

Q&A

Q1: B blockers in hypertension with tachycardia where no other indication?

A1: B blockers fine is additional compelling indication (AFib, migraine, thyrotoxicosis, etc.)

Q2: B blockers in HTN patients with HFpHF?

A2: No evidence. Indeed, those patient do NOT LIKE b-blockers.

Q3: ACEI or ARBs in HTN and CKD?

A3: Yes, up until eGFRs as low as 20—with monitoring for rise in creatinine and K+.

Q4: Hi just wondering opinion on home BP monitoring if can't get ABPM?

A4: Recommended if ABPM not available, and better than clinic BP.

Q5. We are seeing more pts. post MI with normal LVSF not being Px'd ACEI/ARB

A5. Thats a problem if their BP is not a target (which is common). For HFpEF with BP at target ACE/ARB not strictly needed

Q6. In (Cardiovascular risk stratified by BP) slide, would you please explain the bars again? Is the risk decreasing?

A6. That is just the prevalence of CVD risk categories at various BP levels, indicating most persons with elevated BP are in fact low risk (<10%) over 10 yrs and do not need meds.

Q7. I was wondering how to treat if systolic is very high but diastolic reading is low ? Also is this an indicator of anything?

A7. Systolic target is 120-129 irrespective of diastolic. Systolic always gets priority. Low diastolic not a problem typically but Sx have to be reviewed

Q8. 24 BP monitors. Targets?

A8. 120-129 systolic by office or by ABPM, preferably latter Roger

Q9. Can I confirm, the goal ABPM for monitoring treatment is 120-129 systolic for the average DAYTIME reading?

A9. Yes, for both Daytime and 24 hr average. Either

Q10. Would you start a patient in their 20s on medication?

A10. Yes, if hypertensive and confirmed. If elevated BP only they would not be high enough risk by virtue of age for meds

Q11. if Systolic BP is elevated but diastolic is low what target do you use?

A11. Systolic always gets priority. Class 1 (is recommended) for systolic target if 120-129, irrespective of diastolic

Q12. If the systolic BP is between 120-129 but the Diastolic is over 80 is this still over the target?

A12. Class 1 is to get systolic to 120-129, irrespective of diastolic. There is a weaker class 2b recommendation to also aim for diastolic 70-79 but that's optional

Q13. With patients with elevated BP and after 3/12 trial of lifestyle, if the BP remains elevated but not >130 what should we do? Thanks

A13. Just ongoing lifestyle

Q14. could you clarify cuff size - bladder of cuff being 80-100% of arm circumference is fine, but ? width of the cuff ? 40% of arm circumference. ? best cuff for small obese patient

A14. The bladder length should be 75%–100% and the width 35%–50% of the arm circumference.

Q15. What is your opinion on the use of Pulse Wave Velocity to help reclassify risk in those with elevated BP?

A15. Yes, PWV was included as an optional risk test for those patients

Q16. Great talks, thanks! You mentioned guidelines don't apply to eGFR <30 - are there specific guidelines for this subgroup in the 2024 guidelines?

A16. Individualized and as low as reasonably achievable (preferably <140 systolic)

Q17. What would be the definition of elevated blood pressure on a ABPM daytime average? 120- <135mmHg? 70-<85mmHg?

A17. Yes

Q18. Patients in the elevated BP group with positive risk modifiers, do they need to be treated? eg women with Hx GDM, do they need treatment if elevated?

A18. They do NOT NEED to be treated, but one could consider (class 2a rec) treating them if systolic remains over 130 after 3 months lifestyle

Q19. Thanks Bill. Do you think there will be interest to implement such an optional tool in Ireland? Is the measurement reimbursed in Ireland?

A19. Not reimbursed per se

Q20. For patients on RAAS inhibitors, should they still be advised around managing potassium intake as before, e.g., not substituting Lo-Salt due to risk of hyperkalaemia, although lifestyle measures now recommend potassium intake?

A20. Sure, most especially if eGFR is <60

Q21. Am I right to say in the new guidelines define HTN as >140/90 on true office BP (which I doubt many OPDs are doing?!), but >135/85 on APBM?

A21. Correct

Q22. What's your approach to Aldo renin testing for the resistant HTN group? Each hospital seems to use different labs with different units and cut offs. How do you handle the interfering meds in someone who is very hypertensive and so difficult to wean off said agents?

A22. We mostly do 'dirty' ARR screens and try to interpret those. If we cant rule out PA, we take them off those meds and repeat the ARR on non-interfering meds. It can be a challenge though

Q23. is magnesium recommended?

A23. IF low

Q24. New ESC guides Treatment target 120-129 systolic range- is e.g. 110 systolic then too low in the treatment group and if yes why?

A24. A BP on treatment of 110 is below target but no need to do anything (no need to reduce meds) so long as the patient feels fine

Q25. exercise for a prolonged period of time was mentioned. is it not still adequate to encourage several short periods of exercise if more practical to clients lifestyle or due to clients ability e.g. painful joints etc. thank you

A25. The evidence is strong that even smaller bouts have an effect so yes every move counts

Q26. Given recent trial findings and guidelines more young patients falling into hypertensive/elevated BP category. Any advice on who/who not to refer for investigation of secondary causes?

A26. Anyone under 40 without obesity and with confirmed HTN is recommended to be assessed. No need to assess young folks with elevated BP. If obese I would just consider OSA

Q27. Can I ask about nocturnal hypertension and day time normotension

A27. Needs OSA assessment

Q28. excellent presentation very helpful in primary care settings. can I ask if someone has persistent elevated systolic BP but diastolic in normal pr elevated range would you treat with medication ?

A28. Systolic is the most important and the priority. If thats at target 120-129, it matters little what the DBP is. If SBP is not at target, I would consider uptitrating meds and ignore DBP as long as patient feels well.

Q29. I was surprised to hear that KCl type salt alternatives would be advised. is there a guideline document or research paper to read up on this?

A29. Yes, there is a few large trials now on this. One recent large trial is called SSaSS , published in NEJM

Q30. until which age you recommend secondary causes HTN screening

A30. Below 40 for all or above 40 if someone cannot get to target or has symptoms of secondary HTN

Q31. Is there a medication that specifically targets a diastolic BP >90

A31. No

Q32. what is OSA abbreviation of please?

A32. Obstructive Sleep Apnoea

Q33. Would you treat high DBP id SBP is normal?

A33. Can be considered (Class 2 rec) but its optional. The main target is systolic BP

Q34. Is the evidence for renal denervation strong?

A34. Not very strong.

Q35. Re SCORE 2 / SCORE 2 OP: Is is now medicolegally indefensible not to calculate at every patient BP visit?

A35. Guidelines do not translate to legal mandates. I understand the concern Roger, but prevention guidelines already recommend CVD risk assessment for adults over 40 (irrespective of what we say in our guideline)