Appendices

Appendix A: Scope

NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE

SCOPE

1 Guideline title

Hypertension: clinical management of primary hypertension in adults

1.1 Short title

Hypertension (partial update)

2 The remit

This is a partial update of ‘Hypertension (persistently high blood pressure) in adults’ (2004) and ‘Hypertension: management of hypertension in adults in primary care’, NICE clinical guideline 34 (2006).

This guideline update is 6 years from publication of the 2004 NICE hypertension guideline, and is being undertaken as part of the guideline review cycle.

3 Clinical need for the guideline.

3.1 Epidemiology

a) High blood pressure (hypertension) is one of the most important preventable causes of premature morbidity and mortality in the UK. Hypertension is a major risk factor for stroke (ischaemic and haemorrhagic), myocardial infarction, heart failure, chronic kidney disease, cognitive decline and premature death. Untreated hypertension is usually associated with a progressive rise in blood pressure. The vascular and renal damage that this may cause can potentially culminate in a treatment-resistant state.

b) Blood pressure is normally distributed in the population and there is no natural cut-off point above which ‘hypertension’ definitively
exists and below which it does not. The risk associated with increasing blood pressure is continuous, with each 2 mmHg rise in systolic blood pressure associated with a 7% increased risk of mortality from ischaemic heart disease and a 10% increased risk of mortality from stroke. Hypertension is remarkably common in the UK and the prevalence is strongly influenced by age. In any individual person, systolic and/or diastolic blood pressures may be elevated. Diastolic pressure is more commonly elevated in younger people, that is, those younger than 50 years. With ageing, systolic hypertension becomes a more significant problem, as a result of progressive stiffening and loss of compliance of larger arteries. At least one quarter of adults (and more than half of those older than 60) have high blood pressure.

c) The clinical management of hypertension is one of the most common interventions in primary care, accounting for approximately £1 billion in drug costs alone in 2006.

3.2 Current practice

a) NICE issued guidance for the management of hypertension in adults in primary care in 2004 (‘Hypertension [persistently high blood pressure] in adults’, NICE clinical guideline 18). The pharmacological section of this guideline was subsequently updated in 2006 (‘Hypertension: management of hypertension in adults in primary care’, NICE clinical guideline 34).

b) Hypertension is usually detected by opportunistic measurement, or during scheduled screening in primary care. The diagnosis of hypertension has traditionally been based on the use of seated measurements of blood pressure in the GP’s surgery. However, there is increasing use of 24-hour ambulatory measurements of blood pressure, as well as patient self-measurement using automated devices in the home. Guidance is needed on the use and interpretation of data from these alternative blood pressure measurements.
c) Once the diagnosis of hypertension has been confirmed, a simple set of routine clinical tests is currently recommended. NICE has also advocated formal estimation of cardiovascular risk to determine whether people with treated hypertension might benefit from other risk-reducing treatments (that is, statins and anti-platelet therapy) to optimally reduce their cardiovascular disease risk.

d) The treatment of hypertension involves both lifestyle advice and drug therapy. Successful adoption of lifestyle advice may be sufficient to manage mild hypertension in people at low cardiovascular risk, and without evidence of cardiovascular disease or organ damage. However, for most people drug therapy will also be needed to lower blood pressure to recommended targets.

e) A wide range of classes of drugs is available for the treatment of hypertension. Individual patients’ blood pressures respond differently to specific classes of drug therapy – there is no perfect drug for every patient. This variation is, in part, determined by age and ethnicity. At the time of drafting the 2006 recommendations, there was inadequate data to inform best treatment options for hypertension that was resistant to treatment with three drugs.

f) Substantial clinical trial data have been published since the original guideline in 2004 and the rapid update in 2006. These data needs to be reviewed in the context of existing guidance; it consolidates and strengthens the evidence for some existing recommendations and fills important evidence gaps where guidance is needed.

4 The guideline

The guideline development process is described in detail on the NICE website (see section 6, ‘Further information’).

This scope defines what the guideline will (and will not) examine, and what the guideline developers will consider.
The areas that will be addressed by the guideline are described in the following sections.

Important aspects regarding the detection and clinical management of high blood pressure that have not been prioritised for review in this update will remain unchanged from the 2004 guidance.

4.1 **Population**

Adults with hypertension who may, or may not, have pre-existing cardiovascular disease.

4.1.1 **Groups that will be covered**

a) Adults with hypertension (18 years and older).

b) Particular consideration will be given to the needs of black people of African and Caribbean descent and minority ethnic groups where these differ from the needs of the general population.

c) People aged 80 years or older.

4.1.2 **Groups that will not be covered**

a) People with diabetes.

b) Children and young people (younger than 18 years).

c) Pregnant women.

d) Secondary causes of hypertension (for example, Conn’s adenoma, phaeochromocytoma and renovascular hypertension).

e) People with accelerated hypertension (that is, severe acute hypertension associated grade III retinopathy and encephalopathy).

f) People with acute hypertension or high blood pressure in emergency care settings.

4.2 **Healthcare setting**

a) Primary care.
b) Secondary care (excluding emergency care).

c) Community settings in which NHS care is received.

4.3 **Clinical management**

4.3.1 **Key clinical issues that will be reviewed**

a) Ambulatory monitoring.

b) Home blood pressure monitoring.

c) Blood pressure thresholds for intervention and targets for treatment.

d) First-line therapy options, for example ACE inhibitors versus angiotension receptors blockers.

e) Calcium-channel blockers versus diuretics as preferred components in step two of the treatment algorithm, for example, combination therapy.

f) Adherence to medication.

g) Provision of appropriate information and support.

h) Resistant hypertension (that is, fourth-line therapy).

i) Response to blood pressure lowering drugs according to age and ethnicity.

4.3.2 **Clinical issues that will not be reviewed**

a) Prevention of hypertension.

b) Screening for hypertension.

c) Specialist management of secondary hypertension (that is, hypertension arising from other medical conditions).

d) Non-pharmacological interventions.
4.4 **Main outcomes**

a) Mortality from any cause.

b) Stroke (ischaemic or haemorrhagic).

c) Myocardial infarction (MI) (including, where reported, silent MI).

d) Heart failure.

e) New-onset diabetes mellitus.

f) Vascular procedures (including both coronary and carotid artery procedures).

g) Angina requiring hospitalisation.

h) Trial withdrawal rates as a surrogate for adverse effects of drug treatment.

i) Major adverse cardiac and cerebrovascular events (MAACE): fatal and non-fatal MI, fatal and non-fatal stroke, hospitalised angina, hospitalised heart failure, revascularisation.

j) Health-related quality of life.

k) Blood pressure response to treatment.

4.5 **Economic aspects**

Developers will take into account both clinical and cost effectiveness when making recommendations involving a choice between alternative interventions. A review of the economic evidence will be conducted and analyses will be carried out as appropriate. The preferred unit of effectiveness is the quality-adjusted life year (QALY), and the costs considered will usually only be from an NHS and personal social services (PSS) perspective. Further detail on the methods can be found in ‘The guidelines manual’ (see ‘Further information’).
4.6 Status

4.6.1 Scope

This is the final scope.

4.6.2 Timing

The development of the guideline recommendations will begin in May 2010.

4.7 Related NICE guidance