



**Lancashire and  
South Cumbria**  
Integrated Care Board



# Hypertension in Adults: Diagnosis and Management

Version 1.0—March 2026

VERSION CONTROL			
Version	Date	Amendments made	By Who
1.0	16/03/2026	Numerous amendments from LSCMMG review	Vicki Wagstaff/Rukaiya Chand

Review dates		
Review Date	Purpose	By Who
02/02/2027	Annual Review to ensure correctness	LSCMMG/MO

# Lancashire & South Cumbria Adult Hypertension Medication Pathway

(based on the Greater Manchester Adult Hypertension Pathway)

\*This is general guidance for the majority of the population and does not replace clinical judgement.

## STEP 1: Diagnosis & Assessment

ABPM or Average Home BP (Twice AM and Twice PM for 4 consecutive days)

Titrate every 4 weeks following BP Reassessment

Consider Pharmacy options: **New Medicines Service** and/or **ABPM** [where available](#)

**Targets:** Age <80; Home/Average <135/85 mmHg or clinic <140/90 mmHg

Age 80+; Home/Average <145/85 mmHg or clinic <150/90 mmHg

**Post Stroke/MI/CKD and urine ACR >70mg/mmol: Aim for clinic BP <130/80 mmHg**

[ESC Guidance](#) suggests lower target where possible

Clinic BP  $\geq 140/90$  mmHg (age <80) or  $\geq 150/90$  mmHg (age 80+)

**Age <40—consider referral and secondary causes**

Previous history of raised BP readings including pregnancy, CKD, TIA, Stroke, Hypertensive retinopathy, sleep apnoea, proteinuria, diabetes, unexplained LVH

## STEP 2: Medication Initiation

Think baseline investigations: lipids; U&Es; LFTs; TFT; HbA1c; ECG; Urine Dip; Albumin Creatinine Ratio (ACR)

Now considered best practice to **initiate medication whilst addressing lifestyle changes, not as a follow-on**

**Initial dose: (usual starting dose—see Note Y for alternative doses)**  
Age <55 or T2 diabetes +/- or NOT African or Black Caribbean  
**Ramipril 1.25-2.5mg OM; or Lisinopril 10mg OM; or**  
if ACEi is not tolerated, e.g. cough  
**ARB: Candesartan 8mg OM**

**Initiating dual therapy at once**  
There are benefits of optimising treatment for hypertension early which can substantially improve quality of life. However, initiating dual therapy at once is outside the scope of this guideline (see **Note X** for details)

**Initial dose: (usual starting dose—see Note Y for alternative doses & intolerance)**  
Age >55 or African or Black Caribbean (NOT diabetic)  
**Amlodipine 5mg OM; or Lercanidipine 10mg OM**

## REMEMBER Lifestyle advice/changes & REMEMBER New Medicine Service at Pharmacy

**ASK THE PERSON ABOUT THEIR CURRENT MOTIVATIONS AND WIDER SITUATION AND DISCUSS GOAL-SETTING FOR SELF-MANAGEMENT AND LIFESTYLE CHANGES.**

Review drugs incl. NSAIDs, steroids, cancer therapies, coarctation, sleep apnoea, co-morbidities, obesity, additives e.g. liquorice etc. Advise reduction in salt/salty foods, reduce alcohol to <15 units/week, healthy BMI <25, **DASH diet**, aim for 150 minutes per week of physical activity. Consider pre-payment certificates for prescriptions.

Not at target after 2-4 weeks

**A+C**

Not at target after 4 weeks

**Introduce a second drug**  
combination therapy is approximately 5 x more effective than doubling monotherapy  
**Combine initial dose of drug A with initial dose of drug C**

Not at target after 2-4 weeks

Not at target after 2-4 weeks

**Increase dose:**  
**Ramipril 2.5-10mg OM; or Lisinopril 20mg OM;**  
or; if ACEi is not tolerated, e.g. cough  
**ARB: Candesartan 8-32mg OM**  
(see **Note Y** for info on increasing doses, monitoring requirements and eGFR change thresholds)  
Ensure being taken at optimal tolerated dose and discuss adherence. Consider other causes of raised BP

**Increase dose:**  
**Amlodipine 10mg OM; or Lercanidipine 10-20mg OM**  
Ensure being taken at optimal tolerated dose and discuss adherence. Consider other causes of raised BP

Not at target after 2-4 weeks

Not at target after 4 weeks

**A+C+D**

**Introduce a third drug: Indapamide 2.5mg OM**  
Discuss adherence. Consider other causes of raised BP

**A+C+D**

Not at target after 2-4 weeks

**A+C+D**

**Combine maximum tolerated dose of drug A, drug C and Indapamide 2.5mg OM**  
Ensure being taken at optimal tolerated doses and discuss adherence. Consider other causes of raised BP

Not at target after 2-4 weeks

**RESISTANT TO THREE DRUGS: >90% of patients resistant to 3 drugs are not taking them—check concordance (THINK New Medicine Service).**

**FURTHER OPTIONS — CONSIDER INTRODUCING A FOURTH DRUG OR REFER TO ADVICE & GUIDANCE FROM CARDIOLOGY OR RENAL TEAM**

K+ > 4.5 mmol/L: Doxazosin IR 2-4mg OD, or Bisoprolol 2.5mg OD, K+ < 4.5 mmol/L: Spironolactone 25mg OM

Re-check after 6 months to 1 year once stable

Achieved target

BP still uncontrolled  
2-4 weeks

REFER TO ADVICE & GUIDANCE FROM  
CARDIOLOGY OR RENAL TEAM

Lifestyle & Self Care

# Lancashire & South Cumbria Adult Hypertension Medication Pathway—NOTES

(based on the Greater Manchester Adult Hypertension Pathway)

## NOTE X: Initiating Dual Therapy at once (if clinical BP $\geq 160/110$ mmHg OR Home Avg BP $\geq 155/105$ mmHg)

Although not part of [national guidance](#), clinicians may choose to initiate dual therapy in certain situations

If CKD is initially suspected, **DO NOT** initiate dual therapy at once

Any decision to do so should be on an individualised basis, informed by risks and benefits of each treatment and the patient's preference.

Combine **A** with **C**

### Consider CKD

CKD (eGFR 25-60 ml/min) and Proteinuria (urine ACR  $>25$ mg/mmol):

**Without T2DM:** 1st line ACEi/ARB. If ACR then remains  $>25$ mg/mmol *consider* Dapagliflozin 10mg OD

**With T2DM:** Ensure already on appropriate ACE-I/ARB. If urine ACR 3-30mg/mmol *consider* adding Dapagliflozin 10mg OD. If urine ACR  $>30$ mg/mmol *offer* Dapagliflozin 10mg OD.

[NG203 Identifying chronic kidney disease in adults visual summary](#)

[NG203 Visual summary on chronic kidney disease \(G1-5, A1-3\): managing proteinuria](#)

[CVD-toolkit LKN-CKD-guidance.pdf](#)

[The Kidney Failure Risk Equation](#)

[CKD Primary Care Management Tool](#)

## NOTE Y: Monitoring requirements and eGFR change thresholds

- Patients at agreed target BP on their anti-hypertensives **should not be switched due to this guidance.**
- This pathway is **Adult only** and is **not applicable in pregnancy.**

### ACEi/ARB

- **Ramipril** 1.25-2.5mg OM; OR, **A**
- **Lisinopril** 10mg OM; OR if ACEi is not tolerated, e.g. cough
- **Candesartan** 8mg OD

Use ARB if Black African or African Caribbean Origin. Avoid ACEi/ARB in women of childbearing potential unless on effective contraception (consider Amlodipine if trying to conceive)

Check U+E's before and 1-2 weeks after initiation and dose change. If eGFR decreases by  $<25\%$ , recheck levels after 1-2 weeks.

If eGFR decreases by  $>25\%$  or creatinine  $>30\%$ : investigate for secondary causes and if persist despite these, stop the ACEi OR reduce dose to previously tolerated (recheck 5-7 days). See [NICE guidance for further information](#) on abnormal test results.

### Calcium Channel Blocker

Amlodipine 5mg gives 80% of the effect of Amlodipine 10mg **C**

- **Amlodipine** 5mg OM; OR if troublesome ankle swelling
- **Lercanidipine** 10mg OM

If a CCB is not tolerated, for example because of oedema, offer a thiazide-like diuretic (indapamide) to treat hypertension

### Increasing doses

Gradually titrate upwards until target BP has been achieved, or until the person has reached the maximum/tolerated dose. See links for further information:

[Angiotensin-converting enzyme inhibitors | Prescribing information | Hypertension | CKS | NICE](#)

[Angiotensin-II receptor blockers | Prescribing information | Hypertension | CKS | NICE](#)

[Calcium-channel blockers | Prescribing information | Hypertension | CKS | NICE](#)

### Diuretic

**1st line: INDAPAMIDE<sup>1</sup> 2.5mg OM** **D**

Check U+E's before starting, and at regular intervals, within 2 months and ensure Na<sup>+</sup> remains  $>130$  mmol/l, otherwise **STOP, Recheck** and, if improved, consider Bendroflumethiazide<sup>1</sup> 2.5mg OD. See [NICE guidance for further information](#).

<sup>1</sup> Medication may require dose adjustment based on co-morbidities (e.g. renal/hepatic impairment) always check the BNF if uncertain.

## Patient information

Hypertension Leaflet



CKD

