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Professor Anthony Wierzbicki
Chair, Hypertension in adults advisory committee
National Institute for Health and Care Excellence

Emailed to: HypertensionInAdults@nice.nhs.uk

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Dear Professor Wierzbicki

NICE Hypertension in adults: diagnosis and management

The BMA is a professional association and trade union representing and negotiating on behalf of all doctors and medical students in the UK. It is a leading voice advocating for outstanding health care and a healthy population. It is an association providing members with excellent individual services and support throughout their lives.

The Association welcomes the opportunity to respond to your consultation on Hypertension in adults: diagnosis and treatment. We are concerned that the recommendation to offer treatment to patients with stage 1 hypertension has been made on an economic model of cost-efficiency based on the treating of populations, rather than treating patients as individuals. The evidence for individual benefit in stage 1 hypertension is not robust and is insufficient for the level of pharmacological intervention that implementing this guideline would produce. We are also concerned about the impact of these recommendations on primary care and secondary care workload. Please find enclosed the BMA's full submission to this consultation, including comments on specific paragraphs in the draft guideline.

We hope that our submission is useful – please do not hesitate to contact us for more information if required.

Yours sincerely

Angela Kyle
Head, Committee Services

Policy Directorate

General comments

We are concerned that the decision to recommend the offering of treatment to patients with stage 1 hypertension in the absence of other concerning features has been made on an economic model of cost-efficiency based on the treating of populations. Within their consultations, doctors do not see populations but individuals, and an examination of the potential benefits and harms to the individual, based on absolute and not relative values, ought to be at the heart of this guideline, together with the information that clinicians will need to have in order to inform their patients. The evidence for individual benefit in stage 1 hypertension is not robust and is insufficient for the level of pharmacological intervention that implementing this guideline would produce.

We are also concerned about the impact of these recommendations on primary care and secondary care workload, the latter will be a particular concern if our comments on paragraph 1.4.49 on referral are not heeded. NICE correctly recognizes the importance of recognizing multimorbidity in individual patients, and encourages clinicians to consider the effect of applying a single-disease guideline to a multimorbid patient. We consider that the current workload and funding crisis in the NHS has produced a multimorbid health-care system in which the addition of tasks will inevitably produce harm elsewhere. We do not believe it is reasonable that guidance that results in increased pressures within the NHS is produced without recognition of lost opportunity costs for patients with other conditions.

Please also see our comments on some specific paragraphs outlined below:

Paragraph 1.2.4 'If ABPM is unsuitable or the person is unable to tolerate it, offer home 5 blood pressure monitoring (HBPM) to confirm the diagnosis of 6 hypertension.'

Comments: In some areas Ambulatory Blood Pressure Monitoring has not been commissioned; therefore, we would recommend either alteration to *If ABPM is unsuitable, unavailable, or the person….* or amending to recommend a choice of ABPM or HBPM.

Paragraph 1.2.5 'While waiting for confirmation of a diagnosis of hypertension, carry out:
• investigations for Target organ damage (see recommendation 1.3.3), followed by
• formal assessment of cardiovascular risk using a cardiovascular risk assessment tool (see the section on full formal risk assessment in the NICE guideline on cardiovascular disease).'

Comments: The predictive value of an isolated moderately raised blood pressure reading taken in surgery, particularly when the patient is ill or anxious, is limited. We would therefore recommend investigations for target organ damage only at the point where it appears that hypertension is likely. If it is done before this point it would be classified as a screening procedure and would therefore need to be shown to produce overall benefit in the general population (as opposed to the hypertensive population) and require separate commissioning following approval from the UK National Screening Committee.

Paragraph 1.4.10 'Offer antihypertensive drug treatment in addition to lifestyle advice to adults aged under 80 with persistent stage 1 hypertension who have 1 or more of the following: target organ damage; Established cardiovascular disease; renal disease; diabetes; an estimated 10-year risk of cardiovascular disease of 10% or more.'

Comments: We do not believe that the word 'offer' should be applied to those with stage 1 hypertension in the absence of the other factors mentioned. Many patients will interpret an offer of drug treatment as a recommendation for it, and the benefits to individual patients does not justify such an approach. We would recommend that, for these patients, it would be more appropriate to say 'discuss with the patient the potential benefits and harms of drug treatment'. For this discussion to be possible, decision-making aids should be supplied explaining the number-needed-to-treat and -number-needed-to-harm values. The guideline committee has noted that the evidence base here is incomplete, and therefore there should be more emphasis placed on facilitating an informed patient choice.

Paragraph 1.4.12 'Consider antihypertensive drug treatment in addition to lifestyle advice for younger adults with stage 1 hypertension and an estimated 10-year risk below 10%. Bear in mind that 10-year cardiovascular risk may underestimate the lifetime probability of developing cardiovascular disease.'

Comments: We believe that the evidence for this is insufficient to justify the recommendation even with 'consider' and request that a comparison of outcomes be provided with annual monitoring without treatment.

Paragraph 1.4.13 'Consider starting antihypertensive drug treatment for people aged over 80 with stage 1 hypertension. Use clinical judgement for people with frailty or multimorbidity (see also NICE's guideline on multimorbidity).'

Comments: We welcome the reference to multimorbidity and frailty, but even without these features the greater propensity of adverse effects from drug treatment in this age group, combined with concerns about the effects of low blood pressure, raise significant concerns even at the 'consider' level of recommendation.

Paragraph 1.4.15 'Use clinic blood pressure measurements to monitor the response to lifestyle changes or drug treatment in adults with hypertension.

Paragraph 1.4.16 'Consider HBPM for adults with hypertension who choose to self-monitor their blood pressure.'

Comments for 1.4.15 and 1.4.16: We consider HBPM has significant advantages to clinic blood pressure readings, particularly with regard to empowering patients to share responsibility for their treatment. Clinic and HBPM should be given equal validity.

Paragraph 1.4.49 'If blood pressure remains uncontrolled in people with resistant hypertension taking the optimal tolerated doses of 4 drugs, seek expert advice.'

Comment: The word 'expert' is inappropriate as patients are already under the care of experts in primary care, the phrase should be amended to 'referral for specialist assessment.'

We do not believe that all patients will benefit from this, particularly those who are more frail or multimorbid, or those with readings close to the ideal. The word 'consider' needs to be added to prevent unwanted criticism should referral not be indicated.