan®</td> <td>Combination Therapy</td> </tr> <tr> <td>TG ↑ & HDL ↓</td> <td>Fibrate or Niacin/Niaspan®</td> <td>Combination Therapy</td> </tr> </tbody> </table> <p>* Primary goal: For patients CHD Risk equivalent: any of CAD, TIA, CVA, AAA, PVD/bruits, DM with one additional categorical risk factor or for patients with very high 10-year risk for total CV events (20%).</p> <ul style="list-style-type: none"> • Target initial Rx medication dose required to achieve target LDL < 2.0 (1.8) mmol/L or ≥ 50% LDL ↓ • For 10 yr CV risk for hard endpoints 10-20%, LDL Rx threshold is 3.5 mmol/L target ≥ 50% LDL ↓ • For 10 yr CV risk for hard endpoints < 10%, LDL Rx threshold is 5.0 mmol/L target ≥ 50% LDL ↓ • Consider CRP measurement for males >50 & females >60. Initiate lipid lowering if CRP >2.0 mg/L <p>For specific medications and dosing strategy see Lipid Optimization Tool</p>	Lipid Profile	1 st Line Therapy	2 nd Line Therapy	LDL ↑	Statin	Ezetimibe	LDL ↑↑ & TG	Statin	Comb. Therapy Ezetimibe, Niaspan or Fibrate	LDL ↑ & TG ↑↑	Fibrate or Niacin/Niaspan®	Combination Therapy	TG ↑ & HDL ↓	Fibrate or Niacin/Niaspan®	Combination Therapy
Lipid Profile	1 st Line Therapy	2 nd Line Therapy															
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TG ↑ & HDL ↓	Fibrate or Niacin/Niaspan®	Combination Therapy															
	Hypertension Goal < 150 systolic (Age ≥ 80) < 140/90 (non-diabetic CKD) < 135/85 (Home BP) < 130/80 (DM+/-CKD) < 120/80 (LVD) <i>AHA 2007</i> 2013 CHS CHEP www.hypertension.ca Measure BP at all appropriate visits. Assess overall cardiac risk. Home BPM an important monitoring tools. Treat to target. Lifestyle modifications to reduce BP and CV risk. Lifestyle and Rx to achieve BP targets. Combination Rx. Focus on adherence.	<ul style="list-style-type: none"> • Assess BP at all visits. Assess global CV risk. Lifestyle modifications are cornerstone of anti-hypertensive and anti-atherosclerotic therapy. • Initiate Rx immediately if hypertensive urgency. Dx HTN on second visit if : target organ damage, DM, chronic kidney disease (CKD) or BP > 180/110. Dx HTN on 3rd visit if BP ≥ 140-179 or ≥ 90-109 • Validate hypertension with: 1) Office BP (< 140/90), ambulatory BP (< 135/85 daytime average/ or 130/80-24 hr average) or Awake ABPM ≥ 135 or 85. 24-hour ≥ 130 or 80 DM, or 130/<80 DM, and/or DM nephropathy. Target < 140/90 (non diabetic CK.), < 120/80 LVD. AHA. • Initial Rx for systolic/diastolic HTN in absence of compelling indication: Low dose thiazide; β-blocker if age < 60 yr; ACE-I in non-black pts; long-acting CCB and ARB. ISH: LDD/ DHP-CCB/ARB. Combination therapies generally necessary to achieve target BP. • Consider Rx ASA (once BP controlled) and statin in HTN patients if ≥ 3 CV risks. • CHF&HTN-Rx β-blocker; ACE-I (ARB if ACE-I intolerant) & aldosterone antagonist (Class III/IV HF or post MI). Thiazide or loop diuretics, DHP-CCB. • CKD or Type 2 DM with micro-albuminuria, proteinuria or nephropathy ACE-I/ARB are 1st line Rx. Combination of ACE-I and ARB not recommended in non-proteinuric CKD. • In DM if ACE combination therapy required: ACE-DHP CCB preferable to ACE-thiazide combinations (ACCOMPLISH) 															
	Diabetes CDA 2013 guidelines.diabetes.ca Guidelines Released April 2013	<ul style="list-style-type: none"> • Dx DM: FPG ≥ 7.0 mmol/L or 2 hr PC Glucose ≥ 11.1 mmol/L (Normal A1C < 5.5; FPG < 5.6 mmol/L; 2 hr PC FPG < 7.8 mmol/L). Dx Impaired Glucose Tolerance: FPG < 6.1 mmol/L and 2 hr PC PG 7.8-11.0 mmol/L. • At diagnosis target euglycemia ASAP: A1C ≤ 8.5 - Initiate diabetes education, diet to achieve weight loss (5-10%), exercise and lifestyle (+/- metformin). If not at target 2-3 mo - Start/Increase metformin. If A1C > 8.5 start metformin immediately. Consider initial combination therapy. If symptomatic hyperglycemia with metabolic decompensation, initiate insulin immediately. • Aggressive BP Control (Target < 130/80). Rx: ACE-i, ARB, DHP-CCB, thiazide diuretic, then cardio-selective β blocker or non-DHP-CCB. Alpha blockers not recommended as first line agent. • Vascular Protection: Macro/microvascular disease: Statin + ACEi or ARB + Antiplatelet (ASA or clopidogrel). DM > 15 years and age > 30 years: statin. 															

Rx ✓	Intervention	Recommendations
	<p>Physical activity: Minimum goal 30 mins of moderate activity 5 times a week. Cumulative 150 mins/week. See website exercisemedicine.ca</p>	<ul style="list-style-type: none"> • Assess risk, preferably with exercise test, to guide prescription. • Encourage minimum of 30 minutes of moderate intensity activity 5-7 times weekly (walking, jogging, cycling or other aerobic activity) supplemented by an increase in daily lifestyle activities (e.g., walking breaks at work, using stairs, gardening, household work) • Max benefits 5 to 6 hours per week. Medically supervised programs for moderate to high-risk patients. Resistance exercise 3 times/week does not adversely influence BP.
	<p>Obesity/weight management:</p>	<p>Start intensive diet and appropriate physical activity intervention, as outlined above, in patients >120% of ideal weight for height. Particularly emphasise need for weight loss in patients with hypertension, elevated triglycerides or elevated glucose levels. Ideal body weight BMI < 25</p>
	<p>Antiplatelet agents/ anticoagulants:</p>	<p>Start aspirin 81-325 mg per day if not contraindicated. Consider clopidogrel 75mg OD post MI, post CABG, CVA, PVD in ASA intolerant or allergic patients CAPRIE Trial. Consider clopidogrel 75mg OD + ASA for ACS: unstable angina/non-ST elevation MI CURE Trial: duration of therapy 9-12 months. No chronic benefit of ASA+ clopidogrel CHARISMA. Consider alternate antiplatelet therapy for post MI patients unable to take ASA or dual antiplatelet therapy for up to a year post ACS/PCI (Clopidogrel, Ticagrelor or Prasugrel post ACS with PCI).</p>
	<p>ACE inhibitors/ARBs Post MI/LV Dysfunction:</p>	<p>Start early post-MI in stable high risk patients (anterior MI, previous MI, Killip class II (S3 gallop, rales, radiographic CHF). Continue indefinitely for all with LV dysfunction (EF<40%) or symptoms of CHF. Use as needed to manage HPT or symptoms in all other patients. In ACEi intolerant patients consider Valsartan VALIANT or Candesartan CHARM.</p>
	<p>ACE inhibitors/ARBs Vascular Disease/ Diabetes</p>	<p>Rx ACE inhibitors in all patients >55 yrs with evidence of vascular disease or DM and one other risk factor: HOPE Trial - Ramipril 2.5 → 10 mg OD or all CAD patients >18 yrs EUROPA Trial -Perindopril 4 → 8 mg OD. If LVF preserved, patient non diabetic and other risk factors optimized may not need ACE inhibitor PEACE.</p>
	<p>Beta-blockers: Post-MI</p>	<p>Start acutely or within a few days of event in all post-MI patients (unless contra-indication). Continue indefinitely if residual ischemia, heart failure LV dysfunction, heart failure, severe LV dysfunction with EF < 40% or symptomatic arrhythmias. No mortality benefit of Beta blockers beyond 1 year post MI, in chronic CAD without MI or in patients with CAD risk factors. (JAMA, Vol 308, No. 13, pp. 1340-1349). Rx as needed to manage angina or HTN.</p>
	<p>Beta-blockers: CHF</p>	<p>Rx Add Beta-blocker to ACE-inhibitor/diuretic/+/- digoxin in stable Class II-IV CHF/LVEF ≤ 40% Bisoprolol 1.25 → 10 mg OD, carvedilol 3.125 mg BID → 25 mg BID (50 mg BID if weight > 85 kg) or nebivolol 1.25 → 10 mg daily (Titrate q 2 weeks. Avoid mod-high dose in the elderly).</p>
	<p>Omega-3 fatty acids HOMOCYST(E)INE</p>	<p>Rx: Omega-3 fatty acids 1-3 gm/day. No identifiable benefit in lowering elevated homocysteine with vitamin supplements combining folic acid, B6 and B12 in patients with CVD, DM or post MI. HOPE 2/NORVIT.</p>
	<p>Estrogens</p>	<p>HRT not recommended for 1° or 2° prevention. Stop HRT in ACS, MI, PTCA, CABG, CHF, other surgery.</p>

