BLMK ICB Hypertension Treatment Protocol – Supporting Information

These protocols have been approved by the BLMK CVD Group and the BLMK Area Prescribing Committee, having been informed by feedback from clinicians across BLMK.

While remaining concordant with current NICE guidelines, they are designed to simplify and standardise the hypertension treatment pathway, direct clinicians to use agents and doses with an optimal balance of efficacy and tolerability, reduce therapeutic inertia and time taken to achieve BP control and minimise the number of contacts required, recognising the multiple competing pressures on General Practice.

The key principles underlying the protocols are:

- Standardising agents and doses can support more efficient treatment to target with better balance between efficacy and side effect burden
- While initial monotherapy is recommended, avoiding delay in escalating to dual therapy is encouraged (particularly in those with stage 2/3 HTN)
- As appropriate, patients may be empowered to intensify treatment according to self-monitoring and tolerability (e.g . postural symptoms)

As with all guidelines, these do not replace individual clinical judgement which should always prevail.

Please note that 'onboarding to Florence' refers to an SMS-based self-management tool we will be offering shortly to all BLMK practices. Further information on this and the process for roll-out will be shared soon.

The remainder of this document outlines some of the rationale behind the protocol. A more complete evidence summary complete with references is available on request. Please email c.bakhai@nhs.net and matthewdavies@nhs.net if you have any unanswered questions.

Why have we recommended ARBs in preference to ACEis?

- Historically, ARBs were more expensive than ACEis. This is no longer of any significance
- NICE guidance does not direct clinicians to prefer one of these classes over the other
- In meta-analyses ACEis/ARBs have been shown to have similar BP lowering effect
- However ACEis require a different approach according to ethnicity while ARBs do not
- ARBs also have evidence for being better tolerated than ACEis and do not have the common adverse effect of cough associated with ACEis
- Fewer steps are generally required for titrating an ARB such as losartan to near-maximal BP lowering efficacy than would be needed for an ACEi – meaning fewer blood tests and clinical contacts required

Why have we recommended an earlier move to combination therapy?

- Traditionally, a single anti-hypertensive agent is initiated at low/standard dose before being up-titrated to maximum dose. If BP control is not achieved then another drug is added
- This traditional approach can be time-consuming, inefficient and require multiple contacts
- Large meta-analyses have shown limited additional BP-lowering from increasing anti-hypertensives from standard to maximum dose with according disproportionate increases in adverse effects
- In any case, most people with Stage 2 or 3 hypertension require two or more drugs to manage BP
- Recent international guidelines (such as from the European Society of Cardiology) are clear that early combination treatment, even at sub-maximal doses, is generally a more effective approach
- BP is a multiregulated variable depending on many compensating pathways. Combination therapy targets multiple mechanisms, such as RAS blockade, vasodilation and/or diuresis, to interrupt this

What is Florence and how do I on-board someone to it?

- Florence is an innovative SMS-based system to support people with hypertension to self-manage their condition and improve lifestyle
- It also allows for home BP monitoring and inputting of these readings into the GP clinical system
- Following a pilot in BLMK, we are planning to make this available across all GP practices
- More information will follow shortly

What underlies the choice of agents and doses in the protocol?

- Lercanidipine is the CCB of choice. It is as effective as amlodipine but is better tolerated
- Feedback from the Prescribing Committee was that clinicians were often less familiar with newer CCBs and having a more widely-used CCB option such as amlodipine would be helpful
- Losartan is the ARB of choice as its starting dose in suitable patients can be 50mg, which is almost as effective as its maximum dose of 100mg. It therefore requires fewer (likely none) steps of titration

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