Although these guidelines provide evidence-based recommendations for the management of hypertension and will meet the clinical needs of most patients, these recommendations are not a substitute for clinical judgment, and decisions about care should incorporate recommendations for high-risk clinical conditions and circumstances of the individual patient.

**Abbreviations**

1. HTN = Hypertension
2. JNC 8 = Eighth Joint National Committee
3. USPSTF = United States Preventive Services Task Force
4. BP = Blood pressure; SPB = Systolic blood pressure; DBP = Diastolic blood pressure
5. CKD = Chronic kidney disease
6. DM = Diabetes mellitus
7. ACEI = Angiotensin converting enzyme inhibitor
8. ARB = Angiotensin receptor blocker
9. CCB = Calcium channel blocker
1. Rationale
   
a. Hypertension leads to myocardial infarction, stroke, renal failure, and death if not detected early and treated appropriately. Patients want to be assured that blood pressure treatment will reduce their disease burden, while clinicians want guidance on hypertension management using the best scientific evidence. (JNC 8)

b. High blood pressure is a prevalent condition, affecting approximately 30% of the adult population.¹ It is the most commonly diagnosed condition at outpatient office visits. High blood pressure is a major contributing risk factor to heart failure, heart attack, stroke, and chronic kidney disease. In 2010, it was the primary or contributing cause of death for more than 362,000 Americans. (USPSTF)

2. Adults 18 and over should be screened for hypertension

3. Proper blood pressure measurement
   
a. Office: A minimum of two readings should be taken at intervals of at least one minute, and the average of those readings should be used to represent the patient’s blood pressure. If there is 5mm Hg difference between the first and second readings, additional (one or two) readings should be obtained, and then the average of these multiple readings is used.

b. Ambulatory and home monitoring may be used to confirm a diagnosis of hypertension after initial screening.

4. Initial diagnosis of hypertension should be made after blood pressure measurement by provider

5. Blood pressure goal is < 140/90 for patients age 18-59 (and 60-85 with diabetes). Goal of < 150/90 for patients age 60-85 without diabetes acceptable.

6. Patient education and self-care
   

b. Community services: to be identified local clinically integrated network care coordinator and approved by executive director and medical director prior to local distribution to all providers.

7. Treatment
   
a. The actual level of blood pressure elevation should not be the sole factor in determining treatment. Clinicians should consider the patient’s overall cardiovascular risk profile, including smoking, diabetes, abnormal blood lipid values, age, sex, sedentary lifestyle, and obesity, when making treatment decisions. (USPSTF)

Lifestyle therapy:
healthy eating / DASH diet, weight control and increased physical activity

ACEI/ARB* alone or in combination with other drug class (CCB or thiazide^ diuretic)

*ACEIs and ARBs should not be used in combination
^Thiazide diuretics should be used with caution in patients prone to dehydration, such as the elderly
8. Care Coordination (patient will automatically be engaged by care team and provider will be involved in care plan after needs assessment for high risk and rising risk patients performed)
   a. High risk (uncontrolled hypertension and hospitalization/emergency department visit)
   b. Rising risk (uncontrolled hypertension and multiple chronic conditions)
   c. Low risk – patient seen by provider every six months if controlled

9. Provider visit frequency
   a. Provider visits every six months for controlled patients
   b. Follow up at least monthly for uncontrolled patients

10. Specialist consultation or referral recommended if:
    a. Unable to control hypertension (within six weeks) with multiple chronic conditions
    b. Uncontrolled hypertension on three or more drugs

11. Quality measures and goals
    a. HTN control 80%

12. Responsibilities of clinically integrated network
    a. Secure board approval of guideline
    b. Ensure that all practices are educated on guideline
    c. Train office staff on proper BP measurement
    d. Train office staff to download and print educational materials provided
    e. Educate practices on community resources for hypertension
    f. Train practices how to refer patients to care coordination
    g. Develop workflow for care coordination reports back to providers
    h. Maintain registry for uncontrolled hypertension and manage gaps in follow-up care with recall
    i. Review guideline annually in quality committee and provide feedback to CI clinical governance
References


Appendix

AHA Scientific Statement

Recommendations for Blood Pressure Measurement in Humans and Experimental Animals

Part 1: Blood Pressure Measurement in Humans

A Statement for Professionals From the Subcommittee of Professional and Public Education of the American Heart Association Council on High Blood Pressure Research

Thomas G. Pickering, MD, DPhil; John E. Hall, PhD; Lawrence J. Appel, MD; Bonita E. Falkner, MD; John Graves, MD; Martha N. Hill, RN, PhD; Daniel W. Jones, MD; Theodore Kurtz, MD; Sheldon G. Sheps, MD; Edward J. Roccella, PhD, MPH

Abstract—Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure–related risk, and to guide management. The auscultatory technique with a trained observer and mercury sphygmomanometer continues to be the method of choice for measurement in the office, using the first and fifth phases of the Korotkoff sounds, including in pregnant women. The use of mercury is declining, and alternatives are needed. Aneroid devices are suitable, but they require frequent calibration. Hybrid devices that use electronic transducers instead of mercury have promise. The oscillometric method can be used for office measurement, but only devices independently validated according to standard protocols should be used, and individual calibration is recommended. They have the advantage of being able to take multiple measurements. Proper training of observers, positioning of the patient, and selection of cuff size are all essential. It is increasingly recognized that office measurements correlate poorly with blood pressure measured in other settings, and that they can be supplemented by self-measured readings taken with validated devices at home. There is increasing evidence that home readings predict cardiovascular events and are particularly useful for monitoring the effects of treatment. Twenty-four-hour ambulatory monitoring gives a better prediction of risk than office measurements and is useful for diagnosing white-coat hypertension. There is increasing evidence that a failure of blood pressure to fall during the night may be associated with increased risk. In obese patients and children, the use of an appropriate cuff size is of paramount importance. (Circulation. 2005;111:697-716.)

Key Words: hypertension ■ ambulatory monitoring ■ self-measurement

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Ten years have passed since the last version of the American Heart Association (AHA) blood pressure measurement recommendations, during which time there have been major changes in the ways by which blood pressure is measured in clinical practice and research; hence, this document is a radical revision of previous versions. Blood pressure determination continues to be one of the most important measurements in all of clinical medicine and is still one of the most inaccurately performed. Hypertension is a major risk factor for coronary heart disease, stroke, and renal failure, and affects approximately one-third of the American population. The latest version of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC) recommendations has drawn attention to the condition of “prehypertension,” that is, people with blood pressures at the high end of the normal range, which applies to another one-quarter of the adult population. The target blood pressure for patients using antihypertensive treatment has recently been lowered for those with diabetes or renal disease.¹ Thus, it is becoming increasingly important to be able to detect small differences in blood pressure.

The gold standard for clinical blood pressure measurement has always been readings taken by a trained health care provider using a mercury sphygmomanometer and the Korotkoff sound technique, but there is increasing evidence that this procedure may lead to the misclassification of large numbers of individuals as hypertensive and also to a failure to diagnose blood pressure that may be normal in the clinic setting but elevated at other times in some individuals. There are 3 main reasons for this: (1) inaccuracies in the methods, some of which are avoidable; (2) the inherent variability of blood pressure; and (3) the tendency for blood pressure to increase in the presence of a physician (the so-called white coat effect).

Numerous surveys have shown that physicians and other health care providers rarely follow established guidelines for blood pressure measurement; however, when they do, the readings correlate much more closely with more objective measures of blood pressure than the usual clinic readings. It is generally agreed that conventional clinic readings, when made correctly, are a surrogate marker for a patient’s true blood pressure, which is conceived as the average level over prolonged periods of time, and which is thought to be the most important component of blood pressure in determining its adverse effects. Usual clinic readings give a very poor estimate of this, not only because of poor technique but also because they typically only consist of 1 or 2 individual measurements, and the beat-to-beat blood pressure variability is such that a small number of readings can only give a crude estimate of the average level.

There are potentially 3 measures of blood pressure that could contribute to the adverse effects of hypertension. The first is the average level, the second is the diurnal variation, and the third is the short-term variability. At the present time, the measure of blood pressure that is most clearly related to morbid events is the average level, although there is also evidence accumulating that suggests that hypertensive patients whose pressure remains high at night (nondippers) are at greater risk for cardiovascular morbidity than dippers.² Less information is available for defining the clinical significance of blood pressure variability, although it has been suggested that it is a risk factor for cardiovascular morbidity.

The recognition of these limitations of the traditional clinic readings has led to 2 parallel developments: first, increasing use of measurements made out of the clinic, which avoids the unrepresentative nature of the clinic setting and also allows for increased numbers of readings to be taken; and second, the increased use of automated devices, which are being used both in and out of the office setting. This decreased reliance on traditional readings has been accelerated by the fact that mercury is being banned in many countries, although there is still uncertainty regarding what will replace it. The leading contenders are aneroid and oscillometric devices, both of which are being used with increasing frequency but have not been accepted as being as accurate as mercury.

**Epidemiology of Hypertension**

**Overview**

Blood pressure is a powerful, consistent, and independent risk factor for cardiovascular disease and renal disease. According to the National Health and Nutrition Examination Survey (NHANES), at least 65 million adult Americans, or nearly one-third of the US adult population, have hypertension, defined as a systolic blood pressure ≥140 mm Hg, diastolic blood pressure ≥90 mm Hg, and/or current use of antihypertensive medication.³ Another one-quarter of US adults have blood pressure in the “prehypertension” range, a systolic blood pressure of 120 to 139 mm Hg or diastolic blood pressure of 80 to 89 mm Hg, i.e., a level above normal yet below the hypertensive range.⁴ The prevalence of hypertension rises progressively with age, such that more than half of all Americans aged 65 years or older have hypertension.

Data from numerous observational epidemiological studies provide persuasive evidence of the direct relationship between blood pressure and cardiovascular disease. In a recent meta-analysis that aggregated data across 61 prospective observational studies that together enrolled 958,074 adults,⁵ there were strong, direct relationships between average blood pressure and vascular mortality. These relationships were evident in middle-aged and older-aged individuals. Importantly, there was no evidence of a blood pressure threshold, that is, cardiovascular mortality increased progressively throughout the range of blood pressure, including the prehypertensive range. It has been estimated that ~15% of blood pressure–related deaths from coronary heart disease occur in individuals with blood pressure in the prehypertensive range.⁶
It remains unclear to what extent such adverse effects are a manifestation of more extensive target organ damage impairing the baroreflex regulation of blood pressure (and hence increasing blood pressure variability) as opposed to a direct effect of the variability itself.

“Labile hypertension” is a term that has been used in the past to describe blood pressure that is unusually variable, but the wider use of out-of-office monitoring has shown that lability of blood pressure is the rule rather than the exception.

### Classification/Subtypes of Hypertension

#### Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure Classification

The health risks attributable to increasing blood pressure in adults are continuous, beginning at 115/75 mm Hg. Definitions have been established based on these risks and on the demonstrated net health benefits of blood pressure reduction. The Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) has continued the definition of hypertension beginning at 140/90 mm Hg for adults aged 18 or older. The classification is based on the average of ≥2 seated blood pressure measurements, properly measured with well-maintained equipment, at each of ≥2 visits to the office or clinic. Hypertension has been divided into stages 1 and 2, as shown in Table 1. JNC 7 has defined normal blood pressure as <120 and <80. The intervening levels, 120 to 139 and 80 to 89 mm Hg, are now defined as prehypertension, a group that has increasing health risks and from which definite hypertension progresses.

Current recommendations from World Health Organizations, International Society of Hypertension, and European Society of Hypertension/European Society of Cardiology continue to divide stage 2 hypertension, with stage 3 beginning at ≥180 and ≥110. They also refer to <120/<80 as optimal, 120 to 129/80 to 84 as normal, and 130 to 139/85 to 89 as high normal. Classification determined by self-measurement or ambulatory assessment is provided in those sections of this statement.

#### Isolated Systolic Hypertension

As adults age, systolic blood pressure tends to rise and diastolic tends to fall. When the average systolic blood pressure is ≥140 and diastolic blood pressure is <90, the patient is classified as having isolated systolic hypertension. The increased pulse pressure (systolic–diastolic) and systolic pressure predict risk and determine treatment.

#### Isolated Diastolic Hypertension

More commonly seen in some younger adults, isolated diastolic hypertension is defined as a systolic pressure <140 and a diastolic ≥90. Although diastolic pressure is generally thought to be the best predictor of risk in patients younger than 50, some prospective studies of isolated diastolic hypertension have indicated that the prognosis may be benign. This topic remains controversial, however.

#### White-Coat Hypertension or Isolated Office Hypertension

In ~15% to 20% of people with stage 1 hypertension, blood pressure may only be elevated persistently in the presence of a health care worker, particularly a physician. When measured elsewhere, including while at work, the blood pressure is not elevated. When this phenomenon is detected in patients not taking medications, it is referred to as white-coat hypertension (WCH). The commonly used definition is a persistently elevated average office blood pressure of >140/90 and
an average awake ambulatory reading of <135/85 mm Hg.\(^\text{18}\) Although it can occur at any age, it is more common in older men and women. The phenomenon responsible for WCH is commonly referred to as the white coat effect and is defined as the difference between the office and daytime ambulatory blood pressure; it is present in the majority of hypertensive patients. Its magnitude can be reduced (but not eliminated) by the use of stationary oscillometric devices that automatically determine and analyze a series of blood pressures over 15 to 20 minutes with the patient in a quiet environment in the office or clinic. Other health risk factors are often present and should be treated accordingly. Its prognosis is discussed further in the section on Prognostic Significance in Ambulatory Blood Pressure Measurement. In some patients, WCH may progress to definite sustained hypertension, and all need to be followed-up indefinitely with office and out-of-office measurements of blood pressure. Treatment with antihypertensive drugs may lower the office blood pressure but does not change the ambulatory measurement.\(^\text{19}\) This pattern of findings suggests that drug treatment of WCH is less beneficial than treatment of sustained hypertension.

Masked Hypertension or Isolated Ambulatory Hypertension

Somewhat less frequent than WCH but more problematic to detect is the converse condition of normal blood pressure in the office and elevated blood pressures elsewhere, eg, at work or at home. Lifestyle can contribute to this, eg, alcohol, tobacco, caffeine consumption, and physical activity away from the clinic/office. Target organ damage is related to the more prolonged elevations in pressure away from the physician’s office and the presence of such when the blood pressure is normal in the office can be a clue.\(^\text{20}\) There is also some evidence that such patients are at increased risk.\(^\text{21}\)

Pseudohypertension

When the peripheral muscular arteries become very rigid from advanced (often calcified) arteriosclerosis, the cuff has to be at a higher pressure to compress them. Rarely, usually in elderly patients or those with longstanding hypertension or chronic renal failure, it may be very difficult to do so. The brachial or radial artery may be palpated distal to the fully inflated cuff in these instances (positive Osler sign). The patients may be overdosed with antihypertensive medications inadvertently, resulting in orthostatic hypotension and other side effects. When suspected, an intra-arterial radial artery blood pressure can be obtained for verification. The Osler maneuver is not a reliable screen for pseudohypertension. It was present in 7.2% of 3387 persons older than 59 years screened for the Systolic Hypertension in the Elderly Program (SHEP) study—more common in men, those found to be hypertensive, and those with a history of stroke.\(^\text{22}\) However, the Osler maneuver may be positive in the absence of pseudohypertension in one-third of hospitalized elderly subjects.\(^\text{23}\)

Orthostatic or Postural Hypotension

Orthostatic hypotension is defined as a reduction of systolic blood pressure of at least 20 mm Hg or 10 mm Hg in diastolic blood pressure within 3 minutes of quiet standing.\(^\text{17}\) An alternative method is to detect a similar fall during head-up tilt at 60 degrees. This may be asymptomatic or accompanied by symptoms of lightheadedness, faintness, dizziness, blurred vision, neck ache, and cognitive impairment. Factors affecting this response to posture include food ingestion, time of day, medications, ambient temperature, hydration, deconditioning, standing after vigorous exercise, and age.\(^\text{24,25}\) If chronic, the fall of blood pressure may be part of pure autonomic failure, multiple system atrophy, associated with Parkinsonism or a complication of diabetes, multiple myeloma, and other dysautonomias. Patients with autonomic failure exhibit a disabling failure of control of many autonomic functions. The major life-limiting failure is inability to control the level of blood pressure, especially in those patients with orthostatic hypotension who concomitantly have supine hypertension. In these patients, there are great and swift changes in pressure so that the patients faint because of profound hypotension on standing and have very severe hypertension when supine during the night. Often the heart rate is fixed as well. The supine hypertension subjects them to life-threatening target organ damage such as left ventricular hypertrophy, coronary heart disease, flash pulmonary edema, heart failure, renal failure, stroke, and sudden death (presumably caused by central apnea or cardiac arrhythmias).\(^\text{26–28}\)

Blood Pressure Measurement Methods

The auscultatory method has been the mainstay of clinical blood pressure measurement for as long as blood pressure has been measured but is gradually being supplanted by other techniques that are more suited to automated measurement.

The Auscultatory Method—Mercury, Aneroid, and Hybrid Sphygmomanometers

It is surprising that nearly 100 years after it was first discovered, and the subsequent recognition of its limited accuracy, the Korotkoff technique for measuring blood pressure has continued to be used without any substantial improvement. The brachial artery is occluded by a cuff placed around the upper arm and inflated to above systolic pressure. As it is gradually deflated, pulsatile blood flow is re-established and accompanied by sounds that can be detected by a stethoscope held over the artery just below the cuff. Traditionally, the sounds have been classified as 5 phases: phase I, appearance of clear tapping sounds corresponding to the appearance of a palpable pulse; phase II, sounds become softer and longer; phase III, sounds become crispier and louder; phase IV, sounds become muffled and softer; and phase V, sounds disappear completely. The fifth phase is thus recorded as the last audible sound.

The sounds are thought to originate from a combination of turbulent blood flow and oscillations of the arterial wall. There is agreement that the onset of phase I corresponds to systolic pressure but tends to underestimate the systolic pressure recorded by direct intra-arterial measurement.\(^\text{29}\) The disappearance of sounds (phase V) corresponds to diastolic pressure but tends to occur before diastolic pressure determined by direct intra-arterial measurement.\(^\text{29}\) No clinical significance has been attached to phases II and III.
The Korotkoff sound method tends to give values for systolic pressure that are lower than the true intra-arterial pressure, and diastolic values that are higher. The range of discrepancies is quite striking: One author commented that the difference between the 2 methods might be as much as 25 mm Hg in some individuals. There has been disagreement in the past as to whether phase IV or V of the Korotkoff sounds should be used for recording diastolic pressure, but phase IV tends to be even higher than phase V when compared against the true intra-arterial diastolic pressure and is more difficult to identify than phase V. There is now general consensus that the fifth phase should be used, except in situations in which the disappearance of sounds cannot reliably be determined because sounds are audible even after complete deflation of the cuff, for example, in pregnant women, patients with arteriovenous fistulas (eg, for hemodialysis), and aortic insufficiency. Most of the large-scale clinical trials that have evaluated the benefits of treating hypertension have used the fifth phase.

In older patients with a wide pulse pressure, the Korotkoff sounds may become inaudible between systolic and diastolic pressure, and reappear as cuff deflation is continued. This phenomenon is known as the auscultatory gap. In some cases, this may occur because of fluctuations of intra-arterial pressure and is most likely to occur in subjects with target organ damage. The auscultatory gap can be eliminated by elevating the arm overhead for 30 seconds before inflating the cuff and then bringing the arm to the usual position to continue in the measurement. This maneuver reduces vascular volume in the limb and improves inflow to enhance the Korotkoff sounds. The auscultatory gap is not an issue with nonauscultatory methods.

**Mercury Sphygmomanometers**

The mercury sphygmomanometer has always been regarded as the gold standard for clinical measurement of blood pressure, but this situation is likely to change in the near future, as discussed. The design of mercury sphygmomanometers has changed little over the past 50 years, except that modern versions are less likely to spill mercury if dropped. In principle, there is less to go wrong with mercury sphygmomanometers than with other devices, and one of the unique features is that the simplicity of the design means that there is negligible difference in the accuracy of different brands, which certainly does not apply to any other type of manometer. However, this should not be any cause for complacency. One hospital survey found that 21% of devices had technical problems that would limit their accuracy, whereas another found >50% to be defective. The random zero sphygmomanometer was designed to eliminate observer bias but is no longer available.

**Aneroid Sphygmomanometers**

In these devices, the pressure is registered by a mechanical system of metal bellows that expands as the cuff pressure increases and a series of levers that register the pressure on a circular scale. This type of system does not necessarily maintain its stability over time, particularly if handled roughly. They therefore are inherently less accurate than mercury sphygmomanometers and require calibrating at regular intervals. Recent developments in the design of aneroid devices may make them less susceptible to mechanical damage when dropped. Wall-mounted devices may be less susceptible to trauma and, hence, more accurate than mobile devices.

The accuracy of the manometers varies greatly from one manufacturer to another. Thus, 4 surveys conducted in hospitals in the past 10 years have examined the accuracy of the aneroid devices and have shown significant inaccuracies ranging from 1% to 44%. The few studies that have been conducted with aneroid devices have focused on the accuracy of the pressure registering system as opposed to the degree of observer error, which is likely to be higher with the small dials used in many of the devices.

**Hybrid Sphygmomanometers**

Devices have been developed that combine some of the features of both electronic and auscultatory devices, and are referred to as “hybrid” sphygmomanometers. The key feature is that the mercury column is replaced by an electronic pressure gauge, such as are used in oscillometric devices. Blood pressure is taken in the same way as with a mercury or aneroid device, by an observer using a stethoscope and listening for the Korotkoff sounds. The cuff pressure can be displayed as a simulated mercury column, as a digital readout, or as a simulated aneroid display. In one version, the cuff is deflated in the normal way, and when systolic and diastolic pressure are heard a button next to the deflation knob is pressed, which freezes the digital display to show systolic and diastolic pressures. This has the potential of minimizing terminal digit preference, which is a major source of error with mercury and aneroid devices. The hybrid sphygmomanometer has the potential to become a replacement for mercury, because it combines some of the best features of both mercury and electronic devices at any rate until the latter become accurate enough to be used without individual validation.

**The Oscillometric Technique**

This was first demonstrated by Marey in 1876, and it was subsequently shown that when the oscillations of pressure in a sphygmomanometer cuff are recorded during gradual deflation, the point of maximal oscillation corresponds to the mean intra-arterial pressure. The oscillations begin well above systolic pressure and continue below diastolic, so that systolic and diastolic pressures can only be estimated indirectly according to some empirically derived algorithm. One advantage of the method is that no transducer need be placed over the brachial artery, so that placement of the cuff is not critical. Other potential advantages of the oscillometric method for ambulatory monitoring are that it is less susceptible to external noise (but not to low-frequency mechanical vibration), and that the cuff can be removed and replaced by the patient, for example, to take a shower. The main problem with the technique is that the amplitude of the oscillations depends on several factors other than blood pressure, most importantly the stiffness of the arteries. Thus, in older people with stiff arteries and wide pulse pressures the mean arterial pressure may be significantly underestimated.
rithms used for detecting systolic and diastolic pressures are different from one device to another and are not divulged by the manufacturers. The differences between devices have been dramatically shown by studies using simulated pressure waves, in which a systolic pressure of 120 mm Hg was registered as low as 110 and as high as 125 mm Hg by different devices. Another disadvantage is that such recorders do not work well during physical activity, when there may be considerable movement artifact. Additionally, the bladders deflate at a manufacturer-specific “bleed rate,” which assumes a regular pulse between bleed steps as part of the algorithms used to determine systolic and diastolic pressure.

The oscillometric technique has been used successfully in ambulatory blood pressure monitors and home monitors. Comparisons of several different commercial models with intra-arterial and Korotkoff sound measurements have shown generally good agreement, but the results have been better with ambulatory monitors than with the cheaper devices marketed for home use. Oscillometric devices are also now available for taking multiple measurements in a clinic setting.

The Finger Cuff Method of Penaz
This interesting method was first developed by Penaz and works on the principle of the “unloaded arterial wall.” Arterial pulsation in a finger is detected by a photoplethysmograph under a pressure cuff. The output of the photoplethysmograph is used to drive a servo-loop, which rapidly changes the cuff pressure to keep the output constant, so that the artery is held in a partially opened state. The oscillations of pressure in the cuff are measured and have been found to resemble the intra-arterial pressure wave in most subjects. This method gives an accurate estimate of the changes of systolic and diastolic pressure, although both may be underestimated (or overestimated in some subjects) when compared with brachial artery pressures; the cuff can be kept inflated for up to 2 hours. It is now commercially available as the Finometer (formerly Finapres) and Portapres recorders, and has been validated in several studies against intra-arterial pressures. The Portapres enables readings to be taken over 24 hours while the subjects are ambulatory, although it is somewhat cumbersome.

This method in its present form is not suited to clinical use because of its cost, inconvenience, and relative inaccuracy for measuring absolute levels of blood pressure. Its greatest value is for research studies assessing short-term changes of blood pressure and its variability. The finger blood pressure monitors that are available in drug stores do not use this method.

Ultrasound Techniques
Devices incorporating this technique use an ultrasound transmitter and receiver placed over the brachial artery under a sphygmomanometer cuff. As the cuff is deflated, the movement of the arterial wall at systolic pressure causes a Doppler phase shift in the reflected ultrasound, and diastolic pressure is recorded as the point at which diminution of arterial motion occurs. Another variation of this method detects the onset of blood flow, which has been found to be of particular value for measuring systolic pressure in infants and children.

In patients with very faint Korotkoff sounds (for example those with muscular atrophy), placing a Doppler probe over the brachial artery may help to detect the systolic pressure, and the same technique can be used for measuring the ankle–arm index, in which the systolic pressures in the brachial artery and the posterior tibial artery are compared to obtain an index of peripheral arterial disease.

Tonometry
The principle of this technique is that when an artery is partially compressed or splinted against a bone, the pulsations are proportional to the intra-arterial pressure. This has been developed for measurement of the blood pressure at the wrist, because the radial artery lies just over the radius bone. However, the transducer needs to be situated directly over the center of the artery; hence, the signal is very position-sensitive. This has been dealt with by using an array of transducers placed across the artery. Although the technique has been developed for beat-to-beat monitoring of the wrist blood pressure, it requires calibration in each patient and is not suitable for routine clinical use.

Another application is applanation tonometry, in which a single transducer is held manually over the radial artery to record the pressure waveform while systolic and diastolic pressures are measured from the brachial artery. This technique has been used to estimate central aortic pressure. The rationale for this is that the arterial pressure at the level of the aortic root is different from the brachial artery pressure, and that this difference varies according to a number of physiological and pathological variables. Thus, it might be expected that the aortic pressure might predict cardiac events more closely than the brachial artery pressure. The shape of the pressure waveform in the arterial tree is determined by a combination of the incident wave and the wave reflected from the periphery. In hypertensive subjects and subjects with stiff arteries, the systolic pressure wave in the aorta and brachial artery is augmented by a late systolic peak, which can be attributed to wave reflection and which is not seen in more peripheral arteries such as the radial artery. Using Fourier analysis, it is possible to derive the central aortic pressure waveform from the radial artery trace. However, comparisons with directly recorded aortic pressure made during cardiac catheterization have shown considerable scatter between the estimated and true values, so the technique cannot yet be recommended for routine clinical practice.

Location of Measurement—Arm, Wrist, Finger
The standard location for blood pressure measurement is the upper arm, with the stethoscope at the elbow crease over the brachial artery, although there are several other sites where it can be performed. Monitors that measure pressure at the wrist and fingers have become popular, but it is important to realize that the systolic and diastolic pressures vary substantially in different parts of the arterial tree. In general, the systolic pressure increases in more distal arteries, whereas the diastolic pressure decreases. Mean arterial pressure falls by only 1 to 2 mm Hg between the aorta and peripheral arteries.


Wrist Monitors

Wrist monitors have the advantages of being smaller than the arm devices and can be used in obese people, because the wrist diameter is little affected by obesity. A potential problem with wrist monitors is the systematic error introduced by the hydrostatic effect of differences in the position of the wrist relative to the heart. This can be avoided if the wrist is always at heart level when the readings are taken, but there is no way of knowing retrospectively whether this was performed when a series of readings are reviewed. Devices are now available that will only record a measurement when the monitor is held at heart level. Wrist monitors have potential but need to be evaluated further.

Finger Monitors

Finger monitors have so far been found to be inaccurate and are not recommended.

Validation of Monitors

All monitors in clinical use should be tested for accuracy. This involves 2 stages. First, all oscillometric automated monitors that provide read-outs of systolic and diastolic pressure should be subjected by independent investigators to formal validation protocols. The original 2 protocols that gained the widest acceptance were developed by the Association for the Advancement of Medical Instrumentation (AAMI) in 1987 and the British Hypertension Society (BHS) in 1990, with revisions to both in 1993, and to AAMI in 2002. These required testing of a device against 2 trained human observers in 85 subjects, which made validation studies difficult to perform. One consequence of this has been that there are still many devices on the market that have never been adequately validated. More recently, an international group of experts who are members of the European Society of Hypertension Working Group on Blood Pressure Monitoring has produced an International Protocol that could replace the 2 earlier versions and is easier to perform. Briefly, it requires comparison of the device readings (4 in all) alternating with 5 mercury readings taken by 2 trained observers. Devices are recommended for approval if both systolic and diastolic readings taken are at least within 5 mm Hg of each other for at least 50% of readings.

It is recommended that only those devices that have passed this or similar tests should be used in practice. However, the fact that a device passed a validation test does not mean that it will provide accurate readings in all patients. There can be substantial numbers of individual subjects in whom the error is consistently >5 mm Hg with a device that has achieved a passing grade. This may be more likely to occur in elderly or diabetic patients. For this reason, it is recommended that each oscillometric monitor should be validated on each patient before the readings are accepted. No formal protocol has yet been developed for doing this, but if sequential readings are taken with a mercury sphygmomanometer and the device, then major inaccuracies can be detected.

Another problem is that manufacturers may change the model number after a device has been tested without indicating whether the measurement algorithm has also been changed.

With nonautomatic devices, such as mercury and aneroid monitors, it is recommended that the accuracy of the pressure registration mechanism be checked. In the case of mercury sphygmomanometers, this involves checking that the upper curve of the meniscus of the mercury column is at 0 mm Hg, that the column is free of dirt, and that it rises and falls freely during cuff inflation and deflation.

Aneroid devices or other nonmercury devices should be checked by connecting the manometer to a mercury column or an electronic testing device with a Y-tube. The needle should rest at the zero point before the cuff is inflated and should register a reading that is within 4 mm Hg of the mercury column when the cuff is inflated to pressures of 100 and 200 mm Hg. The needle should return to zero after deflation.

Blood Pressure Measurement in the Clinic or Office

Accurate auscultatory office blood pressure measurement is the bedrock of the diagnosis and treatment of hypertension and has been the standard method used in the major epidemiologic and treatment trials of the past 50 years. However, it is becoming increasingly clear that as it is used in everyday practice, there are major shortcomings. Thus, surveys of mercury devices in clinical practices have shown that there are frequently mechanical defects, and physicians rarely follow official guidelines for their use. Added to these is the phenomenon of the white coat effect, whereby the recorded blood pressure may be unrepresentative of the patient’s true blood pressure.

Subject Preparation

A number of factors related to the subject can cause significant deviations in measured blood pressure. These include room temperature, exercise, alcohol or nicotine consumption, positioning of the arm, muscle tension, bladder distension, talking, and background noise. The patient should be asked to remove all clothing that covers the location of cuff placement. The individual should be comfortably seated, with the legs uncrossed, and the back and arm supported, such that the middle of the cuff on the upper arm is at the level of the right atrium (the mid-point of the sternum). Measurements made while the patient is on an examining table do not fulfill these criteria and should preferably be made while the patient is seated in a chair. At the initial visit, blood pressure should be measured in both arms. The patient should be instructed to relax as much as possible and to not talk during the measurement procedure; ideally, 5 minutes should elapse before the first reading is taken.

Choice of Blood Pressure Measurement Devices

The “gold standard” device for office blood pressure measurement has been the mercury sphygmomanometer, but these are being removed from clinical practice because of environmental concerns about mercury contamination. Mercury sphygmomanometers are already banned in Veterans Administration hospitals. There is a role for other types of device in office use, both as a substitute for the traditional mercury readings (eg, aneroid and hybrid sphygmomanome-
Cuff Size

Von Recklinghausen in 1901 recognized that Riva Rocci’s device for determination of accurate systolic blood pressure by palpation had a significant flaw, its 5-cm-width cuff. Multiple authors have shown that the error in blood pressure measurement is larger when the cuff is too small relative to the patient’s arm circumference than when it is too large. Previous epidemiological data from Britain and Ireland had suggested that arm circumferences of >34 cm were uncommon. Data from NHANES III and NHANES 2000 have shown the opposite in the United States. In the United States during the period from 1988 to 2000, there has been a significant increase in mean arm circumference and an increase in the frequency of arm circumferences of >33 cm was found because of increasing weight in the American population. This should not be surprising, because the prevalence of obesity in the United States has increased from 22.9% in NHANES III (1988 to 1994) to >30% in 2000. Similar data regarding the increased frequency of larger arm circumferences were also found in a study of a referral practice of hypertensive subjects, in which a striking 61% of 430 subjects had an arm circumference of 33 cm.

Recognition of the increasing need for the “large adult” cuff, or even the thigh cuff, for accurate blood pressure measurement is critical, because frequently in practice only the standard adult size has been demonstrated to be available. More importantly, it has been demonstrated that the most frequent error in measuring blood pressure in the outpatient clinic is “miscuffing,” with undercuffing large arms accounting for 84% of the “miscuffings.”

The “ideal” cuff should have a bladder length that is 80% and a width that is at least 40% of arm circumference (a length-to-width ratio of 2:1). A recent study comparing intra-arterial and auscultatory blood pressure concluded that the error is minimized with a cuff width of 46% of the arm circumference. The recommended cuff sizes are:

- For arm circumference of 22 to 26 cm, the cuff should be “small adult” size: 12×22 cm
- For arm circumference of 27 to 34 cm, the cuff should be “adult” size: 16×30 cm
- For arm circumference of 35 to 44 cm, the cuff should be “large adult” size: 16×36 cm
- For arm circumference of 45 to 52 cm, the cuff should be “adult thigh” size: 16×42 cm

The optimum ratios of width and length to arm circumference are shown for the small adult and standard adult cuffs. For the large adult and thigh cuffs, the ideal width ratio of 46% of arm circumference is not practical, because it would result in a width of 20 cm and 24 cm, respectively. These widths would give a cuff that would not be clinically usable for most patients, so for the larger cuffs, a less than ideal ratio of width to arm circumference must be accepted. The ideal ratio of length to arm circumference is maintained in all 4 cuffs.

In practice, bladder width is easily appreciated by the clinician but bladder length often is not, because the bladder is enclosed in the cuff. To further complicate the issue for clinicians, there are no standards for manufacturers of different sizes of blood pressure cuff. This has led to significant differences in which arm circumferences are accurately measured by individual manufacturers’ standard adult and large adult cuffs.

Individual cuffs should be labeled with the ranges of arm circumferences, to which they can be correctly applied, preferably by having lines that show whether the cuff size is appropriate when it is wrapped around the arm. In patients with morbid obesity, one will encounter very large arm circumferences with short upper arm length. This geometry often cannot be correctly cuffed, even with the thigh cuff. In this circumstance, the clinician may measure blood pressure from a cuff placed on the forearm and listening for sounds over the radial artery (although this may overestimate systolic blood pressure) or use a validated wrist blood pressure monitor held at the level of the heart.

Effects of Body Position

Blood pressure measurement is most commonly made in either the sitting or the supine position, but the 2 positions give different measurements. It is widely accepted that diastolic pressure measured while sitting is higher than when measured supine (by ~5 mm Hg), although there is less agreement about systolic pressure. When the arm position is meticulously adjusted so that the cuff is at the level of the right atrium in both positions, the systolic pressure has been reported to be 8 mm Hg higher in the supine than the upright position.

Other considerations include the position of the back and legs. If the back is not supported (as when the patient is seated on an examination table as opposed to a chair), the diastolic pressure may be increased by 6 mm Hg. Crossing the legs may raise systolic pressure by 2 to 8 mm Hg.

In the supine position, the right atrium is approximately halfway between the bed and the level of the sternum; thus, if the arm is resting on the bed, it will be below heart level. For this reason, when measurements are taken in the supine position the arm should be supported with a pillow. In the sitting position, the right atrium level is the midpoint of the sternum or the fourth intercostal space.

Effects of Arm Position

The position of the arm can have a major influence when the blood pressure is measured; if the upper arm is below the level of the right atrium (when the arm is hanging down while in the sitting position), the readings will be too high. Similarly, if the arm is above the heart level, the readings will be too low. These differences can be attributed to the effects...
of hydrostatic pressure\textsuperscript{49} and may be 10 mm Hg or more,\textsuperscript{93} or 2 mm Hg for every inch above or below the heart level.

Other physiological factors that may influence the blood pressure during the measurement process include muscle tension. If the arm is held up by the patient (as opposed to being supported by the observer), the isometric exercise will raise the pressure.

**Differences Between the 2 Arms**

Several studies have compared the blood pressure measured in both arms, mostly using the auscultatory technique. Almost all have reported finding differences, but there is no clear pattern; thus, the difference does not appear to be determined by whether the subject is right- or left-handed.\textsuperscript{94} One of the largest studies was conducted in 400 subjects using simultaneous measurements with oscillometric devices, which found no systematic differences between the 2 arms, but 20% of subjects had differences of $>10$ mm Hg.\textsuperscript{94} Although these findings are disturbing, it is not clear to what extent the differences were consistent and reproducible, as opposed to being the result of inherent blood pressure variability. Nevertheless, it is recommended that blood pressure should be checked in both arms at the first examination. This may be helpful in detecting coarctation of the aorta and upper extremity arterial obstruction. When there is a consistent interarm difference, the arm with the higher pressure should be used. In women who have had a mastectomy, blood pressure can be measured in both arms unless there is lymphedema.

**Cuff Placement and Stethoscope**

Cuff placement must be preceded by selection of the appropriate cuff size for the subject’s arm circumference. The observer must first palpate the brachial artery in the antecubital fossa and place the midline of the bladder of the cuff (commonly marked on the cuff by the manufacturer) so that it is over the arterial pulsation over the patient’s bare upper arm. The sleeve should not be rolled up such that it has a tourniquet effect above the blood pressure cuff. The lower end of the cuff should be 2 to 3 cm above the antecubital fossa to allow room for placement of the stethoscope. However, if a cuff that leaves such space has a bladder length that does not sufficiently encircle the arm (at least 80%), a larger cuff should be used, recognizing that if the cuff touches the stethoscope, artificial noise will be generated. The cuff is then pulled snugly around the bare upper arm. Neither the observer nor the patient should talk during the measurement. Phase 1 (systolic) and phase 5 (diastolic) Korotkoff sounds are best heard using the bell of the stethoscope. The key to good measurement is the use of a high-quality stethoscope with short tubing, because inexpensive models may lack good tonal transmission properties required for accurate auscultatory measurement.

**Inflation/Deflation System**

Indirect blood pressure measurement requires that occlusion of the brachial artery is produced by gradual inflation and deflation of an appropriately sized cuff. The tubing from the device to the cuff must be of sufficient length (70 cm or more) to allow for its function in the office setting. Successful inflation and deflation requires an airtight system; ongoing inspection and maintenance of the tubing for deterioration of the rubber (cracking) and the release valve are required. The cuff should initially be inflated to at least 30 mm Hg above the point at which the radial pulse disappears. The rate of deflation has a significant effect on blood pressure determination. Deflation rates $>2$ mm per second can lead to a significant underestimation of systolic and overestimation of diastolic blood pressure. Automated devices with a linear deflation rate may have improved accuracy over the more common circumstances in automated devices that have stepwise deflation. It is recommended that a deflation rate of 2 to 3 mm Hg per second (or per pulse when the heart rate is very slow) be used.\textsuperscript{96,97}

**Important Points for Clinical Blood Pressure Measurement**

- The patient should be seated comfortably with the back supported and the upper arm bared without constrictive clothing. The legs should not be crossed.
- The arm should be supported at heart level, and the bladder of the cuff should encircle at least 80% of the arm circumference.
- The mercury column should be deflated to 2 to 3 mmHg, and the first and last audible sounds should be taken as systolic and diastolic pressure. The column should be read to the nearest 2 mm Hg.
- Neither the patient nor the observer should talk during the measurement.

**Observer**

The observer is the most critical component of accurate blood pressure measurement. For accurate blood pressure measurement, the observer must: (1) be properly trained in the techniques of blood pressure measurement; (2) use an accurate and properly maintained device; (3) recognize subject factors, such as anxiety and recent nicotine use, that would adversely affect blood pressure measurements; (4) position the subject appropriately; (5) select the correct cuff and position it correctly; and (6) perform the measurement using the auscultatory or automated oscillometric method and accurately record the values obtained.

Observer error is a major limitation of the auscultatory method.\textsuperscript{98} Systematic errors lead to intra-observer and inter-observer error. Terminal digit preference is perhaps the most common manifestation of suboptimal blood pressure determination. It is generally recommended that the observer should read the blood pressure to the nearest 2 mm Hg, but an inappropriate excess in the recording of “zero” as the last digit in auscultatory blood pressure determinations has been reported by multiple investigators in clinical and research settings.\textsuperscript{99,100} Digit bias or digit prejudice is particularly common when the observer recognizes a specific threshold value for blood pressure and, depending on the circumstances, records a pressure just above or below that number. A good example is the Syst-Eur Trial, which showed both increased zero preference and a significant digit bias for...
148 mm Hg systolic, the threshold for successful treatment in that trial.95

Number of Measurements
It is well recognized that the predictive power of multiple blood pressure determinations is much greater than a single office reading.101 One of the potential advantages of supplementing auscultatory readings with readings taken by an automated device is the ability to obtain a larger number of readings. When a series of readings is taken, the first is typically the highest. A minimum of 2 readings should be taken at intervals of at least 1 minute, and the average of those readings should be used to represent the patient’s blood pressure. If there is >5 mm Hg difference between the first and second readings, additional (1 or 2) readings should be obtained, and then the average of these multiple readings is used.

Automated Methods
Automated oscillometric blood pressure devices are increasingly being used in office blood pressure measurement, as well as for home and ambulatory monitoring. When they are used in the office, the readings are typically lower than readings taken by a physician or nurse. The potential advantages of automated measurement in the office are the elimination of observer error, minimizing the white coat effect, and increasing the number of readings. The main disadvantages are the error inherent in the oscillometric method and the fact that epidemiologic data are mostly based on auscultated blood pressure measurements.

Automated devices may also offer the opportunity to avoid expensive and repetitive training of health care professionals in auscultation, which is necessary to reduce observer errors. Their use still requires careful patient evaluation for caffeine or nicotine use, selection of the correct cuff size, and proper patient positioning if accurate blood pressures are to be obtained. Devices are now available that can take a series of sequential readings and automatically average them.

The White Coat Effect and the Differences Between Physician and Nurse Blood Pressure Measurements
The initial epidemiological studies of hypertension and the first major hypertension treatment trial (VA Cooperative Study) were performed using physician blood pressure measurements.102-104 Since that time, all the major hypertension treatment trials of hypertension are based on blood pressure measurements made by a nurse, “a trained observer,” or automated blood pressure measurements. In hypertensive patients (but not necessarily in normotensive patients), the blood pressure recorded by a physician or nurse is typically higher than the average daytime level, and this difference is commonly referred to as the white coat effect.

In addition to these effects of the medical environment on blood pressure measurement, there is a recognized difference between blood pressure levels measured by a physician versus a nurse in the same subjects. In the largest study of physician–nurse blood pressure differences, it was found that a nurse recorded significantly lower mean systolic and diastolic pressures than a physician (by 6.3/7.9 mm Hg).108 This difference is not caused by any difference in technique, because when a dual-headed stethoscope is used and the physician and nurse simultaneously take the blood pressure, the physician–nurse difference is insignificant. In addition, the nurse-recorded blood pressure is usually closer to the patient’s daytime average pressure than the pressure recorded by the physician. Because all of the most recent treatment trials of hypertension are based on blood pressure measurements made by nurses or other professionals, but not by physicians, the difference in office blood pressure measured by physicians and nurses suggests that physician blood pressures should not be used exclusively in the routine management of the hypertensive subject.

Training of Observers
As the number and type of blood pressure measurement devices and direct-to-consumer advertising increase, more people are measuring blood pressure more frequently. In medical settings, physicians, nurses, nurses’ aids, students, and pharmacists all measure blood pressure and record the values in a patient’s records. Outside medical settings, patients, family members, or lay persons also measure blood pressure. The training given to lay observers should be as comprehensive and similar to that recommended for health care professionals in ambulatory and community settings.106 With careful training even unpaid volunteers in large population surveys can measure blood pressure accurately.107 However, even with the newer automated devices, the accuracy of the readings can be optimal only if all observers are appropriately trained and retrained and conscientious about using appropriate techniques.

Required Competencies
Before training begins, potential observers should be assessed for physical and cognitive competencies required to perform the procedure. The physical requirements include the following:

- Vision. The observer must be able to see the dial of the manometer or the meniscus of the mercury column at eye level without straining or stretching, and must be able to read well enough to see the sphygmomanometer or digital display no further than 3 feet away.
- Hearing. The observer must be able to hear the appearance and disappearance of Korotkoff sounds.
- Eye/hand/ear coordination. This is required for the use of mercury and aneroid sphygmomanometers but not for the newer electronic technologies.

Training
Traditionally, health professionals are trained in blood pressure measurement in introductory courses on physical assessment. They may receive a classroom lecture with a video on how to measure blood pressure, some laboratory skills training with demonstration and practice on fellow trainees, and mentored experience measuring blood pressure of patients, potential research subjects, or community volunteers. In clinical trials, standardized programs with audiovisual tapes that test and retest accuracy in measurement are
extremely effective in training and retraining. In contrast, such training and retraining is not routinely required in nonresearch settings.

Some information is available on the Internet, and the British Hypertension Society has a web-based video that can be used for the training and evaluation of observers.

**Evaluation of Observers**

Pencil-and-paper questionnaires or interviews can be used to assess knowledge of the correct methodology of blood pressure measurement. The evaluation of observers should include an assessment of their knowledge of the different types of observer bias, general technique, and the interpretation of the measurements, including an understanding of the normal variability of blood pressure by time of day, exercise, timing of antihypertensive medications, etc. The observers should also know how and when to communicate blood pressure readings gathered at home or other settings to the health care professional responsible for the care of the patient and management of hypertension.

Observers should be aware of the need to use only well-maintained and calibrated equipment, choosing a quiet location with adequate room temperature, correctly positioning the person having blood pressure measured, and ensuring that the person does not talk or move during the measurement.

The skills of the observer should be demonstrated by assessing items such as positioning the patient, selecting the right size cuff, obtaining a valid and reliable measurement, recording the measurement accurately, and appropriate reporting of abnormal levels.

**Retraining**

Correct blood pressure measurement technique is difficult to maintain without careful attention to all steps in the protocol and retraining. The gold standard for retraining has been set by federally funded multisite clinical trials of hypertension care and control, in which retraining is required of all blood pressure observers every 6 months. Retraining requires competency in cuff selection, patient positioning, no talking, and accurate observation of the blood pressure level by either auditory or visual assessment. Four methods of assessment are used: audio–video test tapes; Y-tube–connected simultaneous readings by 2 trained observers; a written quiz; and direct observation. In the National Heart, Lung, and Blood Institute (NLHBI)-sponsored multisite clinical trials, a senior al reported that because the introduction of the VitaStat device in 1976, >8000 devices were in use in the United States, providing >10 million measurements per year. The initial version was the 8000 model, which was never tested by approved protocols and which was found to give very inconsistent results, particularly for systolic pressure. A later model (the 90550) has been tested in a community setting and has also failed to meet the BHS or AAMI criteria for accuracy. Other potential problems with these devices are that the cuff size (23 × 33 cm) is inadequate for patients with large arms, and that they are not labeled to show when or if there has been recent maintenance and revalidation of the device’s performance. Clear demonstration to the user of ongoing device servicing and validation would be critical to acceptance of the devices for public blood pressure screening.

**Blood Pressure Measurement in Other Settings**

**Acute Care**

Blood pressure measurements in acute care settings, such as the emergency department, dialysis unit, or operating suite, are usually performed to judge vital signs and volume status of the patient rather than the presence or absence of hypertension. Oscillometric devices are widely used for this purpose and may give accurate assessment of mean arterial pressure, but are often inaccurate for registering systolic and diastolic pressure. Blood pressure values obtained in acute care settings are unlikely to be useful for decisions on chronic hypertension management, because of inadequate patient preparation, faulty equipment, and the impact of the acute illness on blood pressure. Still, high readings recorded in the emergency room do predict hypertension on subsequent clinic visits, to some extent, and warrant follow-up.

Blood pressure measurement is also important in the prehospital setting. Multiple techniques of blood pressure determination in the field and ambulance and helicopter transportation environments, including auscultatory, oscillometric, palpation, and use of obliteration of the pulse wave on the pulse oximeter, have been used. All of these suffer from a high degree of error that is worse with systolic blood pressures of <90 mm Hg. In addition, it has been shown that standard equipment used by emergency medical services for blood pressure determination is often highly unreliable. Determining blood pressures in prehospital settings requires a high degree of clinical experience and repetitive measurement. In this setting, establishment of trends in blood pressure before arriving in the more controlled hospital environment is more important than the absolute value of the blood pressure.

An elevated blood pressure in the acute care setting should raise the suspicion that the patient has hypertension, and a referral to the outpatient setting for further evaluation is warranted. Because of the lack of precision of blood pressure measurement (and the impact of bed rest, acute illness, medication administration, and alteration in the patient’s usual diet while in the hospital), blood pressures obtained in the acute care setting should not be used to judge the adequacy of blood pressure control.

**Public Places**

Automated blood pressure devices are commonly found in public places and represent a potential mechanism for increased screening for hypertension. In 1995, Whitcomb et al. reported that because the introduction of the VitaStat device in 1976, >8000 devices were in use in the United States, providing >10 million measurements per year. The initial version was the 8000 model, which was never tested by approved protocols and which was found to give very inconsistent results, particularly for systolic pressure. A later model (the 90550) has been tested in a community setting and has also failed to meet the BHS or AAMI criteria for accuracy. Other potential problems with these devices are that the cuff size (23 × 33 cm) is inadequate for patients with large arms, and that they are not labeled to show when or if there has been recent maintenance and revalidation of the device’s performance. Clear demonstration to the user of ongoing device servicing and validation would be critical to acceptance of the devices for public blood pressure screening.
Self-Measurement

Types of Monitor

When self-monitoring or home-monitoring was first used, the majority of studies used aneroid sphygmomanometers. In the past few years, automatic electronic devices have become increasingly popular. The standard type of monitor for home use is now an oscillometric device that records pressure from the brachial artery. Unfortunately, only a few have been subjected to proper validation tests such as the AAMI and BHS protocols, and of 24 devices that have been tested by these, only 5 have passed. An up-to-date list of validated monitors is available. The advantages of electronic monitors have begun to be appreciated by epidemiologists, who have always been greatly concerned about the accuracy of clinical blood pressure measurement and have paid much attention to the problems of observer error, digit preference, and the other causes of inaccuracy described. It has been argued that the ease of use of the electronic devices and the relative insensitivity to who is actually taking the reading can outweigh any inherent inaccuracy compared with the traditional sphygmomanometer method. This issue remains controversial, however.

Electronic devices are now available that will take blood pressure from the upper arm, wrist, or finger. Although the use of the more distal sites may be more convenient, measurement of blood pressure from the arm (brachial artery) has always been the standard method and is likely to remain so for the foreseeable future. The fact that a device has passed the validation criteria does not guarantee accuracy in the individual patient, and it is essential that each device be checked on each patient before the readings are accepted as being valid (see the previous section on Validation of Monitors). Home-monitoring devices should be checked for accuracy every 1 to 2 years.

Clinical Applications

Home- or self-monitoring has numerous advantages over ambulatory monitoring, principal among which are that it is relatively cheap and provides a convenient way for monitoring blood pressure over long periods of time. There is some evidence that it improves both therapeutic compliance and blood pressure control. However, technical, economic, and behavioral barriers have until now inhibited the widespread use of home-monitoring in clinical practice. Two technological developments, low-cost monitors with memory and systems for sending stored readings over the telephone, have the potential of overcoming these barriers.

Unfortunately, accurate readings do not guarantee accurate reporting to the physician. In 2 separate studies, patients were given home monitors, but they were not told that the devices had memory. Patients were urged to carefully record all readings, but in both studies, more than half the subjects omitted or fabricated readings. Devices that have memory or printouts of the readings are therefore recommended. It is recommended that when readings are taken, the patient should not have recently indulged in any activity such as exercise or eating that is likely to affect the blood pressure, and the patient should be resting quietly in a comfortable chair for 3 to 5 minutes with the upper arm at heart level. Three readings should be taken in succession, separated by at least 1 minute. The first is typically the highest, and the average should be used as the blood pressure reading. It is helpful to get readings in the early morning and the evening.

What Is Normal Home Blood Pressure?

Home blood pressures are consistently lower than clinic pressures in most hypertensive patients. Several recent studies have addressed the question of the level of home pressure that best corresponds to a normal clinic pressure of 140/90 mm Hg. The largest, the Ohasama study, proposed a level of 137/84 mm Hg as an acceptable upper limit for home readings on the grounds that cardiovascular risk increases above this level. An ad hoc committee of the American Society of Hypertension, reviewing several studies, recommended 135/85 mm Hg as the upper limit of normal for home and ambulatory blood pressure. As with office blood pressure, a lower home blood pressure goal is advisable for certain patients, including diabetic patients, pregnant women, and patients with renal failure.

Prognostic Significance

One factor that has held back the wider use of self-monitoring in clinical practice has been the lack of prognostic data. Two prospective studies, 1 from Japan and 1 from France, have found that home blood pressure predicts morbid events better than conventional clinic measurements. There is an increasing body of evidence that home blood pressure may also predict target organ damage better than clinic pressure.

Telemonitoring

Devices are now available that have the capacity to store readings in their memory and then transmit them via the telephone to a central server computer, and then to the health care provider. They have the potential to improve patient compliance and, hence, blood pressure control. Readings taken with a telemonitoring system may correlate more closely than clinic readings with ambulatory blood pressure.

Features of different methods of BP measurement are provided in Table 2.

Ambulatory Blood Pressure Measurement

Types of Monitor

Ambulatory blood pressure (ABP) monitoring is a noninvasive, fully automated technique in which blood pressure is
recorded over an extended period of time, typically 24 hours. It has been used for many years as a research procedure and has recently been approved by Medicare for reimbursement of a single recording in patients with suspected WCH. The standard equipment includes a cuff, a small monitor attached to a belt, and a tube connecting the monitor to the cuff. Most, but not all, ABP devices use an oscillometric technique. Of the available ABP devices, most have undergone validation testing as recommended by the AAMI or the BHS. An up-to-date list of validated monitors is available.126

During a typical ABP monitoring session, blood pressure is measured every 15 to 30 minutes over a 24-hour period including both awake and asleep hours, preferably on a workday. The total number of readings usually varies between 50 and 100. Blood pressure data are stored in the monitor and then downloaded into device-specific computer software. The raw data can then be synthesized into a report that provides mean values by hour and period: daytime (awake), nighttime (asleep), and 24-hour blood pressure, both for systolic and diastolic blood pressure. The most common output used in decision-making are absolute levels of blood pressure, that is, mean daytime, nighttime, and 24-hour values.

The monitors can be attached by a trained technician, who should be skilled in blood pressure measurement techniques (see the previous section on Blood Pressure Measurement in Other Settings). The cuff is attached to the nondominant upper arm, and a series of calibration readings are taken with a mercury sphygmomanometer to ensure that the device is giving accurate readings (within 5 mm Hg of the mercury readings). It is important to instruct the patient to hold the arm still by the side while the device is taking a reading. It may be helpful to ask the patient to keep a diary of activities, particularly when going to bed and getting up in the morning.

Clinical Applications

Although ABP could be used to monitor therapy, the most common application is diagnostic, that is, to ascertain an individual’s usual level of blood pressure outside the clinic setting and thereby identify individuals with WCH. Other potential applications of ABP include the identification of individuals with a nondipping blood pressure pattern (eg, in diabetes), patients with apparently refractory hypertension but relatively little target organ damage, suspected autonomic neuropathy, and patients in whom there is a large discrepancy between clinic and home measurements of blood pressure. The Centers for Medicare and Medicaid Services has approved the use of ABP measurement for the diagnosis of patients with suspected WCH (documented high clinic pressures and normal pressures in other settings, and no evidence of target organ damage).

A recent overview sponsored by Agency for Healthcare Research and Quality summarized available evidence on cross-sectional associations of ABP with subclinical outcomes and on prospective associations of ABP with clinical outcomes.142 In cross-sectional studies of blood pressure with left ventricular mass (22 studies) and albuminuria (6 studies), ABP levels were directly associated with both measurements. Left ventricular mass was less in individuals with WCH than in those with sustained hypertension but was greater in WCH than in nonhypertensive subjects. Such evidence suggests that WCH is an intermediate phenotype. In each of 10 prospective studies, at least one dimension of ABP predicted clinical outcomes. In studies that compared the prognostic importance of ABP to clinic measurements, ABP was usually superior to clinic measurements. In some instances, including a recent study unavailable at the time of the overview,143 mean ABP levels provided additional predictive information beyond that of clinic measurements, confirming the seminal study by Perloff et al.144 In a few prospective studies, WCH predicted a reduced risk of cardiovascular disease events compared with sustained hypertension. However, data were inadequate to compare the risk associated with WCH to the risk associated with normotension. A nondipping or inverse dipping pattern predicted an increased risk of clinical outcomes. Just 2 ABP trials tested the usefulness of ABP to guide blood pressure management. Overall, available studies indicate that ABP monitoring can provide useful prognostic information.145

What Is Normal ABP?
The normal range for ABP has been established in 2 ways: first, by comparison of the ABP level that corresponds to a clinic pressure of 140/90 mm Hg and, second, by relating ABP to risk in prospective studies. The suggested values for daytime, nighttime, and 24-hour average levels are shown in Table 3.

Prognostic Significance

Several prospective studies have documented that the average level of ABP predicts risk of morbid events better than clinic blood pressure.136,143,144,146–149 In addition to mean absolute levels of ABP, certain ABP patterns may predict blood pressure-related complications. The patterns of greatest interest are WCH and nondipping blood pressure. WCH is a pattern in which clinic blood pressure is in the hypertensive range but ABP is normal or low. Individuals with WCH are at lower risk for blood pressure-related complications in comparison to individuals with sustained hypertension. An important but unresolved issue is whether the risk of cardiovascular disease in WCH exceeds that of nonhypertensive subjects. Using both daytime and nocturnal ABP, one can identify individuals, termed nondippers, who do not experience the decline in blood pressure that occurs during sleep hours. Usually, nighttime (asleep) blood pressure drops by 10% or more from daytime (awake) blood pressure. Individuals with a nondipping pattern (<10% blood pressure reduction from night to day) appear to be at increased risk for blood pressure-related complications compared with those with a normal dipping pattern.146,150 Other evidence suggests that the nighttime blood pressure may be the best predictor of risk.151

| TABLE 3. Suggested Values for the Upper Limit of Normal Ambulatory Pressure |
|---------------------------------|------------------|------------------|
| Daytime                         | <130/80          | <135/85          | >140/90          |
| Nighttime                       | <115/65          | <120/70          | >125/75          |
| 24-Hour                         | <125/75          | <130/80          | >135/85          |

[version 1.0]
Blood Pressure Recording in Special Situations

Elderly Patients
Elderly patients are more likely to have WCH, isolated systolic hypertension, and pseudohypertension (see the previous section on Pseudohypertension). Blood pressure should be measured while seated, 2 or more times at each visit, and the readings should be averaged. Blood pressure should also be taken in the standing position routinely because the elderly may have postural hypotension. Hypotension is more common in diabetic patients. It is frequently noticed by patients on arising in the morning, after meals, and when standing up quickly. Self-measurements can be quite helpful when considering changes in dosage of antihypertensive medications. Ambulatory blood pressure monitoring, sometimes coupled with Holter recordings of ECGs, can help elucidate some symptoms such as episodic faintness and nocturnal dyspnea.

Pulseless Syndromes
Rarely, patients present with occlusive arterial disease in the major arteries to all 4 limbs (eg, Takayasu arteritis, giant cell arteritis, or atherosclerosis) so that a reliable blood pressure cannot be obtained from any limb. In this situation, if a carotid artery is normal, it is possible to obtain retinal artery systolic pressure and use the nomogram in reverse to estimate the brachial pressure (oculoplethysmography), but this procedure and the measurement of retinal artery pressures are not generally available. If a central intra-arterial blood pressure can be obtained, a differential in pressure from a noninvasive method can be established and used as a correction factor.

Arrhythmias
When the cardiac rhythm is very irregular, the cardiac output and blood pressure varies greatly from beat to beat. There is considerable interobserver and intra-observer error. Estimating blood pressure from Korotkoff sounds is a guess at best; there are no generally accepted guidelines. The blood pressure should be measured several times and the average value used. Automated devices frequently are inaccurate for single observations in the presence of atrial fibrillation, for example, and should be validated in each subject before use. However prolonged (2 to 24 hours) ambulatory observations do provide data similar to that in subjects with normal cardiac rhythm. Sometimes, an intra-arterial blood pressure is necessary to get a baseline for comparison. If severe regular bradycardia is present (eg, 40 to 50 bpm), deflation should be slower than usual to prevent underestimation of systolic and overestimation of diastolic blood pressure.

Obese Patients
A longer and wider cuff is needed for adequate compression of the brachial artery in the obese patient with a very large upper arm (see the previous section on Cuff Size). A large cuff may also be required for a big, muscular arm with a prominent biceps over which a regular, nontapered cuff might not fit smoothly. In both situations, it is particularly important to place the center of the bladder over the brachial artery pulse. If the upper arm is relatively short despite the large circumference, it may be difficult to fit a standard large adult cuff over the arm. The BHS’s recommendation to use a very long cuff (12×40 cm; BHS web site August 13, 2003, http://w3.abdn.ac.uk/BHS/booklet/special.htm) could obviate this problem. In the rare patient with an arm circumference >50 cm, when even a thigh cuff cannot be fitted over the arm, it is recommended that the health care practitioner wrap an appropriately sized cuff around the patient’s forearm, support it at heart level, and feel for the appearance of the radial pulse at the wrist. Other potential methods for measuring radial artery pressure include listening for Korotkoff sounds over the radial artery, detecting systolic pressure with a Doppler probe, or using an oscillometric device to determine systolic blood pressure; diastolic blood pressure is largely overestimated by both methods. The accuracy of these methods has not been validated, but they provide at least a general estimate of the systolic blood pressure. The error of overestimating the pressure when measuring with a cuff that is too small for an obese arm can be considerable and can lead to misclassification of an individual as hypertensive and to unnecessary concern and therapy.

Children
Blood pressure is most conveniently measured in children by auscultation with a standard mercury sphygmomanometer. As with adults, the stethoscope is placed over the brachial artery pulse, proximal and medial to the antecubital fossa, and below the bottom edge of the cuff. The right arm is generally the preferred arm for blood pressure measurement for consistency and comparison with the reference tables.

Correct blood pressure measurement in children requires the use of a cuff that is appropriate for the size of the child’s upper arm. A technique that can be used to select a blood pressure cuff size of appropriate size is to select a cuff that has a bladder width that is at least 40% of the arm circumference midway between the olecranon and the acromion. This will usually be a cuff bladder that will cover 80% to 100% of the circumference of the arm. The equipment necessary to measure blood pressure in children 3 years of age through adolescence includes pediatric cuffs of different sizes. For newborn–premature infants, a cuff size of 4×8 cm is recommended; for infants, 6×12 cm; and for older children, 9×18 cm. A standard adult cuff, a large adult cuff, and a thigh cuff for leg blood pressure measurement and for use in children with very large arms should also be available.

Blood pressure measurements in children should be conducted in a quiet and comfortable environment after 3 to 5 minutes of rest. With the exception of acute illness, the blood pressure should be measured with the child in the seated position with the antecubital fossa supported at heart level. It is preferable that the child has feet on the floor while the blood pressure is measured, rather than feet dangling from an examination table. Overinflation of the cuff should be avoided because of discomfort, particularly in younger children. It is useful to initially inflate the cuff while palpating the pulse to estimate the approximate range for the systolic pressure and then inflate the cuff to 30 mm Hg above this estimate when the blood pressure is auscultated. The blood pressure should be measured and recorded at least twice on each measurement occasion, and the
average of these 2 measurements is the measurement for systolic and diastolic blood pressure.

Systolic blood pressure is determined by the onset of the auscultated pulsation or first Korotkoff sound. The phase of the Korotkoff sounds that defines diastolic blood pressure has been somewhat controversial. The disappearance of Korotkoff sounds or fifth Korotkoff sound (K5, the last sound heard) is the definition of diastolic pressure in adults. In children, particularly preadolescents, a difference of several millimeters of mercury is frequently present between the fourth and fifth Korotkoff sounds.\textsuperscript{157,158} In some children, the Korotkoff sounds can be heard to 0 mm Hg, which has limited physiological meaning.

Elevated blood pressure measurements in a child or adolescent must be confirmed on repeated visits before characterizing a child as having hypertension. Within individual children, blood pressure at high levels tends to fall on subsequent measurement as a result of an accommodation effect (reduction of anxiety as the circumstances become more familiar) and regression to the mean, a nonbiological phenomenon that derives, in part, from mathematical considerations. Therefore, a more precise characterization of an individual’s blood pressure level is an average of multiple blood pressure measurements taken for weeks or months. A notable exception to this general guideline for asymptomatic generally well children would be situations in which the child is symptomatic or has profoundly elevated blood pressure. Children who show elevated blood pressure on repeated measurement should also have the blood pressure measured in the leg as a screen for coarctation of the aorta. To measure the blood pressure in the leg, a thigh cuff or an oversized cuff should be placed on the thigh and the blood pressure measured by auscultation over the popliteal fossa. If the systolic blood pressure measured in the thigh is $\geq 10$ mm Hg lower than the systolic blood pressure measured in the arm, additional studies for coarctation should be performed.

There continues to be an increase in the use of automated devices to measure blood pressure in children. These devices are easier to use and are becoming alternative instruments for blood pressure measurement when use of mercury sphygmomanometers is not permitted for ecological reasons. The most commonly used devices use oscillometric methods (see the previous section on The Oscillometric Technique). Situations in which the use of the automated devices is acceptable include blood pressure measurement in newborn and young infants in whom auscultation is difficult, as well as in an intensive care setting, where frequent blood pressure measurement is necessary. The reliability of these instruments in an ambulatory clinical setting is less clear, however.\textsuperscript{45}

The interpretation of the blood pressure measurement in children requires consideration of the child’s age, sex, and height. Hypertension in children and adolescents is defined as systolic and/or diastolic blood pressure that is consistently equal to or greater than the 95th percentile of the blood pressure distribution. Tables are available that provide the systolic and diastolic blood pressure level at the 95th percentile according to age, sex, and height.\textsuperscript{159} These tables should be consulted to determine if the blood pressure measurements are normal or elevated. Children also demonstrate white coat effects, but the role of ambulatory blood pressure monitoring is less clear in children. Validated devices should be used, preferably in a center with experience using ABPM. Large population-based normative data in children using ABPM are limited.\textsuperscript{160,161}

### Pregnant Women

Hypertension is the most common medical disorder of pregnancy and occurs in 10% to 12% of all pregnancies. The detection of elevated blood pressure during pregnancy is one of the major aspects of optimal antenatal care; thus, accurate measurement of blood pressure is essential.\textsuperscript{161} Mercury sphygmomanometry continues to be the recommended method for blood pressure measurement during pregnancy. Blood pressure should be obtained in the seated position. Measurement of blood pressure in the left lateral recumbency, on the left arm, does not differ substantially from blood pressure that is recorded in the sitting position. Therefore, the left lateral recumbency position is a reasonable alternative, particularly during labor. If the patient’s upper arm circumference is 33 cm or greater, a large blood pressure cuff should be used. In the past, there had been some question as to whether the fourth (K4) or fifth (K5) Korotkoff sound should be used to define the diastolic blood pressure. The International Society for the Study of Hypertension in Pregnancy currently recommends using K5 for the measurement of diastolic blood pressure in pregnancy.\textsuperscript{161} When sounds are audible with the cuff deflated, K4 should be used.

It is recognized that alternatives to mercury devices may be necessary in the future, and a small number of automated blood pressure recorders have been validated for use in pregnancy.\textsuperscript{162} Self-monitoring may be useful in evaluating blood pressure changes during pregnancy.\textsuperscript{163,164}

### Summary and Recommendations

Accurate measurement of blood pressure is essential to classify individuals, to ascertain blood pressure-related risk, and to guide management. The objective of this report is to provide clinicians with a standardized set of recommendations that, if followed, should lead to accurate estimation of blood pressure.

We recognize that many committees and organizations have published recommendations and that, in practice, blood pressure measurement remains suboptimal. In view of the consequences of inaccurate measurement, including both the risks of overtreatment and undertreatment, it is the opinion of the committee that regulatory agencies should establish standards to ensure the use of validated devices, routine calibration of equipment, and the training and retraining of manual observers. Because the use of automated devices does not eliminate all major sources of human error, the training of observers should be required even when automated devices are used.
Disclosures

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<th>Consultant/Advisory Board</th>
<th>Other</th>
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<tbody>
<tr>
<td>Dr Thomas G. Pickering</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<td>None</td>
</tr>
<tr>
<td>Dr John E. Hall</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tr>
<tr>
<td>Dr Lawrence J. Appel</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>None</td>
</tr>
<tr>
<td>Dr Bonita E. Falkner</td>
<td>None</td>
<td>None</td>
<td>None</td>
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<td>None</td>
</tr>
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<td>Dr John W. Graves</td>
<td>None</td>
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</tr>
<tr>
<td>Dr Martha N. Hill</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tr>
<tr>
<td>Dr Daniel W. Jones</td>
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<td>None</td>
<td>None</td>
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</tr>
<tr>
<td>Dr Theodore Kurtz</td>
<td>None</td>
<td>None</td>
<td>None</td>
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</tr>
<tr>
<td>Dr Sheldon G. Sheps</td>
<td>None</td>
<td>None</td>
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<tr>
<td>Dr Edward J. Roccella</td>
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Understanding and Managing High Blood Pressure
What is Blood Pressure?

When your heart pumps blood through the blood vessels, the blood pushes against the walls of your blood vessels. This creates blood pressure. Your body needs blood pressure to move the blood throughout your body, so every part of your body can get the oxygen it needs.

Healthy arteries (the blood vessels that carry oxygen-rich blood from the heart to the rest of the body) are elastic. They can stretch to allow more blood to push through them. How much they stretch depends on how hard the blood pushes against the artery walls.

For your arteries to stay healthy, it’s important that your blood pressure be within a healthy range. Fortunately, there are things you can do to help keep your blood pressure in that range. We’ll talk about that more later in this guide.

For some people, blood pressure can get too high. This is true for about one-third of American adults (33.0%). This can cause health problems that need to be dealt with as you work with your healthcare provider. We’ll talk about this, too, later in the guide.

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Arbor
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This workbook is not intended as a substitute for professional medical care. Only your doctor can diagnose and treat a medical problem.
How Blood Pressure is Measured

How can you tell what your blood pressure is? By using a device called a blood pressure monitor, your healthcare provider can measure your blood pressure to see if it’s in a healthy range. You’ve probably had your blood pressure taken during a visit to your healthcare provider’s office.

Your blood pressure is recorded as two numbers. The systolic blood pressure (the “upper” number) tells how much pressure blood is exerting against your artery walls while the heart is pumping blood. The diastolic blood pressure (the “lower” number) tells how much pressure blood is exerting against your artery walls while the heart is resting between beats. Blood pressure is measured in units of millimeters of mercury, or mm Hg. For example, a blood pressure reading might be 120/80 mm Hg.

A healthy blood pressure is under 120/80 mm Hg. A blood pressure reading of 120-139 systolic or 80-89 diastolic is defined as “prehypertension.” This means that the blood pressure is not high enough to be called high blood pressure (hypertension), but that it is higher than normal. If systolic blood pressure is 140 or greater, or diastolic blood pressure is 90 or greater, it’s high blood pressure.

The table below shows healthy and unhealthy blood pressure ranges as recognized by the American Heart Association:

<table>
<thead>
<tr>
<th>Blood Pressure Category</th>
<th>Systolic mm Hg (Upper #)</th>
<th>Diastolic mm Hg (Lower #)</th>
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<tbody>
<tr>
<td>Normal</td>
<td>Less than 120</td>
<td>Less than 80</td>
</tr>
<tr>
<td>Prehypertension</td>
<td>120-139</td>
<td>Or 80-89</td>
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<td>High Blood Pressure (Hypertension) Stage 1</td>
<td>140-159</td>
<td>Or 90-99</td>
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<tr>
<td>High Blood Pressure (Hypertension) Stage 2</td>
<td>160 or higher</td>
<td>Or 100 or higher</td>
</tr>
<tr>
<td>Hypertensive Crisis (Emergency care needed)</td>
<td>Higher than 180</td>
<td>Or Higher than 110</td>
</tr>
</tbody>
</table>
Causes of high blood pressure

High blood pressure cannot be cured. It can, however, be managed very effectively through lifestyle changes and, when needed, medication.

In most cases, the cause of high blood pressure is not known. In fact, high blood pressure usually doesn’t have symptoms. This is why it is sometimes called “the silent killer.”

However, there are known risk factors for high blood pressure. These are conditions that are known to increase the risk for getting high blood pressure. Risk factors fall into two categories: those you can control, and those that are out of your control.

Risk factors that are outside of your control

- **Family history:** Just as hair and eye color can run in families, so can high blood pressure. If your parents or other close blood relatives have high blood pressure, there’s an increased chance that you’ll get it, too. This is why it’s important to get your blood pressure checked on a regular basis. The American Heart Association recommends checking at your regular healthcare visit or every two years for people whose blood pressure is in a normal range.

- **Age:** The older you are, the more likely you are to get high blood pressure. As we age, our blood pressures gradually lose some of the elastic quality, which increases blood pressure.

- **Gender:** Until age 54, men are more likely to get high blood pressure than women are. But that changes as we age. From age 55 to 64, men and women get high blood pressure at similar rates. And at 65 and older, women are more likely to get high blood pressure than men are.

- **Race:** African Americans tend to develop high blood pressure more often than Caucasians. For African Americans, high blood pressure also tends to occur at younger ages and to be more severe.

Risk factors that you can control

- **Lack of physical activity:** Not getting enough physical activity as part of your lifestyle increases your risk of getting high blood pressure. Physical activity is great for your heart and circulatory system in general, and blood pressure is no exception.

- **An unhealthy diet, especially one high in sodium.** Good nutrition from a variety of sources is critical for your health. A diet that is too high in salt consumption, as
well as calories, saturated fat, and sugar, carries an additional risk of high blood pressure. On the other hand, making healthy food choices can actually help lower blood pressure.

- **Overweight and obesity**: Carrying too much weight puts an extra strain on your heart and circulatory system, and can cause serious health problems. Being overweight increases your risk of cardiovascular disease and diabetes. It also increases your risk of getting high blood pressure.

- **Drinking too much alcohol**: Regular, heavy use of alcohol can cause many health problems, including heart failure, stroke, and irregular heartbeats. Drinking too much alcohol can increase your risk of cancer, obesity, alcoholism, suicide, and accidents. It can also cause your blood pressure to increase dramatically.

  In addition to these risk factors, there are others that may contribute to high blood pressure, although how is still uncertain. These include:

- **Smoking and tobacco use**: Using tobacco can cause your blood pressure to temporarily increase and can contribute to damaged arteries, which can make high blood pressure worse.

- **Stress**: Stress is not necessarily a bad thing in and of itself. But too much stress may contribute to increased blood pressure. Also, too much stress can encourage behaviors that increase blood pressure, such as poor diet, physical inactivity, and using tobacco or drinking alcohol more than usual.

- **Sleep apnea**: This is a condition in which some of the tissues in the throat collapse during sleep and block the breathing passageway. In response to that, the brain awakens the sleeper, who then gulps for air in order to open the trachea again. This cycle often repeats many times a night, leading to severe fatigue the following day from a lack of good sleep. Sleep apnea can be a contributing factor to high blood pressure.
How high blood pressure affects the body

Left untreated, high blood pressure can have damaging effects on your health. The primary way it causes harm is by increasing the workload of the heart and arteries, which causes damage to the circulatory system over time.

High blood pressure can cause the heart to enlarge because it has to work harder to supply the blood the body needs. It also can contribute to a condition called atherosclerosis, in which the walls of the arteries become stiff and brittle as fatty deposits build up inside them.

Untreated high blood pressure can lead to coronary heart disease, heart failure, heart attack, stroke, kidney damage, angina (chest pain related to heart disease), peripheral artery disease, and other serious conditions.

In fact, people with high blood pressure over 140/90 are far more likely to have these dangerous conditions. According to the American Heart Association, 77% of Americans who’ve had a first stroke had high blood pressure at or over this level, while the same is true of 69% of Americans who’ve had a first heart attack. And 74% of Americans who have congestive heart failure have blood pressure levels above 140/90.

How high blood pressure is diagnosed

While high blood pressure rarely has symptoms, the good news is that it can be diagnosed using a simple test with a blood pressure monitor. Your healthcare provider will perform this test. The most accurate type of monitor is called a bicep cuff monitor. You’ve probably had this test already, using this device.

To get your blood pressure reading, the cuff is placed around your upper arm and inflated. This temporarily stops the blood flow in the arm. Your healthcare provider then slowly deflates the cuff, observing the reading on the monitor or listening through a stethoscope.
As this happens, your healthcare provider takes note of your systolic and diastolic pressure to determine your blood pressure reading.

Many things can affect blood pressure, so a diagnosis of high blood pressure is usually made after two or more successive readings that exceed healthy blood pressure ranges. Your healthcare provider will test you at least every two years if your blood pressure readings are within healthy ranges, but more often if they’re not.

**Monitoring, treating, and managing high blood pressure**

If you’ve been diagnosed with high blood pressure, it’s very important to follow the treatment plan your healthcare provider gives you. This will almost certainly include changes to your diet and level of physical activity, and may include medication, too.

**Eating healthy**

For people with high blood pressure (and those at risk for it), a healthy diet is a must. There are many healthy diet plans available, but the best for high blood pressure include limiting sodium (salt) intake and including a variety of nutritious foods. One proven diet plan is called the DASH plan (DASH stands for Dietary Approaches to Stop Hypertension).

The DASH plan emphasizes eating plenty of fruits and vegetables, as well as low-fat protein sources (such as skinless poultry, fish, and legumes), low-fat dairy products, and whole grains. It is also low in sugars and red meat, and offers many other nutritional benefits. You can learn more about the DASH plan by visiting the website of the National Heart, Lung, and Blood Institute: [http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf](http://www.nhlbi.nih.gov/health/public/heart/hbp/dash/new_dash.pdf).

As for sodium, you’ll want to limit your intake to no more than 1,500 mg per day, which is associated with the greatest reduction in blood pressure. How can you tell how much sodium you’re eating? By reading food labels. Be careful when you do so—many foods that don’t seem to be salt-heavy may contain “hidden” sodium, especially canned foods. Fortunately, food labels give an accurate picture of how much you’ll ingest by eating that particular product.
Physical activity

Physical activity is great for everyone. The health benefits of being active are many, and among them are proven benefits to your heart and circulatory system. One of the best ways to manage high blood pressure is to get plenty of physical activity.

Keep in mind that you don’t have to be an athlete to get the benefits of physical activity. And you don’t even have to get all your daily activity in at one session. In addition to traditional forms of exercise, healthy physical activity can include:

- Parking farther away from your destination to walk a bit more
- Taking the stairs instead of the elevator
- Taking your dog out for a stroll
- Walking instead of driving

To get the greatest benefits from physical activity, the American Heart Association recommends:

- Aim for 3 to 4 40-minute sessions per week of moderate-to-vigorous intensity physical activity
- Getting at least 10 minutes of physical activity per episode

It’s a good idea to check with your healthcare provider before beginning a physical activity program.
Maintaining a healthy weight

Many Americans are overweight or obese, and this is itself a risk factor for high blood pressure, among many other serious health conditions.

If you are overweight or obese, your healthcare provider can gauge how much weight you need to lose by determining your body mass index (BMI). BMI is determined by assigning a numerical value to your weight in relation to your height. The American Heart Association has a BMI calculator you can use here: http://www.heart.org/HEARTORG/GettingHealthy/WeightManagement/BodyMassIndex/Body-Mass-Index-In-Adults-BMI-Calculator-for-Adults_UCM_307849_Article.jsp.

There’s good news here, too. Even losing 3% to 5% of your body weight can bring good health benefits, such as reducing the workload on your heart. Talk with your healthcare provider about the best way to lose weight. The safest way to lose weight is typically to do so a few pounds at a time, by making changes to how many calories you eat and how much physical activity you get. By reducing calories and increasing your physical activity, you’re on your way to a healthier weight.

Reducing stress

Researchers continue to study how stress affects our health, and while we don’t know exactly how stress impacts high blood pressure, we do know that it has an effect. Stress makes us more likely to overeat or eat unhealthy foods, drink too much alcohol, smoke (or smoke more than usual), and engage in other risky behaviors that are known to have a bad effect on high blood pressure.

While stress is unavoidable, it can be managed effectively. There are some simple things you can do to reduce the amount of stress you have to deal with. These include:

- **Giving yourself time to get things done.** Overscheduling yourself can increase your stress load.
- **Not overpromising what you can do.** There’s nothing wrong with saying “no” if adding one more responsibility would be too much for you.
- **Understanding your stress triggers.** Knowing what causes you to become stressed and taking steps to avoid or manage (when you can’t avoid) those triggers can help you control stress.
Planning to address what you can change, and accepting what you can't change. No one can do it all. Some things must be dealt with, and it's good to have a plan in place for doing just that. But some things are out of your control. Learn to let those go.

Taking time to relax. There are countless ways to relax, from breathing exercises to getting into a hobby, from sitting in a favorite chair and listening to soothing music to having a chat with a cherished friend. Make sure you make time to relax in a way that is good for you.

Building relationships with people who care about you. We all need friends. Having a support network helps you get through tough times and enjoy good times all the more.

Taking care of yourself. Eating healthy and getting plenty of physical activity has many benefits beyond your physical health—it's great for your emotional and spiritual health, as well. Physical activity is a great stress reducer.

Limit (or avoid) alcohol

Drinking too much alcohol raises your blood pressure and is a risk factor for many other serious health conditions. If you do drink alcohol, limit your drinking to no more than two drinks per day (for men) or one drink per day (for women). A drink is one 12 oz. beer, 4 oz. of wine, 1.5 oz. of 80-proof spirits, or 1 oz. of 100-proof spirits.

Avoid or quit tobacco

It's simple: Tobacco is terrible for your health. It is a known risk factor for many potentially deadly diseases, including cancer, heart disease, and lung disease, among many other conditions. Smoking is the single most important preventable cause of premature death in the U.S.

While the exact connection between tobacco and high blood pressure is unclear, we do know that smoking causes blood pressure to temporarily rise. Smoking also contributes to atherosclerosis, the hardening of and buildup of fatty deposits in the arteries. Atherosclerosis can lead to serious conditions of the heart and blood vessels.
If you don’t smoke, don’t start. If you do smoke, talk with your healthcare provider about ways you can begin to quit. There are medications and programs available to help you, and they have proved effective for many people.

**Home blood pressure monitoring**

One way to stay on top of how you’re doing in managing your high blood pressure is to use a home blood pressure monitor. This can be a very important tool for you and your healthcare provider to use in getting a “broader” picture of how well you’re controlling your high blood pressure. Sometimes, a healthcare provider will even recommend a home blood pressure monitor for people who are at risk for high blood pressure but haven’t been diagnosed yet.

Choose a bicep monitor with an appropriately sized cuff, which will give the most accurate readings. Make sure the monitor has been tested and validated. A list of validated monitors is available [here](http://www.dableducational.org/sphygmomanometers/devices_2_sbpm.html#ArmTable).

Home monitoring can help eliminate false blood pressure readings, which happen when temporary factors affect your blood pressure, and can help give a more reliable picture of how your blood pressure is being managed to you and your healthcare provider.

**Medications**

For many people, making changes to diet and lifestyle doesn’t do enough to lower blood pressure to a healthy range. Fortunately, there are many medications that can help. They each work in different ways to help lower your blood pressure. Not all blood pressure medications work the same way for everyone, so you and your healthcare provider may need to work together to try different medications until you find the best one for you.

**Other high blood pressure medications**

- **Diuretics**: Often the first medication tried with a person newly diagnosed high blood pressure, diuretics work by removing excess salt and water from your body, which is passed through urine. Diuretics are enough for some people, but others need more help to lower blood pressure to a healthy range. In these cases, a healthcare provider may prescribe an additional medication or a medication that contains a diuretic and an additional medication. Diuretics can have side effects. These can include reduced potassium in the body (which can be supplemented), increased blood sugar levels (a potential problem for diabetics), and in some cases, flare-ups of gout or impotence.
Check. Change. Control.

- **ACE inhibitors**: These medications work by expanding blood vessels and reducing resistance inside them. By doing this, ACE inhibitors allow blood to flow more easily and reduce the workload on the heart. Side effects can include skin rash, loss of taste, and a chronic, dry hacking cough. In rare instances, kidney damage can result. ACE inhibitors should not be taken by pregnant women, and are not recommended for most women of child-bearing age.

- **Angiotensin II receptor antagonists**: These medications stop a hormone called angiotensin II from narrowing the blood vessels. These can cause occasional dizziness. They should not be used in pregnant women.

- **Beta blockers**: These reduce the heart rate and decrease cardiac output, which both help lower blood pressure. Side effects can include insomnia, cold hands or feet, tiredness or depression, asthma symptoms, or a slow heartbeat. For people with diabetes who take insulin, beta blockers have to be monitored carefully. Women receiving beta blockers who are or may become pregnant should consult with their healthcare providers to determine the safest treatment strategy.

- **Calcium channel blockers**: These interrupt the movement of calcium into the heart and blood vessel cells. These can cause palpitations, swollen ankles, constipation, headache, and dizziness. Side effects can vary depending on the specific calcium channel blocker prescribed.

- **Central agonists**: These work by limiting the ability of blood vessels to expand and contract, thus lowering blood pressure. These can cause a rapid drop in blood pressure while standing or moving, which can make you feel weak or faint. They can also cause drowsiness or sluggishness, dry mouth, constipation, fever, or anemia.

- **Peripheral andrenergic inhibitors**: These lower blood pressure by blocking the chemical message the brain sends to the blood vessels to make them constrict. These medications are typically only prescribed if other medications don’t help. Stuffy nose, diarrhea, or heartburn can be side effects from this medication.

- **Blood vessel dilators**: These cause the blood vessel walls to relax, which helps them expand more easily and allow blood to flow more freely. These can cause headaches, swelling around the eyes, heart palpitations, or aches and pains in the joints.
Monitoring blood pressure medications

No matter what blood pressure medication you’re prescribed, you will need to work with your healthcare provider to carefully monitor how well the medication is working. It’s important to understand that taking blood pressure medication isn’t a short-term fix. High blood pressure is a lifelong condition, so taking medication may be a lifelong need. Do not stop taking your medication unless your healthcare provider tells you to do so.

Your healthcare provider may want you to come in for office visits frequently at first to check your blood pressure. Once your blood pressure is under control, you will likely be tested less often.

Another important purpose of careful monitoring is to minimize the impact of side effects. If you’re having side effects from the medications you’re prescribed, talk with your doctor. A change in dosage or in the type of medication you’re taking may be appropriate. Your healthcare provider will work with you to figure out the best changes to make.

Take medications exactly as prescribed

Your medications are designed to reduce your blood pressure to a healthy range, but they can only work if they’re taken exactly as prescribed. This means following the dosage instructions on your medicine bottle to the letter. If you are unsure about how to take your medication, talk with your healthcare provider or pharmacist.

Again, do not stop taking your medication unless you’re instructed to do so by your healthcare provider.

If affording your medication is an issue, ask your healthcare provider if a generic medication might be appropriate. These are as effective as name-brand medications and are usually much cheaper. You may also want to look into getting help affording your medications. Visit the Partnership for Prescription Assistance at [www.pparx.org](http://www.pparx.org) or Needy Meds at [www.needymeds.org](http://www.needymeds.org) to learn more.
Living with high blood pressure

High blood pressure is a lifelong condition. Making healthy changes can help control blood pressure, and you should consider eating healthy and getting more physical activity to be lifelong habits.

The same is true of taking medication. Dealing with side effects can be a difficult matter, but it’s worth working with your healthcare provider to manage side effects because taking medication can make a huge difference in how well you manage your blood pressure. Controlling your blood pressure means you’re lowering your risk for heart disease, heart attack, diabetes, stroke, and kidney disease. Most people who control their high blood pressure are able to live full, healthy lives.

To keep your blood pressure under control, follow these tips:

- Keep your appointments with your healthcare provider.
- Make changes to your diet and physical activity routines lifelong habits. Remember, you don’t have to make dramatic changes all at once. Make gradual changes that you’re likely to keep pursuing.
- Follow your healthcare provider’s advice, including losing weight if recommended.
- Keep your eyes on the prize: better health. By reminding yourself of your goal, you are putting yourself in a position to succeed.
Keep Track of Your Heart Health at Heart360!

You can take control of your blood pressure and other vital cardiovascular information by signing on at the American Heart Association’s website, www.heart360.org/cholesterol. Here you can keep track of your cholesterol, blood pressure, physical activity, medications, blood glucose, and weight—storing all your vital information in a Microsoft® HealthVault™ account. This easy-to-use tool puts you in control of your heart’s health. Sign up today!
Your Comments and Suggestions are Needed!

And now, please tell us what you think about this workbook! We need your suggestions to make sure that this has everything you need to know about high blood pressure. Go to our online survey www.surveymonkey.com/s/AHA_HBP and answer just a few questions. It will only take a few minutes of your time. Thank you for your help!
Care Team Guidelines