

# 10 terms every doctor should know about BP

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Nearly half of adults in the U.S. have hypertension. And while significant progress has been made in reducing high BP, blood-pressure control remains far from ideal.

The AMA has developed online tools and resources created using the latest evidence-based information to support physicians to help diagnose and manage their patients' high BP. These resources are available to all physicians and health systems as part of Target: BP™, a national initiative co-led by the AMA and American Heart Association (AHA).

Now is the time to fight back harder with better tools. This brief glossary will help guide you through different terms to make strides in improving blood pressure control.

## Self-measured blood pressure

Often referred to as “home blood pressure monitoring,” self-measured blood pressure (SMBP) occurs when a patient measures their blood pressure outside of a clinical setting. SMBP enables physicians to better diagnose and manage hypertension while also helping patients take an active role in the process.

Having patients measure their own blood pressure at home can improve the accuracy in making a diagnosis of hypertension, and for those patients who have it, can help get their blood pressure under control.

## Automated office blood pressure

For the most accurate BP readings measured in an ambulatory clinical setting, it is recommended that physicians use automated office blood pressure (AOBP) measurements. The use of AOBP devices

validated for clinical accuracy helps physicians and health care professionals obtain accurate, representative BP measurements.

An AOBP device can be programmed to take and average three or more readings, which is now the preferred approach for evaluating office BP over using auscultation for most patients. To ensure the patient and staff member are not talking during BP measurement—and to improve workflow efficiency—unattended AOBP is preferred over attended BP in many practice settings.

Unattended AOBP is when AOBP is performed without clinical staff present in the room during the BP measurements.

## White coat hypertension

You've most certainly heard about white coat hypertension (WCH), which occurs in patients without an existing diagnosis of hypertension. WCH is when the BP measurements in-office are in the hypertensive range and BP measurements out-of-office are not in the hypertensive range.

The use of SMBP or 24-hour ambulatory BP monitoring is required to make a diagnosis in patients with suspected hypertension based on office BP measurements. High in-office BP measurements can also occur due to patients not being properly positioned.

For example, if a patient's feet are not flat on the ground, they are talking during the measurement or their arm is not supported with the BP cuff at heart level, it can lead to high BP readings. By understanding how BP measurements can go wrong, you can take steps to improving accuracy.

## Alerting response

This response is a phenomenon due to the presence of a healthcare professional that produces a transient rise in BP in the patient. The alerting response is often associated with patients feeling nervous or anxious when their doctor is in the room. Using AOBP or SMBP instead of manual readings can help reduce the alerting response.

## Single-pill combination therapy

It is important to partner with patients to simplify antihypertensive medication regimens whenever possible. This can be accomplished with once daily dosing, increased use of low cost generic

medications and through using more single-pill combination therapy, which can improve adherence in patients taking antihypertensive medications.

Single-pill combination therapy incorporates two or more antihypertensive medications into one pill, which is more convenient for patients and has been shown to get people to goal BP faster than when they take two medication classes that aren't combined.

This can help improve BP control rates without increasing the risk of adverse events. Better BP control would lead to the prevention of many heart attacks, strokes and other complications associated with uncontrolled hypertension.

## Normal, elevated, hypertension stages

A joint task force formed by the American College of Cardiology (ACC) and the AHA released the 2017 guideline for high BP in adults. The ACC and AHA partnered with many other organizations representing physicians and other health professionals to create the new guideline.

The 2017 ACC/AHA guideline for high BP in adults provides four BP categories based on the average of two or more in-office readings on 2 or more occasions:

- **Normal:** Lower than 120 mm Hg systolic BP (SBP) and 80 mm Hg diastolic BP (DBP).
- **Elevated:** 120–129 mm Hg SBP and lower than 80 mm Hg DBP.
- **Stage 1 hypertension:** 130–139 mm Hg SBP or 80–89 mm Hg DBP.
- **Stage 2 hypertension:** Higher than or equal to 140 mm Hg SBP or 90 mm Hg DBP.

## DASH eating plan

Under the ACC/AHA hypertension guideline more people will have hypertension, but that doesn't mean medication is the only option. For most of the patients with Stage 1 hypertension, healthy lifestyle changes—not medications—are recommended to treat hypertension. Healthy lifestyle changes are recommended for all patients with elevated or high BP, including those who also are prescribed antihypertensive medications.

This is where the dietary approaches to stop hypertension (DASH) diet can be recommended. The DASH diet is low in saturated fat and high in vegetables and fruits. DASH can help a patient lose weight and allow them to maintain a healthier diet.

Reduction in salt intake is an important lifestyle change, along with increasing potassium rich foods in the diet (in those that do not need to limit potassium intake), increasing exercise and limiting alcohol

consumption to two drinks a day for men and one drink a day for women who drink alcohol.