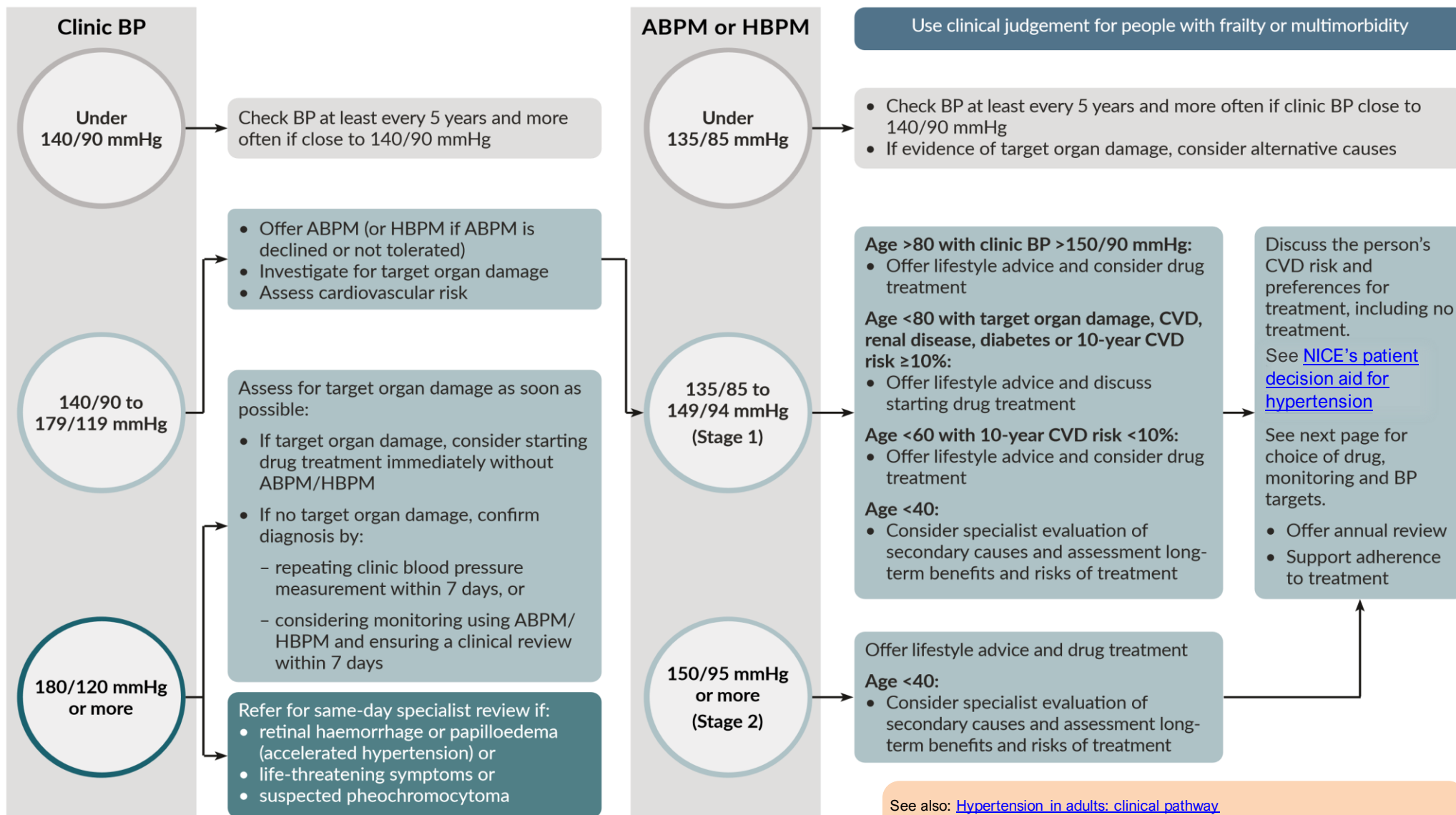


Hypertension guidelines in adults; diagnosis and treatment summary (adapted from [NICE Guideline 136](#))

Offer lifestyle advice and continue to offer it periodically

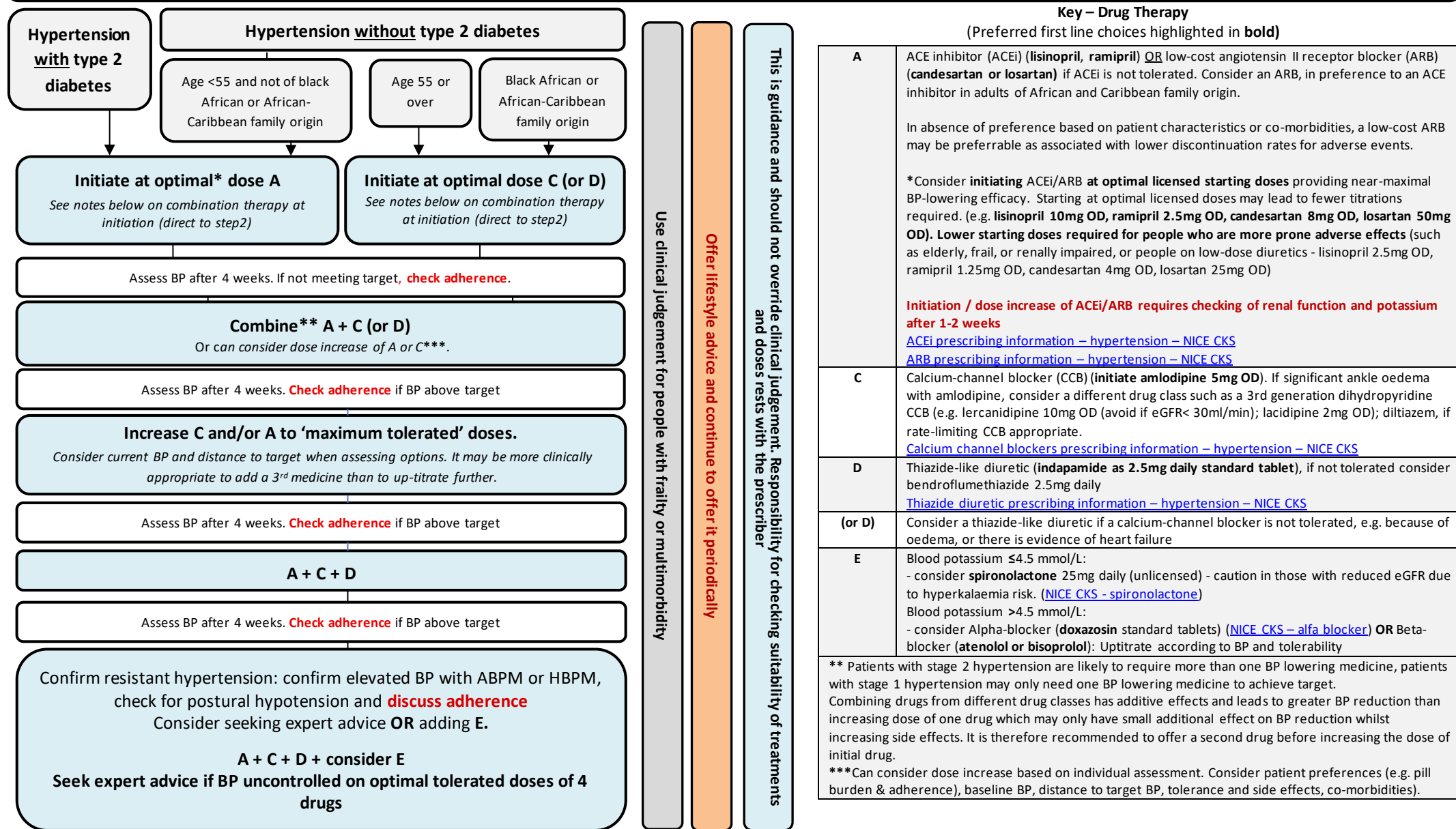
Use clinical judgement for people with frailty or multimorbidity



See also: [Hypertension in adults: clinical pathway](#)

***Lifestyle factors** include diet, salt intake, smoking, alcohol, physical activity and weight. [Consider referral to the NHS Digital Weight Management programme](#)

***Cardiovascular (CVD) risk** <https://www.nice.org.uk/guidance/ng238>

Summary of adult antihypertensive drug treatment (not for pregnant women or those with type 1 diabetes – follow notes below)**Check:** • Lipids • LFTs • Renal • HbA1c • urine ACR and dip (haematuria) • fundoscopy • ECG • consider BMI / CV exam**Further investigation/referral if suspected secondary hypertension – e.g. renal cause, renal artery stenosis, obstructive sleep apnoea, thyroid cause, pheochromocytoma, etc**

Additional notes

- Patients with stage 2 hypertension and home average BP $\geq 150/95$ mmHg or clinic BP $\geq 160/100$ mmHg): can be considered for combination therapy at initiation. This approach is included in the treatment pathway recommended as an option by the British and Irish Hypertension Society (BIHS) and some international consensus guidelines (eg ESC). NICE CG136 has not recommended this approach as it was unable to make a recommendation. A decision to this approach would be made on an individual patient basis. Exclusions to consider include e.g. those frail or elderly ≥ 80 yrs, patients with orthostatic hypotension.
- Do **NOT** switch patients stable and controlled on bendroflumethiazide/ hydrochlorothiazide to alternatives.
- ACE inhibitors and angiotensin II receptor blockers should **NOT** be used in combination.
- Indapamide MR, doxazosin MR, aliskiren and perindopril arginine are **NOT** recommended for prescribing.
- Assessing BP; ESC 2024 advises that BP-lowering effect of pharmacological therapy is typically evident after 1–2 weeks of treatment, but the maximum effect might take longer to manifest. Therefore, the advised follow-up after 1–3 months (1 month preferred with a GP or specialist) allows for assessment of tolerance/safety. In line with recommendations from EoE hypertension guidance, an assessment of BP after 4 weeks is therefore recommended.

Comorbidities and other medical conditions

- For people with CVD follow the recommendations in the NICE guideline relevant to their condition. If their blood pressure remains uncontrolled, offer antihypertensive drug treatment in line with the recommendations in this guidance. When there are other compelling indications for using beta-blockers e.g. angina, post-myocardial infarction, chronic heart failure, or for heart rate control, beta-blockers are combined with any of the other major BP-lowering drug classes [Beta-blocker prescribing information – NICE CKS](#)
- For patients with chronic heart failure; see [chronic heart failure \(NG106\)](#) do not use rate limiting CCB
- For guidance in people with type 1 diabetes; see [type 1 diabetes in adults: diagnosis and management](#) – section 1.12 control of cardiovascular risk
- For patients with chronic kidney disease; see [chronic kidney disease \(NG203\)](#) consider titrating ACEi/ARB to max tolerated dose before starting a new medicine
- If benign prostatic hyperplasia, consider using alpha-blocker 1st-line
- For women considering pregnancy or who are pregnant or breastfeeding; see NICE's guideline on [hypertension in pregnancy](#). ACEi or ARB: See MHRA drug safety updates on ACE inhibitors and ARBs: [not for use in pregnancy](#), which states 'use in women who are planning pregnancy should be avoided unless absolutely necessary, in which case the potential risks and benefits should be discussed', as well as [ACE inhibitors and angiotensin II receptor antagonists: use during breastfeeding](#) and [clarification: ACE inhibitors and angiotensin II receptor antagonists](#)

Monitoring treatment

- Use clinic BP to monitor treatment.
- Measure standing & sitting BP in people with type 2 diabetes or, symptoms of postural hypotension (base target BP on standing BP), or aged 80 and over.
- Advise people who want to self-monitor to use HBPM. Provide training and advice. Please see - [NHS pressure@home scheme](#)
- Consider ABPM or HBPM, in addition to clinic BP, for people with white-coat effect or masked hypertension.

Abbreviations: ABPM - ambulatory blood pressure monitoring; BP - blood pressure, HBPM - home blood pressure monitoring, CVD - cardiovascular disease, CKD – chronic kidney disease

Blood pressure targets

- | | |
|----------------------------|----------------------------|
| Age <80 years | Age ≥ 80 years |
| • Clinic BP: < 140/90 mmHg | • Clinic BP: < 150/90 mmHg |
| • ABPM/HBPM: < 135/85 mmHg | • ABPM/HBPM < 145/85 mmHg |

Blood pressure target CKD - See [NICE's guideline on chronic kidney disease](#)

Postural hypotension - Base target on standing BP

Frailty or multimorbidity - Use clinical judgement

References:

1. NICE guidance 136; [Hypertension in adults: diagnosis and management](#) (last update 21 Nov 2023), accessed August 2025
2. East of England Protocols for the Management of Hypertension (02/2025)
3. 2018 ESC [Guidelines for the management of arterial hypertension](#), accessed August 2025
4. 2024 ESC [Guidelines for the management of elevated blood pressure and hypertension](#), including [supplementary data](#) (TableS7), accessed August 2025
5. [NICE CKS](#) (drug specific links embedded in document)
6. Adult hypertension referral pathway and therapeutic management: British and Irish Hypertension Society; position statement, accessed via <https://bihs.org.uk/education/guidelines.aspx> August 2025

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