

Lifestyle Management for Patients with Hypertension

Suggestions for the following lifestyle changes should be offered and reviewed at each visit:

Smoking cessation

Recommend complete cessation of smoking and exposure to second hand smoke.
QuitNow Services: 1 877 455-2233 (toll-free in BC; available 24/7/365) www.quitnow.ca

Physical activity

Prescribe 30-60 minutes of moderate intensity dynamic activity (such as walking 3 km [2 miles] in 30 minutes once per day, or 1.5 km [1 mile] in 15 minutes two times per day, jogging, cycling or swimming) 4-7 days per week. Recommend getting a pedometer for immediate positive feedback.

Weight reduction

All overweight patients with hypertension should be advised to lose weight. Weight loss strategies should be long-term and employ a multidisciplinary approach that includes dietary education, increased physical activity, and behavioural intervention. Target: body mass index (BMI) 18.5-24.9 kg/m², waist circumference <102 cm [40"] for men and <88 cm [35"] for women.

Dietary recommendations

Advise a diet high in fruits, vegetables, low-fat dairy products, fibre, whole grains and protein sources reduced in saturated fats and cholesterol (Dietary Approaches to Stop Hypertension [DASH] diet). Reduce consumption of trans-fats and increase intake of fish high in omega 3 fatty acids.

Reduce salt intake

Recommend reduced dietary sodium intake of $\leq 1,500$ milligrams per day (approximately 1 tsp of table salt).

Alcohol consumption

Limit to two drinks or less per day, and consumption should not exceed 14 standard drinks per week for men and 9 standard drinks per week for women.

Potassium, calcium and magnesium intake

Supplementation of potassium, calcium and magnesium is not recommended for the prevention or treatment of hypertension.

Pharmacologic Treatment without Co-morbid Conditions

The benefits of pharmacologic treatment in people with mild hypertension (average BP between 140/90 and 160/100), and a 10-year coronary heart disease risk of less than 20%, are unclear. Use clinical judgment when recommending therapy for this patient group.

Pharmacologic treatment, in addition to lifestyle modification is recommended for patients with an average BP $\geq 160/100$, even in the absence of other major cardiovascular risk factors.

Consider monotherapy with a low-dose thiazide diuretic as first-line treatment.

If BP is not controlled, use combination therapy by adding 1 or more of:

- ACEI or ARB if ACEI intolerant
- Long-acting dihydropyridine calcium channel blockers (DHP-CCB)

Note:

- Long-acting DHP-CCB are preferred 2nd line treatment for patients at risk for, or with a history of, stroke
- Beta blockers may no longer be a first line treatment option, with some exceptions
- Alpha blockers are not a 1st line treatment option

Consider addition of low-dose ASA therapy if Framingham risk score is $\geq 20\%$ and patient is between 50 to 70 years-of-age. Avoid using ASA in patients with a history of hemorrhagic stroke. Blood pressure must be well controlled.

See hypertension guideline for pharmacologic management if co-morbid conditions exist.