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Overview of hypertension in adults

Mixed systolic and diastolic hypertension. In clinical practice, patients who are taking medications for hypertension are usually defined as having hypertension, specifically “treated hypertension,” regardless of... Secondary or contributing causes of hypertension

Hypertension

Summary and recommendations

Choice of drug therapy in primary (essential) hypertension

Initial treatment of hypertension will be presented here. The dictum of goal blood pressure in the treatment of hypertension, as provided... Summary and recommendations

Coronavirus disease 2019 (COVID-19): Issues related to kidney disease. End-stage kidney disease (ESKD), acute kidney injury (AKI), and other aspects of COVID-19 infection that may affect this population are...
Overview of hypertension in adults

Authors: Jan Basile, MD, Michael J Bloch, MD, FACP, FASH, FSVM, FNLA
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Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.

Literature review current through: Mar 2020. | This topic last updated: May 02, 2019.

INTRODUCTION

The global prevalence of hypertension is high, and among nonpregnant adults in the United States, hypertension is the most common reason for office visits and for the use of chronic prescription medications. In addition, roughly half of hypertensive individuals do not have adequate blood pressure control. These topics are discussed in detail elsewhere. (See "The prevalence and control of hypertension in adults" and "Pathophysiology of hypertension and the treatment of hypertension".)
COMPLICATIONS OF HYPERTENSION

Hypertension is associated with a significant increase in risk of adverse cardiovascular and renal outcomes. Each of the following complications is closely associated with the presence of hypertension (see "Cardiovascular risks of hypertension"):

- Left ventricular hypertrophy (LVH) (Figure 1) [17, 18] (see "Clinical implications and treatment of left ventricular hypertrophy in hypertension")
- Heart failure, both reduced ejection fraction (systolic) and preserved ejection fraction (diastolic) [19] (see "Epidemiology and causes of heart failure")
- Ischemic stroke [20, 21] (see "Clinical diagnosis of stroke subtypes", section on "Etiology and risk factors")
- Intracerebral hemorrhage [20, 22] (see "Spontaneous intracerebral hemorrhage. Pathogenesis, clinical features and diagnosis")
- Ischemic heart disease, including myocardial infarction and coronary interventions [20, 23] (see "Overview of established risk factors for cardiovascular disease")
Overview of hypertension in adults

Likely the result of numerous genetic and environmental factors that have multiple compounding effects on cardiovascular and renal structure and function. Some of these factors are discussed in the ensuing section.

Risk factors for primary (essential) hypertension are multifactorial and include:

- **Age**: Advancing age is associated with increased blood pressure, particularly systolic blood pressure, and an increased incidence of hypertension.

- **Obesity**: Obesity and weight gain are major risk factors for hypertension and are also determinants of the rise in blood pressure that is commonly observed with aging [11, 12]. (See "Overweight, obesity, and weight reduction in hypertension".)

- **Family history**: Hypertension is about twice as common in subjects who have one or two hypertensive parents, and multiple epidemiologic studies suggest that genetic factors account for approximately 30 percent of the variation in blood pressure in various populations [13, 14]. (See "Genetic factors in the pathogenesis of hypertension".)

- **Race**: Hypertension tends to be more common, be more severe, occur earlier in life, and be associated with greater target-organ damage in blacks. (See "Hypertensive complications in black patients".)

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**International**


**Canada**

- Choosing Wisely Canada. Don’t prescribe angiotensin converting enzyme (ACE) inhibitors, angiotensin II receptor blockers (ARBs) for the treatment of hypertension, diabetic nephropathy, or heart failure (2017)
Treatment of Hypertension

Diabetes Canada Clinical Practice Guidelines Expert Committee

Sheldon W. Tobe MD, FRCP, Richard E. Gilbert MBBS, PhD, FRCP, Charlotte Jones MD, PhD, FRCP, Lawrence A. Leiter MD, FRCP, FACP, FACE, FAHA, Ally P.H. Prebëtni MD, FRCP, Vincent Woo MD, FRCP

Key Messages
Reduce Complications
Keep People Safe
Self-management

For Health-Care Providers
Tools & Resources

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Role of ACE Inhibitors and ARBs
Antihypertensive Choices
Overview of hypertension in adults
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END OF LIFE AND HOSPICE CARE

Physician orders for comfort measures and ICU admission (March 2020)

The effect of physician orders for comfort measures (CM) or limited interventions (LI) on ICU admission rates is unclear. One retrospective cohort study of 1818 decedents who had life-limiting illness and were admitted to hospital within six months of death reported that patients with CM and LI orders were significantly less likely to be admitted to the ICU than those with orders for full treatment (31 versus 62 percent) [1]. However, 38 percent of patients received intensive treatments that were discordant with their orders. These data suggest that physician orders regarding goals of care reduce unnecessary admissions to the ICU. However, tools that reduce discordant care are necessary. (See "Palliative care: issues in the intensive care unit in adults," section on "ICU admission for palliative therapy").

The three wishes project for the dying ICU patient (January 2020)

Medline ® Abstract for Reference 1 of 'What's new in palliative care'

1 PubMed
TI Association of Physician Orders for Life-Sustaining Treatment With ICU Admission Among Terminally Ill Hospital Patients
SO JAMA. 2020;
Importance: Patients with chronic illness frequently use Physician Orders for Life-Sustaining Treatment (POLST), which are intended to guide care in end-stage illness and to reduce the frequency of hospitalization and resuscitation. However, the impact of POLST on ICU admission is unclear. Using a large administrative data set, investigators evaluated whether POLST orders were associated with lower ICU admission rates compared with non-POLST orders. The study included patients with cancer and those aged 65 years or older with one or more of the following conditions: stroke, dementia, metastatic cancer, terminal illness, respiratory failure, chronic heart failure, chronic kidney disease, or severe sepsis. The index date was the date of diagnosis of the condition or hospital admission. The outcome was ICU admission during the index hospitalization. Patients were followed until death, transfer to hospice, or hospital discharge.

Results: Among 1,912,927 patients with cancer (89% receiving active treatment) or with chronic illness, 56% had POLST orders. Patients with POLST orders had lower rates of ICU admission (odds ratio, 0.69; 95% confidence interval, 0.68-0.70; P < .001). This association persisted after adjusting for length of stay and diagnoses.

Conclusion: Physician orders for life-sustaining treatment predicted lower ICU admission among terminally ill patients.
INTRODUCTION

This section highlights selected specific new recommendations and/or updates that we anticipate may change usual clinical practice. Practice Changing UpDates focus on changes that may have significant and broad impact on practice, and therefore do not represent all updates that affect practice. These Practice Changing UpDates, reflecting important changes to UpToDate over the past year, are presented chronologically, and are discussed in greater detail in the identified topic reviews.

INFECTIOUS DISEASES (March 2020, Modified April 2020)

One-time HCV screening for all adults ≥18 years
### Drug Information

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### Pediatric drug information

- 14-C Urea breath test: [Pediatric drug information](#)
- Abacavir and lamivudine: [Pediatric drug information](#)
- Abacavir, lamivudine, and zidovudine: [Pediatric drug information](#)
- Abacavir: [Pediatric drug information](#)
- Abatacept: [Pediatric drug information](#)
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Patient education: Ear tubes (The Basics)

Written by the doctors and editors at UpToDate

What are ear tubes?

Ear tubes are tiny tubes that a doctor puts in the tissue between the ear canal and the middle ear. They are also sometimes called "tympanostomy tubes" or "tubes".

Why might children get ear tubes?

Children might get ear tubes if they:

1. Have a middle ear infection that doesn't clear up on its own
2. Have recurrent ear infections
3. Suffer from chronic ear fluid
4. Have an ear drum that doesn't move properly

How long do ear tubes stay in?

Ear tubes usually stay in for about a year, but they can stay longer if the child has continuing health issues.

How can I decide if my child should get ear tubes?

Consult your child's doctor to determine if ear tubes are the best option for your child's health.

Ear infection (otitis media)

The ear on the left is normal and does not have an infection. The ear on the right shows what an infection can look like. The infected fluid in the middle ear causes the eardrum to bulge. Normally, fluid in the middle ear drains.
Geriatrics

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- Geriatric Surgery

Neurologic disease

- Delirium
  - Delirium and acute confusional states: Prevention, treatment, and outcomes
  - Diagnosis of delirium and confusional states

- Dementia
  - Cholinesterase inhibitors in the treatment of Alzheimer disease
  - Clinical features and diagnosis of Alzheimer disease
  - Clinical features and diagnosis of dementia with Lewy bodies
Clinical features and diagnosis of Alzheimer disease

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Contributor Disclosures

All topics are updated as new evidence becomes available and our peer review process is complete.


INTRODUCTION

Alzheimer disease (AD) is a neurodegenerative disorder of uncertain cause and pathogenesis that primarily affects older adults and is the most common cause of dementia [1]. The most essential and often earliest clinical manifestation of AD is selective memory impairment, although there are exceptions. While treatments that can ameliorate some symptoms of the illness, there is no cure or disease-modifying therapy (treatments that slow the course of the illness) currently available, and the disease inevitably progresses in all patients.
Pimozide / FLUoxetine

Risk Rating: X: Avoid combination

Summary: FLUoxetine may enhance the QTc-prolonging effect of Pimozide. FLUoxetine may increase the serum concentration of Pimozide.

Patient Management: Concurrent use of pimozide and fluoxetine is contraindicated.

Discussion: According to pimozide prescribing information, the pimozide AUC was increased by an average of 151%, and the pimozide maximum serum concentration (Cmax) was increased by an average of 62% when pimozide (2 mg x 1) was administered with the strong CYP2D6 inhibitor paroxetine 60 mg. The mechanism for this apparent interaction is described as being inhibition of the CYP2D6-mediated metabolism of pimozide by paroxetine. As a result, pimozide prescribing information lists concurrent use of strong CYP2D6 inhibitors such as paroxetine or fluoxetine as contraindicated. The fluoxetine prescribing information also specifically contraindicates concurrent use with pimozide due to the potential for fluoxetine to inhibit the CYP2D6-mediated metabolism of pimozide and to increase the potential for QT interval prolongation.

These findings and conclusions in metabolizers that conducted in vitro studies concluded that CYP2D6 metabolizers also show significant slowing of metabolism. This pharmacology of the pimozide-metabolization and fluoxetine interaction is poorly understood, but the syndrome is associated with many of the same drugs (e.g., antipsychotics, serotonergic antidepressants) as extrapyramidal side effects and similar precautions regarding the use of multiple associated agents should be taken.

Footnotes:
1. Diges, brompropide [prescribing information]. Sao Paulo, Brazil: Sanofi-Aventis Farmaceutica Ltda; May 2016.
### Lexicomp® Drug Interactions

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- **Ginkgo Biloba**
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### Thiazide and Thiazide-Like Diuretics

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**DISCLAIMER:** Readers are advised that decisions regarding drug therapy must be based on the independent judgment of the clinician, changing information about a drug (e.g., as reflected in the literature and manufacturer’s most current product information), and changing medical practices.
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