

Hypertension in adults: diagnosis and management (update)

Consultation on draft guideline - Stakeholder comments table 01/12/21 to 04/01/22

Stakeholder	Document	Page No	Line No	Comments	Developer's response
BAME Health Collaborative	Guideline	004	003	<p>1.4.23 Use the same blood pressure targets for people with and without cardiovascular disease this recommendation requires updating to include:</p> <ol style="list-style-type: none"> 1. People who are at the risk of developing hypertension should have their BP monitor at an interval of six-monthly periods even if ABPM or HBPM confirmed their BP to be within normal range 2. Hypertension in people (especially those of the BAME community) should not be presumed to be idiopathic until all other secondary causes of hypertension, in particular, Conn's syndrome have been excluded. 	<p>Thank you for your comment.</p> <p>1. To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking a targeted approach to updating its guidelines. Monitoring people at risk of developing hypertension was not prioritised for review within the scope of this update. Evidence on this topic has therefore not been reviewed and this recommendation cannot be amended.</p> <p>However, the following recommendations from NG136, published in 2019, are retained in the guideline:</p> <p>1.2.10 If hypertension is not diagnosed, measure the person's clinic blood pressure at least every 5 years subsequently, and consider measuring it more frequently if the person's clinic blood pressure is close to 140/90 mmHg.</p> <p>1.2.11 Measure blood pressure at least annually in an adult with type 2 diabetes without previously diagnosed hypertension or renal disease. Offer and reinforce preventive lifestyle advice.</p> <p>As a registered stakeholder you will be notified of any subsequent activity on the guideline.</p> <p>2. The following recommendation covering this point is retained in the guideline:</p> <p>1.2.12 Consider the need for specialist investigations in people with signs and symptoms suggesting a secondary cause of hypertension.</p>
BAME Health Collaborative	Guideline	004	008 – 014	1.4.30 BHC support NICE recommendations however the guideline emphasised that unless there are compelling	Thank you for your comment. The new recommendations now sit in-line with the existing recommendations that were not updated at this time. Therefore the

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				indications ACEI or ARB is not preferred first-line medications for the African and Caribbean community	recommendation about antihypertensive drug treatment for people with established CVD (now recommendation number 1.4.31) immediately precedes the recommendation for step 1 treatment which includes these considerations (see recommendation 1.4.35), so it will be clear to readers of the guideline.
BAME Health Collaborative	Guideline	General	General	<p>Other Recommendations: - Section: Lifestyle; Hypertension in adults: diagnosis and management /NICE guideline [NG136] Published: 28 August 2019:</p> <p>1.2.11. Measure blood pressure at least 6 monthly in an adult with type 2 diabetes without previously diagnosed hypertension or renal disease. Offer and reinforce preventive lifestyle advice</p> <p>1.3.3 For all people with hypertension offer to:</p> <ul style="list-style-type: none"> • test for the presence of protein in the urine by sending a urine sample for estimation of the albumin: creatinine ratio and test for haematuria using a reagent strip • take a blood sample to measure glycated haemoglobin (HbA1C), electrolytes, creatinine, 	<p>Thank you for your comment.</p> <p>We are unable to change the content of recommendations that were not included within the scope for update. Therefore we cannot change the frequency of monitoring from at least annually to at least every 6 months.</p>

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				<p>estimated glomerular filtration rate, total cholesterol and HDL cholesterol</p> <ul style="list-style-type: none"> • examine the fundi for the presence of hypertensive retinopathy • arrange for a 12-lead electrocardiograph to be performed. [2011, amended 2019] 	
BAME Health Collaborative	Guideline	General	General	<p>14.9 Section: Lifestyle; Hypertension in adults: diagnosis and management /NICE guideline [NG136] Published: 28 August 2019 this needs to be updated to reflect cultural practices in the BAME communities such as food preparation which includes high intake of salt, the risk to stroke and other related illnesses.</p>	<p>Thank you for your comment. To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking a targeted approach to updating its guidelines. This section of the guideline was not prioritised for review within the scope of this update. As a registered stakeholder you will be notified of any subsequent activity on the guideline.</p>
British Cardiovascular Society		001	019	<p>BCS would ask NICE to consider prioritising different antihypertensives after stroke as there is evidence some (CCBs) are possibly harmful and others ineffectual</p>	<p>Thank you for your comment. This option was discussed in detail by the committee when considering the evidence and developing recommendations. However, as detailed</p>

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				(ARBs/ACEIs). We note more encouraging data on the use of indapamide post-stroke (PROGRESS and PATS trials)	in the committee discussion section of the evidence review, the evidence regarding indapamide from the PROGRESS trial was not included in the guideline because this was a non-randomised, post-hoc subgroup analysis, which did not meet the review protocol inclusion criteria. Therefore, this non-randomised data from the PROGRESS trial was not available to consider in this update. Reassessment of the evidence from previous guideline versions, including the PATS trial, did not demonstrate consistent variation in efficacy between drug classes in patients following stroke/TIA. The committee noted the benefit of indapamide compared to placebo for stroke recurrence and total cardiovascular events in the PATS trial (the absolute risk reduction from the pooled analysis was around 20 fewer per 1000 events for these two outcomes). However, the evidence was of low quality, including population indirectness because only 16% of the participants in the PATS trial had diagnosed hypertension (>140/90 mmHg), and there were no data available on the possible adverse events of treatment, nor for any head-to-head comparison with other drug classes. Therefore, it was agreed not possible to make specific recommendations for which anti-hypertensives to use after stroke.
British Cardiovascular Society		003	010	We suggest NICE consider T1DM also, as it is confusing to have varying target BPs for T1 and T2DM. The two conditions are inadequately separated in trial evidence.	Thank you for your comment. Blood pressure management for people with type 1 diabetes is included in the NICE guideline for https://www.nice.org.uk/guidance/ng17 Type 1 diabetes in adults: NG17. A specific blood pressure target is not recommended in that guideline, however it does cross-refer back to this guideline for further information.

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					To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking a targeted approach to updating its guidelines. Type 1 diabetes was not prioritised for review within the scope of this update . As a registered stakeholder you will be notified of any subsequent activity on the guideline.
British Cardiovascular Society		004	Table: 1.4	We suggest NICE include T1DM, not just T2DM. Choosing antihypertensive drugs treatments for people with or without DM and post-stroke.	Thank you for your comment. Blood pressure management for people with type 1 diabetes is included in the NICE guideline for https://www.nice.org.uk/guidance/ng17 Type 1 diabetes in adults: NG17.
British Cardiovascular Society		006	026	After this line, we suggest NICE insert an extra outcome measure: modified Rankin Scale (mRS)-post stroke	Thank you for your suggestion. Review protocols are agreed with committee members with expertise in the area in advance of commencing the review. The outcomes are listed to specify those that will be extracted from the studies to inform decision making, as described in the NICE guidelines manual and the methods chapter accompanying this update. Therefore the outcomes included in our review cannot be altered at this stage.
British Cardiovascular Society	Guideline	006	018	The BCS notes the publication in August 2021 of an individual participant level data metanalysis of cardiovascular outcomes with age-stratified treatment of hypertension. We feel that these data should be the stimulus for a further update of the hypertension guidelines to address potential for harm from the current age-specific recommendations in NICE hypertension guidance.	Thank you for your comment. Despite being published after our final search date, we were aware of the individual patient data meta-analysis highlighted in your comment. This analysis was considered for the blood pressure targets review (evidence review A) but it was not included because <50% had established cardiovascular disease and no subgroup data that could be analysed were reported, whereas the protocol for this guideline evidence review stated at least 80% of the population were required to have CVD as one of the inclusion criteria. Therefore, the population was considered outside the scope of this guideline update which focussed on people with

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					hypertension and established CVD. We note that although the IPD included not only trials randomised to compare different BP targets, but also those randomised to BP lowering drugs versus placebo or versus other BP lowering drugs, a sub analysis stratified by trial design was presented, which provided data for BP-lowering intensity trials separately. Therefore, these data could be considered for inclusion in a future update of the guideline that is not limited to the population with established CVD. The included studies from the IPD were checked and, where relevant, included in the guideline evidence review.
British Cardiovascular Society	Guideline	006	018	<p>BCS do not agree with the committee that there is no evidence relating to age and the effect of BP lowering. In addition to the Lancet metanalysis mentioned above, we would like to point out the results of the SPRINT-SENIOR trial in those over 75 that showed important reductions in cardiovascular events and all-cause mortality with an intensive BP lowering strategy. BCS feels that NICE should review the age-specific guidance on when to treat high blood pressure accordingly.</p> <p>HYVET addresses the over 80's population specifically, although only recruiting patients with a baseline SBP of 160 or more. The SPRINT included patients over the age of 80</p> <p>SPRINT - https://www.nejm.org/doi/full/10.1056/nejmoa1511939.</p> <p>The subgroup of the study looking at over 75's constituted 28% of the overall trial population. This SPRINT-SENIOR cohort showed similar benefits to tighter BP control to the overall SPRINT group, even in the subjects felt to be</p>	<p>Thank you for your comment.</p> <p>As noted in the excluded studies table, the SPRINT SENIOR trial was not relevant for inclusion in the guideline review because only a minority of the participants had established CVD and no subgroup data were available to separate out data for this group.</p> <p>The HYVET trial has been included in the pharmacological management section of the guideline, however, it is not relevant to the population being considered in this guideline update because only 12% of participants had established CVD and results were not reported separately for this subgroup.</p>

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				<p>"frail". https://jamanetwork.com/journals/jama/fullarticle/2524266.</p>	
British Cardiovascular Society	Guideline	General	General	<p>BCS would support more stringent targets for BP reduction in both patients with and without pre-existing cardiovascular disease. We note in particular the recent publication of a patient level metanalysis examining this from the Blood Pressure Lowering Trialists' Collaboration in the Lancet https://doi.org/10.1016/S0140-6736(21)01921-8.</p> <p>We are concerned that NICE have not addressed the increasing emphasis on lower targets raised in this and other recent data such as the STEP trial https://www.nejm.org/doi/full/10.1056/NEJMoa2111437. Can NICE justify the apparent omission of these data in the document?</p>	<p>Thank you for your comment. Despite being published after our final search date, we were aware of the individual patient data meta-analysis highlighted in your comment. This analysis was considered for the blood pressure targets review (evidence review A) but it was not included because <50% had established cardiovascular disease and no subgroup data that could be analysed were reported, whereas the protocol inclusion criterion required at least 80% of the population to have CVD. Therefore, the population was outside the scope of this guideline update which focussed on people with hypertension and established CVD. We note that although the IPD included not only trials randomised to compare different BP targets but also those randomised to BP lowering drugs versus placebo or versus other BP lowering drugs, a sub analysis stratified by trial design was presented, which provided data for BP-lowering intensity trials separately. Therefore, these data could be considered for inclusion in a future update of the guideline that is not limited to the population with established CVD.</p> <p>We also assessed a separate patient level metanalysis from the Blood Pressure Lowering Trialists' Collaboration published in the Lancet in May 2021. Although this review did present data separately for those with established CVD it was excluded because the comparators were not equivalent to those stated in the guideline review protocol. Whilst this IPD did include trials randomised to compare different BP targets, it also</p>

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					<p>included those randomised to BP lowering drugs versus placebo or versus other BP lowering drugs. It was not possible to separate out the data for the comparison of BP targets for inclusion in the guideline review, nor to use the data presented to infer what target should be recommended. The included studies from the IPD were checked and, where relevant, included in the guideline evidence review.</p> <p>The STEP trial was also identified in the review process, but excluded because only 6.3% of included participants had established cardiovascular disease and no subgroup data for this population that could be analysed were reported. Therefore, as the predefined protocol inclusion criteria for this review required at least 80% of participants to have established CVD, the population was outside the scope of this guideline update.</p>
British Cardiovascular Society	Guideline	General	General	BCS do agree that the targets for BP reduction do not need to be different between those with and without pre-existing cardiovascular disease, although again would express our view that both groups would benefit from tighter control of BP than is suggested in the update document.	Thank you for your comment. The full rationale for this decision can be found in the discussion of the evidence in evidence review A. In summary: Although some studies suggested important clinical benefit from more intensive blood pressure control (particularly in people with prior stroke/TIA), others identified associated harm in terms of acute kidney injury and withdrawal due to adverse events. Given the absence of high quality data and the inconsistent findings concerning clinical outcomes, the committee agreed they could not recommend a more intensive blood pressure treatment target for people with established CVD. The committee discussed that this is an active area of research and if more high quality evidence becomes available, for either or both populations (with or

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					without CVD) this may prompt further review of this recommendation.
British Cardiovascular Society	Guideline	General	General	BCS BIHS would like to reaffirm our general support for the NICE hypertension guidelines, which we feel are of high quality and usefulness.	Thank you for your comment.
Diabetes UK	Guideline	004	003 - 004	<p>1.4.23 - The latest ADA guidelines recommend that for individuals with diabetes and hypertension at higher cardiovascular risk (existing atherosclerotic cardiovascular disease [ASCVD] or 10-year ASCVD risk $\geq 15\%$), a blood pressure target of <130/80 mmHg may be appropriate if it can be safely attained. The structured education course DESMOND similarly advises a target of 130/80mmHg. In light of this we are interested to hear the rationale behind continuing with the current recommendations.</p> <p>Reference: https://care.diabetesjournals.org/content/44/Supplement_1/S125</p>	Thank you for your comment. The full rationale for this decision can be found in the discussion of the evidence in evidence review A. In summary: Although some studies suggested important clinical benefit from more intensive blood pressure control (particularly in people with prior stroke/TIA), others identified associated harm in terms of acute kidney injury and withdrawal due to adverse events. Given the absence of high quality data and the inconsistent findings concerning clinical outcomes, the committee agreed they could not recommend a more intensive blood pressure treatment target for people with established CVD. The committee discussed that this is an active area of research and if more high quality evidence becomes available this may prompt further review of this recommendation.
Diabetes UK	Guideline	007	015 - 020	<p>We are disappointed with the decision not to examine the evidence since 2010, and do not understand the rationale behind this decision given the increased evidence base since this date.</p> <p>In particular, SGLT2 inhibitors have not been included despite the overwhelming evidence of their benefits concerning cardiovascular death and heart failure. There is also no mention of this class of drug in NICE's chronic heart failure guidance signposted to in this document.</p>	Thank you for your comment. The focus of this update was on the subgroup of people with established cardiovascular disease (CVD), and so the previously included evidence that informed the anti-hypertensive treatment recommendations was re-examined to establish whether it supported any differences in treatment for those with CVD, compared to those without. At the time of scoping, although we were aware there was new evidence, it was not clear that any of this evidence was likely to alter the existing recommendations, and so a new review was not prioritised for this area.

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				Reference: Cardoso, R. <i>et al.</i> (2021) "Sglt2 Inhibitors Decrease Cardiovascular Death and Heart Failure Hospitalizations in Patients with Heart Failure: A Systematic Review and Meta-Analysis," <i>EClinicalMedicine</i> , 36. doi: 10.1016/j.eclinm.2021.100933.	SGLT2 inhibitors are not currently indicated for the management of hypertension and are not used as anti-hypertensives therefore they are out of scope for future updates of this guideline, however they are included in NICE guideline for Type 2 diabetes in adults: management NG28 .
Diabetes UK	Guideline	General	General	<p>We are concerned about the decision to remove this guidance from 'Type 2 diabetes in adults: management' [NG28] and include it here, particularly as the same practice has not occurred for the type 1 diabetes guideline [NG17]. The rationale for this change remains unclear as the impact of hypertension in type 1 diabetes is very similar to type 2 diabetes, particularly when considering the risk of developing and management of complications such as retinopathy and nephropathy. We would welcome, at least, a justification of this decision included in this guideline document.</p> <p>In practice, most healthcare professionals looking for management information for a patient with type 2 diabetes will first go to the NG28 guideline and search for the relevant comorbidity/condition there. They would then need to refer to this guideline, which would increase time spent researching. We are particularly concerned that the statement in NG28 that management of hypertension for those with type 2 diabetes is "broadly the same" to that of the general population may result in busy healthcare professionals not referring to this guidance.</p>	<p>Thank you for your comment. The decision to replace the recommendations from NG28 was made in a previous update on this guideline, and was reflected in the publication of NG136 in 2019. This is detailed in the update information for NG28: https://www.nice.org.uk/guidance/ng28/chapter/Update-information</p> <p>There is a hyperlink to this guideline from NG28 providing access to these recommendations and all guideline webpages include a 'Finding more information' section that will link to NICE guidance on related topics, including guidance in development.</p> <p>It is not within the remit of this update to edit the wording within NG28.</p>

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Diabetes UK	Guideline	General	General	<p>It would also be useful to include recommendations for people to look at food labels and highlight that most of our salt intake comes from processed foods. The current guidelines “encourage people to keep their dietary sodium intake low, either by reducing or substituting sodium salt” but does not inform people that most salt intake comes from processed foods which will make the recommendation harder to follow for many.</p> <p>In March 2020, the latest NDNS survey of 2018/2019 provided an estimation of the salt intake of adults aged 19-64 years in England from the measurement of 24-hour urine collections. The mean salt intake for adults was 8.4g per day, which is 40% higher than the recommended</p>	<p>Thank you for your comment. To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking a targeted approach to updating its guidelines. This section of the guideline was not prioritised for review within the scope of this update. As a registered stakeholder you will be notified of any subsequent activity on the guideline.</p>

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				<p>maximum of 6g per day. No statistically significant changes in salt intake were observed between 2014 and 2018-2019. In fact, analysis suggests there is no statistically significant change in estimated population salt intake since 2004/2005.</p> <p>Reference: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/876252/Report_England_Sodium_Survey_2018-to-2019_3_.pdf</p>	
Diabetes UK	Guideline	General	General	<p>We are concerned that guidance on home blood pressure (BP) monitoring is not being updated, particularly as many people with type 2 diabetes have informed us that due to the COVID-19 pandemic their blood pressure is not being measured in clinic. The most recent NDA report highlighted care processes for BP was suboptimal in adults with type 2 diabetes (England - 95.4% and Wales - 91.1%). The achievement of the BP treatment target was also suboptimal (England - 73.6% and Wales - 64.6%).</p> <p>People with type 2 diabetes may not realise they have a high blood pressure and the NDA care process concerning urine albumin/creatinine is poor. The most recent ADA standard of diabetes care recommends all hypertensive patients should monitor their blood pressure at home and at every routine clinical visit.</p> <p>Whilst it is pleasing to note the update in November 2021 that included a link to the blood pressure@home scheme in the recommendations, given the NDA audit result we would wish for this to be strengthened as it merely suggests as opposed to recommending home blood</p>	<p>Thank you for your comment. To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking a targeted approach to updating its guidelines. This section of the guideline was not prioritised for review within the scope of this update. As a registered stakeholder you will be notified of any subsequent activity on the guideline.</p> <p>We will pass your comment to the NICE surveillance team which monitors key events, such as ongoing studies or safety alerts, that are judged to be relevant to the guideline content. These are then assessed for priority to ensure reviews focus on areas where we can add most value.</p>

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				<p>pressure monitoring. The 2019 ESC guidelines on diabetes, pre-diabetes, and cardiovascular diseases developed in collaboration with the EASD recommend that home blood pressure self-monitoring should be considered in patients with diabetes on antihypertensive treatments to check that their blood pressure is appropriately controlled.</p> <p>References: https://care.diabetesjournals.org/content/44/Supplement_1/S125. https://academic.oup.com/eurheartj/article/41/2/255/5556890</p>	
Diabetes UK	Guideline	General	General	<p>Due to the limited scope of this consultation there is no signposting to 'Type 2 diabetes: prevention in people of high risk of type 2 diabetes' [PH38] and we feel that it should be cross-referenced to make the link between hypertension and developing type 2 diabetes clear for anyone accessing this document.</p> <p>High blood pressure is a risk factor for type 2 diabetes, and people with high blood pressure should be encouraged to take a risk assessment for the condition (as stated in PH38). Early detection of type 2 diabetes ensures timely care, treatment, and support to help reduce the risk of developing the serious complications of the condition.</p>	Thank you for your comment. It is not possible to include cross-references to all potentially relevant NICE guidelines within this document, however all guideline webpages include a 'Finding more information' section that will link to NICE guidance on related topics, including guidance in development.
Diabetes UK	Guideline	General	General	We are concerned that non-pharmacological interventions have not been expanded in this update. The current 2019	Thank you for your comment. To ensure a dynamic approach to maintaining the large number of published recommendations in the guideline portfolio, NICE is taking

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				<p>guideline only briefly acknowledges the role of lifestyle measures in helping to achieve blood pressure targets.</p> <p>A recent paper has also demonstrated the link between a reduction in blood pressure resulting from weight loss achieved in remission trials.</p> <p>Reference: Leslie WS <i>et al.</i> (2021) "Antihypertensive Medication Needs and Blood Pressure Control with Weight Loss in the Diabetes Remission Clinical Trial (direct)," <i>Diabetologia</i>, 64(9), pp. 1927–1938.</p>	<p>a targeted approach to updating its guidelines. This section of the guideline was not prioritised for review within the scope of this update. As a registered stakeholder you will be notified of any subsequent activity on the guideline.</p> <p>We will pass your comment to the NICE surveillance team which monitors key events, such as ongoing studies or safety alerts, that are judged to be relevant to the guideline content. These are then assessed for priority to ensure reviews focus on areas where we can add most value.</p>
Diabetes UK	Guideline	General	General	<p>There are no thresholds set for when blood pressure might be deemed too low in this update. Given the health consequences of a blood pressure falling too low we would welcome the inclusion of further information about this or the reasons behind the decision not to include the information in this guideline.</p>	<p>Thank you for your comment. The committee discussed whether a range of blood pressures should be recommended, including a lower limit. However, as evidence for a safe lower limit was not specifically looked for they agreed it was not appropriate to recommend a strict lower threshold.</p>
Diabetes UK	Guideline	General	General	<p>We recommend that the guidance acknowledges the need for a person-centred approach, with a joint decision-making process that addresses cardiovascular risk, potential adverse effects of antihypertensive medications, and the person's preferences.</p>	<p>Thank you for your comment. As in CG136 (published 2019), the following text will be included at the beginning of the section on 'Starting antihypertensive drug treatment':</p> <p>"NICE has produced a patient decision aid on treatment options for hypertension to help people and their healthcare professionals discuss the different types of treatment and make a decision that is right for each person.</p> <p>For advice on shared decision making for medicines, see the information on patient decision aids in NICE's guideline on medicines optimisation."</p>

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Royal College of Nursing	Guideline	General	General	<p>The Royal College of Nursing (RCN) welcome the proposal to develop NICE guidance for Hypertension in adults: diagnosis and management (update).</p> <p>The RCN invited members who work with people in these setting to review and comment on the draft scope.</p> <p>The comments below, reflect the views of our reviewers.</p>	Thank you for your comment.
Royal College of Nursing	Guideline	General	General	It seems an appropriate and balanced update.	Thank you for your comment.
The Stroke Association	Guideline	004	003	<p>Recommendation 1.4.23 Reducing blood pressure is key in the management of people with hypertension. Evidence shows that taking action to lower blood pressure can reduce the risk of stroke by about 27%.</p> <p>Currently, 40% of people are not optimally treated to the current 140/90 target. It is important that GPs, pharmacists and voluntary sector staff use these targets for diagnosing, monitoring and where appropriate treating those with hypertension. There needs to be consistent messaging for the public on what blood pressure level is safe. Blood pressure monitors are being distributed to help people manage their blood pressure at home. People living with cardiovascular disease need to be clear on what targets they are aiming for and when they should seek further information and guidance from GPs.</p> <p>Therefore, it is important to improve public awareness of hypertension and treatment options.</p> <p>We understand that the current evidence does not show a clinical benefit to using lower blood pressure targets for</p>	Thank you for your comment. The NICE surveillance team will continue to monitor the evidence becoming available and the review will be updated if evidence is identified that is likely to alter the current recommendations.

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				people with cardiovascular disease compared with standard blood pressure targets. However, we would like NICE to continue to monitor the evidence and keep this under review.	
The Stroke Association	Guideline	004	008	<p>Recommendation 1.4.30 The treatment of hypertension is as important as diagnosis and management. Hypertension treatment with medication is often highly effective at lowering blood pressure and significantly reducing the risk of stroke and other cardiovascular diseases. Optimally treating people with diagnosed high blood pressure could prevent 14,500 strokes and save up to £201.7m over three years in England.ⁱ One of the barriers to optimum blood pressure control is medicine adherence. It's estimated that anywhere between 25% and 47% of patients with high blood pressure do not fully adhere to their prescribed medical treatment.^{ii iii} Poor adherence to blood pressure lowering medication is associated with adverse cardiovascular outcomes such as strokes and premature death and disability.^{iv} We welcome this recommendation in line with the evidence base, however we would like plans to help people work with their GPs to help encourage them adhere to their medicine treatment plans.</p>	<p>Thank you for your support of this recommendation. The guideline will include a cross reference to the NICE guideline on medicines adherence, with the following text:</p> <p>To support adherence and ensure that people with hypertension make the most effective use of their medicines, see NICE's guideline on medicines adherence CG67.</p>
The Stroke Association	Guideline	005	019	We welcome the recommendation for research into the optimum blood pressure target for people aged over 80 with primary hypertension. This is a demographic where there are many cases of high blood pressure as prevalence of hypertension increases to 58% for those	Thank you for your comment.

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				aged 80+.v This is also a group where there's an increased risk of having a stroke due to the range of comorbidities so we welcome this as an area for further exploration into what the blood pressure targets should be.	
The Stroke Association	Guideline	005	025	We welcome the recommendation for research into blood pressure targets for people with prior ischaemic or haemorrhagic stroke. High blood pressure is not only a risk for first stroke but recurrent stroke. Once a person has a stroke they are at an increased risk of further stroke. The cumulative risk of having a stroke after five years is 26% and after ten years it is 39%.vi Secondary prevention for stroke survivors is important and having optimum blood pressure targets for those who have already had a prior stroke can be embedded into stroke recovery plans. We welcome this new recommendation for research.	Thank you for your comment.
The Stroke Association	Guideline	General	General	<p>The Stroke Association welcomes the opportunity to comment on the new recommendations to update the existing guideline for hypertension in adults: diagnosis and management.</p> <p>We have previously provided comments on NICE's update the guideline in March 2021, and this response will also build upon those comments.</p> <p>High blood pressure contributes to around half of all strokes, making it one of the biggest risk factors for stroke. Furthermore, up to 90% of all strokes are preventable by improving the management of key risk factors such as hypertension. Unfortunately, many people are living with undetected or poorly managed hypertension. Research by the Stroke Association shows that only 53% of UK adults</p>	<p>Thank you for summarising this information. The committee are mindful of the effects of the pandemic. NHS services have been and continue to be adapting to implement recommendations as appropriate following national guidance and restrictions relating to COVID-19, with social distancing where appropriate. Implementation of the recommendations should take the current context into account.</p> <p>Your comments about inequalities and the need for a whole system approach will be considered by NICE where relevant support activity is being planned.</p>

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				<p>know that high blood pressure is a top risk factor for stroke.^{vii}</p> <p>Furthermore, the Covid-19 pandemic has caused widespread disruption across the health and social care services. Lockdowns and social distancing measures reduced the number of in person interactions where high blood pressure might be detected i.e. GP appointments. During the first three months of the pandemic (March – May 2020), there was a 43% reduction in the rate of diagnosis of cardiovascular conditions (including high blood pressure) and a 29-52% reduction in first prescriptions of medications.^{viii} This suggests that there is a large number of patients currently living with undiagnosed high blood pressure. Therefore, it's vital that sufficient resources go into hypertension case-finding as well as diagnosis, so that these cases where there's an increased risk of stroke can be treated and managed appropriately. The CORE20PLUS5 approach to addressing health inequalities has identified hypertension case-finding as one of its five clinical areas to allow for interventions to optimise blood pressure and reduce the risk of stroke.</p> <p>In order to meet the ambitions for stroke in the Long Term Plan, NHS England and Improvement and the Stroke Association, in consultation with clinical experts and people affected by stroke, developed the National Stroke Programme. One of the aims of the programme is to achieve 3.6m patients with improved management of hypertension and cholesterol over the course of the Long Term Plan. According to CVDPREVENT data, those of</p>	

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				<p>working age, particularly men could have their hypertension better managed as well as people in the black ethnic group.^{ix} We would like to see efforts made to reduce health inequalities in this area to improve hypertension management of the population as a whole.</p> <p>We need a whole system approach to improve the detection, treatment and management of high blood pressure in order to prevent strokes, especially as we recover from the Covid-19 pandemic. We welcome the new and updated recommendations within this guideline to help contribute to this ambition.</p>	

ⁱ NHS England. (2017). The Size of the Prize in cardiovascular Disease Prevention – England. Available at: <https://www.healthcheck.nhs.uk/commissioners-and-providers/data/size-of-the-prize-and-nhs-health-check-factsheet/>

ⁱⁱ Strauch, B. et al. (2013). 'Precise assessment of noncompliance with the antihypertensive therapy in patients with resistant high blood pressure using toxicological serum analysis'. *Journal of Hypertension*, 31 (12), pp. 2455-61.

ⁱⁱⁱ Tomaszewski, M. et al. (2014). 'High rates of non-adherence to antihypertensive treatment revealed by high-performance liquid chromatography-tandem mass spectrometry (HP LC-MS/MS) urine analysis'. *Heart*, 100 (11), pp. 855-61.

^{iv} Burnier, M. et al. (2013). 'Measuring, analysing and managing drug adherence in resistant high blood pressure'. *Hypertension*, 62(2), pp.218-225.

^v Office for Health Improvement & Disparities (OHID) and NHS Benchmarking Network, (December 2021) CVDPREVENT First Annual Audit Report, for the baseline audit period up to March 2020

^{vi} Mohan KM, Wolfe CD, Rudd AG, Heuschmann PU, et al, 2011. Risk and cumulative risk of stroke recurrence:a systematic review and meta-analysis. *Stroke*, 42, 1489-94

^{vii} Research conducted by 4Media Relations on behalf of the Stroke Association, December 2020

^{viii} Williams, R. et a. (2020). 'Diagnosis of physical and mental conditions in primary care during the Covid-19 pandemic: a retrospective cohort study'. *Lancet Public Health*, 5, pp. 543-50.

^{ix} Office for Health Improvement & Disparities (OHID) and NHS Benchmarking Network (December 2021) CVDPREVENT First Annual Audit Report, for the baseline audit period up to March 2020

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