Management of ADULT HYPERTENSION

BLOOD PRESSURE (BP) GOALS

<140/90 mm Hg – for age 18-59 & age 60 and over with Chronic Kidney Disease (CKD) or Diabetes
Optional for other patients at high risk of cardiovascular events

<150/90 mm Hg – for age 60 and over and not in the presence of Chronic Kidney Disease (CKD) or Diabetes

ACE-Inhibitor / Thiazide Diuretic

- Lisinopril / HCTZ
  (Advance as needed)
  20 / 25 mg x ½ daily
  20 / 25 mg x 1 daily
  20 / 25 mg x 2 daily

Pregnancy Potential: Avoid ACE-Inhibitors

If ACEI intolerant or pregnancy potential

Thiazide Diuretic

- HCTZ 25 mg → 50 mg
- OR
- Chlorthalidone 12.5 mg → 25 mg

For ACEi intolerance due to cough, use ARB

Add Losartan 25 mg daily → 50 mg daily → 100 mg daily

Pregnancy Potential: Avoid ARBs

Calcium Channel Blocker

Add amlodipine 5 mg x ½ daily → 5 mg x 1 daily → 10 mg daily

Spironolactone or Beta-Blocker

IF on thiazide AND eGFR ≥ 60 mL/min/1.73m² AND K < 4.5
Add spironolactone 12.5 mg daily → 25 mg daily
OR
Add Metoprolol ER 25 mg daily → 50 mg daily → 100 mg daily → 200 mg daily
OR
Atenolol 25 mg daily → 50 mg daily (Keep heart rate > 55)

Consider medication non-adherence.
Consider interfering agents (e.g., NSAIDs, excess alcohol).
Consider white coat effect. Consider BP checks by medical assistant (e.g., two checks with 2 readings each, 1 week apart).
Consider discontinuing lisinopril / HCTZ and changing to chlorthalidone 25 mg plus lisinopril 40 mg daily. Consider additional agents (hydralazine, terazosin, reserpine, minoxidil)
Consider stopping atenolol and adding diltiazem to amlodipine, keeping heart rate > 55.
Avoid using clonidine, verapamil, or diltiazem together with a beta blocker. These heart-rate slowing drug combinations may cause symptomatic bradycardia over time.
Consider secondary etiologies.
Consider consultation with a hypertension specialist.

1. ACE-inhibitors and ARBs are contraindicated in pregnancy and not recommended in most women of childbearing age. Calcium Channel Blockers and Spironolactone (Pregnancy Risk Category C), and Beta-Blockers (Pregnancy Risk Category D) should only be used in pregnancy when clearly needed and the benefits outweigh the potential hazard to the fetus.
2. Patients at high risk include those with acute coronary syndromes, or a history of MI, stable or unstable angina, coronary or other arterial revascularization, stroke, TIA, clinical significant peripheral arterial disease presumed to be of atherosclerotic origin, such as claudicaiton or revascularization, or Black race.

Adapted from Kaiser Permanente Medical Care Program and JNC8 Recommendations.
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3. CKD is defined as albuminuria (>30 mg of albumin/g of creatinine) at any age and any level of GFR, or an estimated GFR or measured GFR < 60 mL/min/1.73 m² in people aged < 70 years. When weighing the risks and benefits of a lower BP goal for people aged 70 years or older with estimated GFR < 60 mL/min/1.73 m², antihypertensive treatment should be individualized, taking into consideration factors such as frailty, comorbidities, albuminuria, and estimation of non-age related eGFR decline (for example eGFR + ½ age < 85).

- Medication up-titrations are recommended at 2-4 week intervals (for most patients) until control is achieved. Consider follow-up labs (electrolytes and renal function) when up-titrating or adding lisinopril / HCTZ, chlorthalidone, HCTZ, or spironolactone.
- Use lipid lowering therapy according to AHA/ACC Pooled Cohort Equation: [http://my.americanheart.org/cvriskevaluator](http://my.americanheart.org/cvriskevaluator) and [http://tools.cardiosource.org/ASCVD-Risk-Estimator](http://tools.cardiosource.org/ASCVD-Risk-Estimator)
- Women using ACEI/ARB should be advised to stop these medications and contact their OB/GYN provider immediately if they become pregnant. Women using ACEIs/ARBs for heart failure or cardiomyopathy and become pregnant should be advised to NOT stop these medications and to contact their cardiologist immediately so that they can substitute a suitable alternative (such as hydralazine) to avoid decompensation.

**Lifestyle changes are recommended for all patients:**
- DASH diet
- Sodium restriction (≤ 2.4 gm sodium daily)
- Weight reduction if BMI ≥ 25 kg/m²
- Exercise at a moderate pace to achieve 150 min/week (e.g., 30 min/ day, 5 days/week)
- Limit daily alcohol to no more than 1 drink (women) or 2 drinks (men)
- Smoking cessation is strongly recommended; counsel tobacco users on the health risks of smoking and the benefits of quitting.

**Recommendations for patients with ACEI intolerance due to cough:**
- HCTZ 25 mg, then 50 mg to achieve BP goal.
- Add losartan 25 mg, then 50 mg, then 100 mg to achieve BP goal
- Add amlodipine 2.5 mg, then 5 mg, then 10 mg to achieve BP goal

**Table: Dosage Range for Selected Antihypertensive Medications**

<table>
<thead>
<tr>
<th>SELECTED ANTIHYPERTENSIVE MEDICATION</th>
<th>Usual Dosage Range</th>
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<tbody>
<tr>
<td>Thiazide Diuretics</td>
<td></td>
</tr>
<tr>
<td>Chlorothalidone (Hygroton)</td>
<td>12.5 – 25 mg daily</td>
</tr>
<tr>
<td>Hydrochlorothiazide (HCTZ)(Esidrix)</td>
<td>25-50 mg daily</td>
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<tr>
<td>Thiazide Diuretics Combos</td>
<td></td>
</tr>
<tr>
<td>HCTZ (Prinzide)</td>
<td>10/12.5, 20/12.5, 20/25 mg daily</td>
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<tr>
<td>Spironolactone/HCTZ (Aldactazide)</td>
<td>25/25 mg daily</td>
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<tr>
<td>ACE Inhibitors (ACEI)</td>
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<tr>
<td>Lisinopril (Zestril, Prinivil)</td>
<td>10-40 mg daily</td>
</tr>
<tr>
<td>Captopril (Capoten)</td>
<td>12.5-50 mg BID</td>
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<tr>
<td>Long-Acting Dihydropyridine Calcium Channel Blockers (CCB)</td>
<td></td>
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<tr>
<td>Amlodipine (Norvasc)</td>
<td>2.5-10 mg daily</td>
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<tr>
<td>Felodipine ER (Plendil)</td>
<td>2.5-20 mg daily</td>
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<tr>
<td>Nifedipine ER (Nifedipine XL)</td>
<td>30-90 mg daily</td>
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<tr>
<td>Angiotensin II Receptor Blockers (ARB)</td>
<td></td>
</tr>
<tr>
<td>Losartan (Cozaar)</td>
<td>25-100 mg daily</td>
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<tr>
<td>Aldosterone Receptor Blocker</td>
<td></td>
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<tr>
<td>Spironolactone (Aldactone)</td>
<td>12.5-25 mg daily</td>
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<tr>
<td>Beta-Blockers (BB)</td>
<td></td>
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<tr>
<td>Atenolol (Tenormin)</td>
<td>25-100 mg total, taken daily or BID</td>
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<tr>
<td>Bisoprolol (Zebeta)</td>
<td>5-10 mg daily</td>
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<tr>
<td>Carvedilol (Coreg)</td>
<td>3.125-25 mg BID</td>
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<tr>
<td>Metoprolol (Lopressor)</td>
<td>25-100 mg BID</td>
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<tr>
<td>Metoprolol ER (Toprol XL)</td>
<td>25-200 mg daily</td>
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</table>

This guide is based on the 2014 National Hypertension Guideline. It is not intended or designed as a substitute for the reasonable exercise of independent clinical judgment by practitioners.

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