Hypertension Management — Adults

Diagnosis · risk-based treatment · targets · review

CLINICAL PATHWAY

drregu.com.au

Confirm the diagnosis out of clinic before treating. Use home or ambulatory BP monitoring (or automated office BP) in preference to a single clinic reading — this avoids over- and under-treating white-coat and masked hypertension. Base the decision to treat on BP level **and** absolute CVD risk together, not BP alone.

STEPPED TREATMENT

Preferred — dual therapy from the outset

Two-class combination, often a single pill, for most starting treatment.

Step 1	ACE inhibitor/ARB + CCB or thiazide-like diuretic, low-dose
Step 2	Triple therapy: add the third class if not at target after 4–6 weeks
Step 3	Resistant: add spironolactone once adherence & causes checked
Step 4	Refer if still above target on optimal triple therapy

Alternative — monotherapy start

Reasonable where BP is close to target, or in frailty/older age.

Step 1	Single agent: ACE inhibitor, ARB, CCB or diuretic
Step 2	Add a second class if not at target after 4–6 weeks
Step 3	Move to triple therapy if still above target
Step 4	Refer if resistant on three classes incl. a diuretic

EXACT DOSES & COMBINATIONS

For exact strengths, single-pill combinations and PBS first-line eligibility, use the current Therapeutic Guidelines (eTG) hypertension topic and check pbs.gov.au.

CONFIRM THE DIAGNOSIS — OUT OF CLINIC

Office ≥140/90 (≥2 visits); home ≥135/85; ambulatory ≥130/80. Prefer home/ambulatory or automated office BP over a single clinic reading.

WHO TO TREAT & TARGET BP

High risk (≥10%, cvdcheck.org.au) or BP ≥160/100, diabetes, CKD, CVD → treat. Intermediate → consider. Low → lifestyle first. Target <140/90; <130/80 if tolerated.

LIFESTYLE — OFFER TO EVERY PATIENT

- Salt reduction or substitution, and a DASH-style eating pattern.
- Regular physical activity, alcohol moderation and smoking cessation.
- Structured behavioural support works better than verbal advice alone.

SECONDARY CAUSES AT DIAGNOSIS

Screen for primary aldosteronism in early-onset, resistant, or hypokalaemic hypertension — normal potassium does not exclude it (present in only ~30%).

MONITORING & REVIEW

Recheck BP 4–6 weeks after any change, then 6–12 monthly at target. Reassess CVD risk 2-yearly (intermediate) or 5-yearly (low). Annual: adherence, technique, renal function.

SAFETY

- BP ≥180/110 with symptoms → same-day assessment
- Check renal function & potassium before & after starting an ACEi/ARB or diuretic
- Creatinine >30% rise on ACEi/ARB → stop & investigate
- Avoid ACEi, ARBs & renin inhibitors in or planning pregnancy

RED FLAGS / REFER

- Resistant: above target on 3 classes incl. a diuretic, adherence confirmed
- Age <30 years at diagnosis, or signs of a secondary cause
- Suspected primary aldosteronism: early-onset, resistant or hypokalaemic
- Hypertensive emergency: severe BP with end-organ symptoms — same-day or ED

For health-professional use. Framework: 2016 NHFA hypertension guideline & 2023 Aus CVD risk guideline.
New national hypertension guideline due Q3 2026 — recheck thresholds then. Doses: pbs.gov.au / eTG.