NHS North West London

Practical Guidelines for Hypertension

This document provides practical guidelines for Allied Healthcare Professionals and other clinicians to support hypertension diagnoses and recommended actions.

External resources

- Hypertension in adults: diagnosis and management NICE guidelines [NG136] Last updated: 21st November 2023: https://www.nice.org.uk/guidance/ng136.
- NICE CKS Hypertension. Last updated: March 2025: https://cks.nice.org.uk/topics/hypertension/
- NICE Hypertension in adults: diagnosis and treatment https://www.nice.org.uk/guidance/ng136/resources/visual-summary-pdf-6899919517 or scan the QR code
- North London Severe Hypertension guidelines: https://www.nwlondonicb.nhs.uk/download_file/9979/0
- On treatment BP target: https://www.nature.com/articles/s41371-025-01055-z

Primary Care Considerations Before Referring: Essential Hypertension

Diagnosis

If **clinic BP ≥ 140/90 mmHg**:

- Offer **ABPM** (ambulatory BP monitoring) to confirm diagnosis
- If ABPM not suitable, offer **home BP monitoring**

If **BP 130–139/85–89 mmHg** and **high cardiovascular risk** or suspected **masked hypertension**:

- Consider ABPM/home monitoring (if resources allow)

Hypertension diagnosis = **Daytime average BP ≥ 135/85 mmHg** (via ABPM/home)

Investigations

Assess for organ damage:

- Proteinuria
- Fundoscopy
- Blood tests: glucose, HbA1c, U&Es (yearly bloods for patients on ACE inhibitors/ARB), eGFR, cholesterol (total & HDL)
- **12-lead ECG**

Estimate 10-year CVD risk:

- Use **QRISK3** or **Joint British Societies** tool
- **Heart Age**: Use NHS tool: Heart Age Calculator

BP Targets

- **Age <80 years**:
  - Clinic BP <140/90 mmHg (lower when feasible/tolerable)
  - ABPM/HBPM <135/85 mmHg
- **Age ≥80 years**:
  - Clinic BP <150/90 mmHg (lower when feasible/tolerable)
  - ABPM/HBPM <145/85 mmHg
- **Postural Hypotension**:
  - Base target on **standing BP**
- **Frailty/Multimorbidity**:
  - Use **clinical judgement**

Lifestyle Advice

- **Weight**: Ideal BMI = 18.5-24.9 kg/m2. *If South Asian, Chinese, other Asian, Middle Eastern, Black African, or African-Caribbean family background Ideal BMI = 18.5 to 23 kg/m2.
- **Salt Intake**: Target <6g/day; reduce processed food intake (bread etc.)
- **Physical Activity**: 30 mins/day at least 5 days per week
- **Diet**: ≥5 portions of fruit/veg, less saturated fat
- **Caffeine**: ≤4-5 cups/day
- **Alcohol**: ≤14 units/week; drink-free days
- **Smoking Cessation**
- **Hypotension**: Consider if BP ≤90/60 mmHg with symptoms (e.g. dizziness, weakness)

* National Institute for Health and Care Excellence (NICE). (2013). BMI: preventing ill health and premature death in black, Asian and other minority ethnic groups. Public health guideline [PH46]. Retrieved from: https://www.nice.org.uk/guidance/ph46

<table>
<tr><th>Blood pressure (mmHg)</th><th colspan="2">Recommended action</th></tr>
<tr><td>Normal BP:
NICE: BP reading <140/90 (ABPM/HBPM <135/85)</td><td colspan="2">• Check BP at least every 5 years and annually if clinic BP ≥ 135/85 mmHg
• If evidence of target organ damage, consider alternative causes</td><td>Recheck in 5 years if no CVD risk factors present
Recheck annually if CVD risk factors present
For type 2 Diabetes: check BP annually regardless of QRisk</td></tr>
<tr><td rowspan="2">Stage 1 hypertension:

BP reading
140/90 to 159/99 mmHg (ABPM or HBPM average 135/85 to 149/94 mmHg)</td><td colspan="2">• Offer ABPM (or HBPM if ABPM is declined or not tolerated)
• Investigate for target organ damage
○ Assess cardiovascular risk</td><td rowspan="2">• Age >80 with clinic BP >150/90 mmHg:
○ Offer lifestyle advice and consider drug treatment
• Age <80 with target organ damage, CVD, renal disease, diabetes or 10-year CVD risk ≥10%:
○ Offer lifestyle advice and discuss starting drug treatment
• Age <60 with 10-year CVD risk <10%:
○ Offer lifestyle advice and consider drug treatment
• Age <40:
○ Consider specialist evaluation of secondary causes and assessment long-term benefits and risks of treatment

On-treatment BP target

For patients on treatment for hypertension, BP target < 130/80 mmHg (measured by 7-day average HBPM or day-time average ABPM or office BP*) or ALARA without causing unacceptable side-effects, and within 6-months of initiating treatment, for all adults.

Possible subgroups to whom this may not apply are those who are frail and/or have limited life expectancy where higher targets may be appropriate based on clinical judgement and the individuals' tolerance to treatment.

*Among people with diagnosed white-coat hypertension out-of-office measurements should always be used to evaluate treatment.</td></tr>
<tr><td>Stage 2 hypertension:

BP reading
160/100 to 179/119 mmHg (ABPM or HBPM average ≥150/95 mmHg)</td><td colspan="2">• Offer lifestyle advice and discuss starting drug treatment
• Assess for target organ damage immediately:
○ If target organ damage is present → start drug treatment immediately (no need for ABPM/HBPM)
○ If no target organ damage:
• Repeat clinic BP within 7 days or
• Use ABPM or HBPM, with a clinical review within 7 days</td></tr>
<tr><td>ABPM vs HBPM</td><td colspan="2">It is suggested that
• ABPM is used for diagnosis of hypertension, assessing nocturnal BP and dipping status or resistant hypertension.
• HBPM is used for ongoing monitoring to improve patient engagement and adherence to treatment and detecting white coat effect in stable patients.</td><td>
<table>
<tr><th>Scenario</th><th>Best First Option</th><th>Alternative</th><th>Notes</th></tr>
<tr><td>New hypertension</td><td>ABPM</td><td>HBPM</td><td>ABPM more accurate for diagnosis</td></tr>
<tr><td>Stroke/TIA</td><td>ABPM</td><td>HBPM (monitoring)</td><td>Nocturnal BP important</td></tr>
<tr><td>Pregnancy</td><td>HBPM</td><td>ABPM rarely needed</td><td>Use pregnancy-validated devices</td></tr>
<tr><td>White coat/masked HTN</td><td>ABPM</td><td>HBPM</td><td>ABPM more sensitive to both</td></tr>
<tr><td>Resistant hypertension</td><td>ABPM</td><td>HBPM</td><td>Helps avoid overtreatment</td></tr>
<tr><td>Elderly/frail</td><td>HBPM</td><td>ABPM (with caution)</td><td>Comfort and usability are key</td></tr>
<tr><td>Suspected hypotension</td><td>ABPM</td><td></td><td></td></tr>
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Severe hypertension: **BP reading** ≥180/120 mmHg	North London Severe Hypertension guidelines: https://www.nwlondonicb.nhs.uk/download_file/9979/0	Refer for same-day specialist review if: • retinal haemorrhage or papilloedema (accelerated hypertension) or • life-threatening symptoms or • suspected pheochromocytoma • Age <40: Consider specialist evaluation of secondary causes and assessment long-term benefits and risks of treatment
	Assess for target organ damage as soon as possible: • If target organ damage, consider starting drug treatment immediately without ABPM/HBPM • If no target organ damage, confirm diagnosis by: – repeating clinic blood pressure measurement within 7 days, or – considering monitoring using ABPM/ HBPM and ensuring a clinical review within 7 days	

Medication choices (first line)

Choices align with NWL joint formulary v50			
Class	**Drug**	**Starting dose**	**Daily range**
ACE-i	Ramipril	2.5mg OD	2.5-10mg OD
	Lisinopril	10mg OD	10-80mg OD (usual maintenance dose 20mg OD for hypertension)
A2RA's	Losartan	50mg OD (25mg OD if >75yrs old)	50-100mg OD
CCB's	Amlodipine	5mg OD	5-10mg OD
Thiazide - like diuretics	Indapamide immediate release (IR)	2.5mg OD	2.5mg OD
Aldosterone antagonist	Spironolactone	25mg OD	25mg OD (can go upto 50mg OD)
Alpha-Blocker	Doxazosin immediate release (IR)	1-2mg OD	2-16mg OD (or BD dosing when dose >8mg/day)
Beta-Blocker	Bisoprolol (1st line)	5-10mg OD	5-20mg OD
	Carvedilol (2nd line)	12.5mg OD	12.5-50mg OD Single dose or divided doses. 12.5mg may provide satisfactory control in the elderly

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