

Key messages



General Practitioners and Practice Nurses

<p>Despite strong evidence regarding the benefits of controlling hypertension and the large number of available therapies, controlling raised blood pressure and CVD risk in individual patients and at a population level remains a large national challenge.</p>
<p>Lowering blood pressure by only 1–2 mmHg within a population is known to markedly reduce cardiovascular morbidity and mortality (Stamler et al., 1989 and Verdecchia et al., 2010).</p>
<p>If clinic blood pressure is $\geq 140/90$ mmHg, or hypertension is suspected, ambulatory and/or home monitoring should be offered to confirm the blood pressure level (NHFA, 2016).</p>
<p>A standardised protocol containing resources for Australian patients and doctors on how to assess home blood pressure has been developed (Sharman et al, 2015).</p>
<p>The absolute CVD risk assessment is primarily designed for primary prevention in Australian adults >45 years of age or for Aboriginal and Torres Strait Islander peoples >35 years of age with no known CVD. The risk assessment algorithm and treatment options are not appropriate for people with known CVD (e.g. those with established vascular disease, including prior myocardial infarction, prior stroke and/ or transient ischaemic attacks, peripheral arterial disease, end-stage kidney disease, heart failure, atrial fibrillation or aortic disease).</p>
<p>Lifestyle advice is recommended for all patients with hypertension. Trials using lifestyle interventions in patients with hypertension have shown reductions in blood pressure and a reduction in combined cardiovascular events and total mortality (Eriksson et al., 2009. Folta et al., 2009, Wister et al., 2007).</p>
<p>Once decided to treat, patients with uncomplicated hypertension should be treated to a target of $<140/90$ mmHg or lower if tolerated (NHFA, 2016).</p>
<p>In selected high cardiovascular risk populations where a more intense treatment can be considered, aiming to a target of <120 mmHg systolic blood pressure can improve cardiovascular outcomes (NHFA, 2016). The selected high cardiovascular risk populations include those with: clinical or subclinical cardiovascular disease other than stroke, chronic kidney disease, Framingham risk score for 10 year cardiovascular risk $\geq 15\%$ or ≥ 75 years of age (The SPRINT Group, 2015).</p>
<p>In selected high cardiovascular risk populations where a treatment is being targeted to <120 mmHg systolic, close follow-up of patients is recommended to identify treatment related adverse effects including hypotension, syncope, electrolyte abnormalities and acute kidney injury (NHFA, 2016).</p>