Bedfordshire, Luton and Milton Keynes Health and Care Partnership

NHS

Bedfordshire, Luton and Milton Keynes Area Prescribing Committee

(BLMK APC)

BLMK Hypertension Protocol

(for 80 years and over)

Version 1, April 2023

Review: April 2025

BLMK Hypertension Protocol (for 80 years and over)

If clinic BP is between 140/90 and 179/119 then please confirm diagnosis with ABPM/HBPM

Clinic BP ≥ 180/120
Assess immediately
- if no target-organ damage, rpt in < 7d

HBPM / ABPM avg BP < 135/85

HBPM / ABPM avg BP 135/85 – 149/94

HBPM / ABPM avg BP ≥ 150/95

• Lipids • LFTs • Renal • HbA1c • urine ACR and dip (haematuria) • fundoscopy • ECG • consider BMI / CV exam

No HTN

Stage 1 HTN

Stage 2 HTN

Stage 3 HTN

Offer lifestyle advice and signpost as required

Recommend that patient purchases a BP monitor. If declined, offer to periodically lend a BP monitor from practice (for patient to request prn). All practices/PCNs have been provided with BP monitors.

Onboard to Florence platform (SMS-based system to monitor BP and support titration and lifestyle)

Is HBPM avg BP > 145/85?
(or clinic BP > 150/90?)

No

Yes

Lifestyle advice only. No need to treat HTN currently. Review ≤ 1 yr

Lifestyle advice and consider treatment

Lifestyle advice and treat

Refer for same-day acute assessment if papilloedema / retinal bleeds or any concerning symptoms

Lifestyle advice and treat without delay

BP targets:

- <145/85 if AMBP/HMBP
- <150/90 if clinic BP
- If CKD and ACR<70, lower SBP target by 10mmHg
- If CKD and ACR>70, lower SBP target by 20mmHg and DBP target by 10mmHg

Avoid overtreatment in frailty, if inappropriate or if likely limited benefit (e.g. short life expectancy)

Initiation / dose increase of ARB requires checking of renal function and potassium after 1-2 weeks

The algorithm below may not apply for people with CKD, HF, IHD or BPH
Use clinical judgement in people with frailty or multimorbidity

An 'optimal' dose in this context has high (or near-maximal) efficacy but with lower SE burden than likely to occur with greater doses

*CCB options include:

- Lercanidipine 10mg od (avoid if eGFR < 30)
- Amlodipine 5mg od

A 'cautious' dose in this context is one selected mainly for its lower risk of causing significant SEs (e.g. postural sx)

**ARB options include:

- Losartan 25mg od
- Candesartan 4mg od

Initiate CCB* at optimal dose OR initiate ARB** at cautious dose
(see boxes on left for agents, doses and factors to consider)

Sequentially initiate CCB* at optimal dose AND ARB** at cautious dose
i.e. initial monotherapy with 1st agent and addition of 2nd agent at 4 weeks if indicated

The 2nd agent should be started if there are no significant postural symptoms and BP is not controlled after 4 weeks.

For appropriate patients, prescribe both agents at the outset and empower patient to start taking the 2nd agent at 4 weeks

If BP not treated to target after 4 weeks, then check compliance

Add 2nd agent from the box above rather than increasing dose of 1st

If BP not treated to target after 4 weeks then check compliance

1st choice is usually CCB but may be ARB if:

- Diabetes
- CKD (caution if baseline potassium > 5mmol/l)
  - For patients with CKD, consider titrating ARB to maximum tolerated dose before moving to new agent as per NICE www.nice.org.uk/guidance/ng203
  - If hx of stable angina then consider beta blocker 1st-line
  - If BPH, then consider using alpha-blocker 1st-line

Consider increasing ARB and CCB to 'maximum tolerated' doses. There may be scope to double ARB dose (from the 'cautious' dose) but further dose increases in ARB or CCB may provide limited additional BP-lowering effect while increasing risk of significant SEs

If BP not treated to target after 4 weeks, then check compliance

Add indapamide 2.5mg

If BP not treated to target after 4 weeks, then check compliance

+ Spironolactone 25mg daily if potassium < 4.6 mmol/l
Caution if eGFR < 45 due to hyperkalaemia risk
If not suitable then use alpha / beta blockers and titrate up

If BP not treated to target after 4 weeks, then check compliance

Consider Advice & Guidance or referral as appropriate

Postural hypertension is a sustained reduction in systolic BP of at least 20mmHg, or diastolic BP of 10mmHg, that occurs within three minutes of standing.

Check for symptoms and signs of postural hypotension e.g., standing precipitates feeling lightheaded, dizzy, blurry vision, weakness, syncope, confusion, nausea, palpitations.

Consider checking sitting and standing BP if frail, multimorbidity, diabetes or on multiple anti-hypertensives