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Jnc 8 guidelines on hypertension

[Skip to Content] At the Fam Doctor. 2014 Oct 1;90(7):503-504. Related editorial: JNC 8: Relaxing the Standards• In the general population, pharmacologic treatment should be initiated when bloodis regardless of age.• The initial hypotensive treatment should include a thiazide diuretic, calcium channel blocker, ACE inhibitor or ARB in the general non-black population, or a thiazide diuretic or calcium channel blocker in the general black population.• , the dosage of the first drug should be increased, or a second drug should be added. From the AFP EditorsHypertension is one of the main preventable causes of disease and death in the United States, leading to myocardial infarction, stroke, and kidney failure if it is not detected early and treated appropriately. The Eighth Joint National Committee (JNC 8) recently published evidence-based recommendations on treatment thresholds, targets, and medications for the treatment of high blood pressure in adults. In the general population of adults aged 60 and over, pharmacological treatment should be initiated if the systolic pressure is 150 mm Hg or higher or if the diastolic pressure is 90 mm Hg or higher. Patients should be treated with a systematic target pressure of less than 150 mm Hg and a diastolic target pressure of less than 90 mm Hg. Treatment does not need to be adjusted if it leads to systolic pressure below 140 mm Hg, as long as it is not associated with negative effects on health or quality of life. In the general population under 60 years of age, pharmacological treatment should be initiated if the systolic pressure is 140 mm Hg or higher or if the diastolic pressure is 90 mm Hg or higher. The target systolic pressure in this population is less than 140 mm Hg, and the diastolic pressure is less than 90 mm Hg. For people over 18 years of age with chronic kidney disease (CKD) or diabetes mellitus, the treatment threshold and the target blood pressure are the same as for the general population under 60 years (i.e. the systemtolical threshold of 140 mm Hg or the borderline diastolic pressure of 90 mm Hg; the target systolic pressure of less than 140 mm Hg; the target diastold jerk of less than 90 mm Hg). There is no evidence that treating patients with CKD at a lower blood pressure target slows the progression of the disease. Similarly, there is no evidence from randomized controlled trials that show that treatment with a systolic pressure of less than 140 mm Hg improves health outcomes in adults with diabetes and high blood pressure. In the general non-black population, including patients with diabetes, antihypertensive treatment include a thiazide diuretic, calcium channel blocker, angiotensin-converting enzymes (ACE) inhibitors or angiotensin receptor blockers (ARB). In the general black population, including those with diabetes, initial treatment should include a thiazide diuretic or calcium channel blocker. If the target blood pressure is not reached within one month after the start of therapy, the dosage of the first drug should be increased or a second drug should be added (thiazide diuretic, calcium channel blocker, ACE inhibitor or ARB; do not combine an ACE inhibitor with an ARB). Blood pressure should be monitored and the treatment regimen adjusted until the target blood pressure is reached. A third drug should be added if necessary; However, if the target blood pressure cannot be achieved only with the drug classes listed above, antihypertensive drugs from other classes can be used (e.B.g. beta blockers, aldosterone antagonists). Referral to a doctor with expertise in the treatment of hypertension may be necessary for patients who do not reach the target blood pressure with these strategies. Adults with CKD and hypertension should receive an ACE inhibitor or ARB as first or additional therapy, based on moderate evidence that these drugs improve kidney-related outcomes in these patients. Guideline Source: Eighth Joint National CommitteeProof Assessment System Used? YesLiterature Search? YesGuideline developed by participants with no relevant financial ties to industry? NoPublished source: Journal of the American Medical Association, December 18, 2013Available at: by the AAFP, July 2014: 2 Please note: This information was up-to-date at the time of publication. But medical information is constantly changing, and some of the information given here may be outdated. Regularly updated information on a wide range of health issues can be found on familydoctor.org, the AAFP patient education website. At the Fam Doctor. 2014 Oct 1;90(7):online. See related article about Dysparunia. Dysparosis (DIS-puh-ROO-nee-uh) is pain that occurs during sex. The pain can begin when you first have sex, or it can start later. The pain can be near or in the opening of the vagina or deep in your pelvis. It can feel like a muscle spasm that makes it difficult to enter the vagina. Anxiety or fear of pain can also occur. Many conditions can cause it. Infections, skin diseases and scar tissue in the vagina can all cause pain during sex. Normal changes after birth or after menopause can make sex painful. Other the uterus, bladder, or colon can also cause pain during sex. Your doctor will ask questions about your pain, such as where it is, what makes it worse, and if you have other symptoms. Your doctor will do a pelvic exam. You may need other tests, such as .B or a blood sample, to Doctor find the cause. Your doctor will find out what causes your pain. Treatment depends on the diagnosis. You may need to see a physiotherapist. Your doctor may recommend the use of lubrication during sex. For certain reasons, your doctor may recommend surgery. To view the full article, sign in or purchase Access. This handout is provided by your GP and the American Academy of Family Physicians. For more health-related information, please visit the AAFP online at . This information provides a high-level overview and may not apply to everyone. Please talk to your GP to find out if this information applies to you and to learn more about it. Copyright © 2014 by the American Academy of Family Physicians. This content belongs to the AAFP. A person viewing it online can make an expression of the material and use that expression only for his/her personal, non-commercial reference. This material may not be downloaded, copied, printed, stored, transmitted or reproduced in any medium, whether known or later invented, unless authorized in writing by AAFP. Contact afpserv@aafp.org for copyright issues and/or approval requests. Do you want to use this item elsewhere? Get permissions MOST RECENT ISSUE Dec 1, 2020 Access to the latest issue of American Family Physician Read the issue Don't Miss a Single Problem. Sign up for the free AFP email table of contents. Sign Up Now Compared to previous guidelines for the treatment of hypertension, the Guidelines of the Joint National Committee (JNC 8) recommend higher blood pressure targets and less use of different types of antihypertensive drugs. Patients will ask about the new JNC 8 hypertension guidelines, published December 18, 2013 in the Journal of the American Medical Association.1The new guidelines emphasize the control of systolic blood pressure (SBP) and diastolic blood pressure (DBP) with age- and comorbidity-specific treatment reductions. The new guidelines also introduce new recommendations to promote safer use of angiotensin converting enzyme inhibitors (ACE) inhibitors and angiotensin receptor blockers (ARBs). Important changes compared to JNC 7 guidelines2 are: In patients 60 years and older who do not have diabetes or chronic kidney disease, the target blood pressure is now <150/90 mm Hg.• In patients aged 18 to 59 years without major comorbidities and in patients over 60 years who have diabetes, chronic kidney disease (CKD) or both diseases, new target blood pressure distzer is <140/90 mm Hg.• First-line and later-line treatments should now be limited to 4 classes of drugs: thiazide diuretics, calcium channel blockers (CCBs), ACE inhibitors and ARBs.• Second and third-line alternatives included higher doses or combinations of ACE inhibitors, ARBs, thiazide diuretics, and CCBs. Several drugs are now referred to as later alternatives, including the following: alphablockers, alpha1/beta-blockers (e..B g. carvedilo), vasodilating beta blockers (e.B. nebivolol), central alpha2/-adrenergic agonists (e..B clonidine), direct vasodilators (e.B. hydralazine), loop-diruretics (e.B. Furosemide), aldosterone antagoinsts (e..B spironolactone) and peripheral-acting adrenergic antagonists (e.B. reserpine).• At the start of therapy, patients of African descent without CKD should use CCBs and thiazides instead of ACE inhibitors.• The use of ACE inhibitors and ARBs is recommended in all patients with CKD regardless of ethnic background. AS first-line therapy or in addition to first-line therapy.• ACE inhibitors and ARBs should not be used simultaneously in the same patient.• CCBs and thiazide diuretics should be used instead of ACE inhibitors and ARBs in patients over 75 years of age with impaired renal function due to the risk of hyperkalemia, increased creatinine and other renal dysfunction. The change to a milder systolic blood pressure target can be confusing for many patients accustomed to the lower targets of JNC 7, including the <140/90 mm Hg target for most patients and <130/80 mm Hg target for patients with high blood pressure and large comorbidities. The guidelines were informed by the results of 5 key studies: the Hypertension Detection and Follow-up Program (HDFP), the Hypertension-Stroke Cooperative, the Medical Research Council (MRC) study, the Australian National Blood Pressure (ANBP) study and the Veterans' Administration (VA) Cooperative. In these studies, patients between the ages of 30 and 69 were given medications to lower DBP to a level of <90 mm Hg. The results showed a reduction in cerebrovascular events, heart failure and overall mortality in patients treated with the DBP target level. The data was so compelling that some members of the JNC 8 panel wanted to maintain DBP <90 mm Hg as the only target in younger patients, citing insufficient evidence of the benefits of an SBP target below 140 mm Hg in patients under 60 years of age. However, more conservative panelists pushed to keep the SBP target and the DBP target. In younger patients without major comorbidities, increased DBP is an important cardiovascular risk factor than increased SBP. The JNC 8 panelists are not the first policy authors to recognize this relationship. The AUTHORS of the JNC 7 Guideline also recognized that DBP control is more important than SBP control to reduce cardiovascular risk in patients <60 years of age. However, SBP control remains the most important factor in patients aged 60 and over. Other recent evidence suggests that the SBP target <140 mm Hg recommended by the JNC 7 guidelines for most patients may have been unnecessarily low. The JNC lead to 2 studies in which no improvement in cardiovascular results with an SBP target <140 mm Hg compared to a target SBP content <160 mm Hg or <150 mm Hg has been observed. Despite this finding, the new directives do not prohibit the treatment of a target SBP <140 mm recommend caution to ensure that low SBP levels do not affect quality of life or lead to adverse events. Shifting to a DBP-based target may mean that younger patients are prescribed fewer medications when diagnosed with high blood pressure; This can improve compliance and minimize adverse events associated with low SBP, such as sexual dysfunction. Patients with kidney diseaseAlthough 1 post-hoc analysis showed a possible benefit in kidney outcomes with the lower target of 130/80 mm Hg recommended by JNC 7, 2 other primary analyses did not support this finding. In addition, a further 3 studies showed no advantage with the <130/80 mm Hg target compared to the <140/90 mm Hg target level for patients with chronic kidney disease. Therefore, the new guidelines recommend that patients with chronic kidney disease receive medications that are sufficient to achieve the higher <140/90 mm Hg target level. However, in an exception to this target level, the guidelines suggest that patients with chronic kidney disease or albuminuria from the age of 70 should receive treatment based on comorbidities, frailty and other patient-specific factors. The evidence was insufficient to support a target blood pressure of <140/90 mm Hg in patients over 70 years of age with CKD or albuminuria. Patients with diabetesAdults with diabetes and hypertension have reduced mortality as well as improved cardiovascular and cerebrovascular outcomes with a target of SBP <150 mm Hg, but no randomized controlled trials support a target <140/90 mm Hg. Nevertheless, the panel opted for a conservative recommendation in patients with diabetes and hypertension and opted for a target level of < 140/90 mm Hg in adult patients with diabetes and hypertension instead of the evidence-based target of <150/90 mm Hg.Follow-upThe JNC 8 guidelines authors simplified a complicated recommendation for follow-up in patients with hypertension. The JNC 7 Panel recommended that after an initial high blood pressure measurement, follow-up with a confirming blood pressure level should be carried out within 7 days to 2 months, depending on the level of the first measurement and whether the patient had kidney disease or end organ damage as a result of hypertension. According to JNC 8, in all cases, the target blood pressure targets should be achieved within one month of starting treatment either by increasing the dose of an initial drug or by using a combination of drugs. TreatmentsThe JNC 7 panel recommended the JNC 8 panel of thiazide diuretics as an initial therapy for most patients. Although ACE inhibitors, ARBs and calcium channel blockers (CCBs) are acceptable alternatives, still have the best evidence of effectiveness. The JNC 8 Panel does not recommend first-line therapy with beta-blockers and alpha-blockers based on a 1 study that showed a higher rate of cardiovascular events with the use of beta-blockers compared to the use of an ARB, and another study in which alpha-blockers reported poorer cardiovascular outcomes compared to those associated with Diuretic. In addition, a lack of evidence comparing the 4 first-line therapies with carvedilol, nebivolol, clonidine, hydralazine, reserpine, furosemide, spironolactone and other similar drugs excludes the use of drugs other than ACE inhibitors, ARBs, CCBs and thiazide diuretics in the vast majority of patients. Before taking alpha-blockers, beta-blockers, or one of several different active ingredients, patients would receive dose adjustment and combinations of the 4 first-line therapies in accordance with JNC 8 guidelines. Triple therapy with an ACE inhibitor/ARB, CCB and thiazide type diuretic would precede the use of alpha-blockers, beta-blockers or one of several other active ingredients. These new guidelines eliminate the use of beta-blockers (including nebivolol), alpha-blockers, loop diuretics, alpha-1/beta blockers, central alpha2/adrenergic agonists, direct vasodilators, aldosterone antagonists, and peripheral adrenergic antagonists in patients with newly diagnosed hypertension. Caution should be exercised in patients who are already stable with these therapies. Special therapeutic considerations ACE inhibitors and ARBs may not be an ideal choice in patients of African descent. The results of a subgroup analysis in antihypertensive and lipid reduction treatment to prevent the heart attack study (ALLHAT) showed that ACE inhibitors produced worse cardiovascular outcomes than thiazide diuretics or CCBs in patients of African descent. Despite allHAT's subgroup analysis, the results of the African American Study of Kidney Disease and Hypertension (AASK) support the use of first-line or add-on ACEIs to improve kidney-related outcomes in patients of African descent with high blood pressure, CKD, and proteinuria. Therefore, the JNC 8 panelists recommend that all patients with chronic kidney disease and hypertension, regardless of their ethnic background, receive treatment with an ACE inhibitor or ARB to protect kidney function, either as initial therapy or as an adjunct therapy. An exception to the use of ACE inhibitors or ARBs to protect renal function applies to patients over 75 years of age. The panel cited the potential for ACE inhibitors and ARBs to increase serum creatinine and produce hyperkalemia. Therefore, thiazide diuretics or CCBs are an acceptable alternative to ACEIs or ARBs for patients over 75 years of age with decreased renal function. In addition, the Panel expressly prohibits the simultaneous use of an ACE inhibitor and arb in the same patient. This combination has not been shown to improve the results. Despite the fact that the 2 drugs work at different points in the renin-angiotensin-aldosterone system, other combinations of drugs are better and the simultaneous use of ACEIs and ARBs is not supported by evidence. Lifestyle changes In JNC 7, the JNC 8 guidelines also recommend lifestyle changes as an important part of therapy. Lifestyle interventions include the application of Dietary Approaches to Stop Stop (DASH) Eating plan, weight loss, reducing sodium intake to less than 2,4 grams per day and at least 30 minutes of aerobic activity most days of the week. In addition, to delay the development of hypertension, improve blood pressure - lower the effect of existing medications, and reduce cardiovascular risk, alcohol consumption should be limited to 2 drinks daily in men and 1 drink daily in women. Note that 1 drink is 12 ounces of beer, 5 ounces of wine or 1.5 ounces of 80-proof liqueur. Smoking is also reduced in cardiovascular. ConclusionThe JNC 8 guidelines move away from the assumption that lower blood pressure levels improve results regardless of the type of drug used to reach the lower level. Instead, the JNC 8 guidelines promote the use of active substances with the best evidence for reducing cardiovascular risk. In addition, the guidelines may lead to lower use of antihypertensive drugs in younger patients, which will lead to equivalent results in relation to cardiovascular events with less potential for adverse events that limit compliance. Michael R. Page, PharmD, RPh, is clinical editor of the Pharmacy Times. This story first appeared online in Pharmacy Times on January 6, 2014. James PA, Oparil S, Carter BL, et al. 2014 evidence-based guideline for the treatment of hypertension in adults: Report of panel members appointed to the Eighth Joint National Committee (JNC 8) [published online December 18, 2013]. Jama. doi:10.1001/jama.2013.284427.2. Brotman DJ, Frost SD. The JNC 7 guidelines for high blood pressure. Jama. 2003;290(10):1313-1314; Author's response 1314-1315. 1314-1315.

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