

Final Recommendation Statement

High Blood Pressure in Adults: Screening

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Recommendation Summary

Population	Recommendation	Grade (What's This?)
Adults aged 18 years or older	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment (see the Clinical Considerations section).	

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Preface

The U.S. Preventive Services Task Force (USPSTF) makes recommendations about the effectiveness of specific clinical preventive services for patients without related signs or symptoms.

It bases its recommendations on the evidence of both the benefits and harms of the service and an assessment of the balance. The USPSTF does not consider the costs of providing a service in this assessment.

The USPSTF recognizes that clinical decisions involve more considerations than evidence alone. Clinicians should understand the evidence but individualize decision making to the specific patient or situation. Similarly, the USPSTF notes that policy and coverage decisions involve considerations in addition to the evidence of clinical benefits and harms.

Rationale

Importance

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.¹

Detection

The evidence on the benefits of screening for high blood pressure is well-established. In 2007, the USPSTF reaffirmed its 2003 recommendation to screen for hypertension in adults aged 18 years or older (A recommendation). Previous evidence reviews commissioned by the USPSTF found good-quality evidence that screening for hypertension has few major harms and provides substantial benefits.^{2,3} However, these reviews did not address the diagnostic accuracy of different blood pressure measurement protocols or identify a reference standard for measurement confirmation. For the current recommendation, the USPSTF examined the diagnostic accuracy of office blood pressure measurement, ambulatory blood pressure monitoring (ABPM), and home blood pressure monitoring (HBPM). The USPSTF also assessed the accuracy of these blood pressure measurements and methods in confirming the diagnosis of hypertension. In addition, it reviewed data on optimal screening intervals for diagnosing hypertension in adults.

Benefits of Early Detection and Treatment

The USPSTF found good evidence that screening for and treatment of high blood pressure in adults substantially reduces the incidence of cardiovascular events.

Harms of Early Detection and Treatment

The USPSTF found good evidence that screening for and treatment of high blood pressure has few major harms.

USPSTF Assessment

The USPSTF concludes with high certainty that the net benefit of screening for high blood pressure in adults is substantial.

Clinical Considerations

Patient Population Under Consideration

This recommendation applies to adults aged 18 years or older without known hypertension.

Screening Tests

Office Blood Pressure Measurement

Office measurement of blood pressure is most commonly done with a manual or automated sphygmomanometer. Little research has been done on the best approach to measuring blood pressure in the office setting. Most clinical trials of hypertension treatment, at a minimum, used the mean of 2 measurements taken while the patient was seated (some used the mean of the second and third measurements), allowed for at least 5 minutes between entry into the office and blood pressure measurement, used an appropriately sized arm cuff, and placed the patient's arm at the level of the right atrium during measurement. Multiple measurements over time have better positive predictive value for hypertension than a single measurement. Automated office blood pressure, which is an average of multiple automated measurements taken while the patient is alone in a room, may yield results similar to those of daytime ABPM.^{4, 5} Blood pressure is affected by various short-term factors, such as emotions, stress, pain, physical activity, and drugs (including caffeine and nicotine). In addition to within-patient temporal variability, isolated clinic hypertension in the medical setting and in the presence of medical personnel (known as "white coat" hypertension) is well-documented. Epidemiologic data suggest that 15% to 30% of the population believed to have hypertension may have lower blood pressure outside of the office setting.¹ The disadvantages of diagnosing hypertension solely in the office setting include measurement errors, the limited number of measurements that can be made conveniently, and the confounding risk for isolated clinic hypertension.

Ambulatory and Home Blood Pressure Monitoring

In addition to office blood pressure measurement, ABPM and HBPM may be used to confirm a diagnosis of hypertension after initial screening. Ambulatory blood pressure monitoring devices are small, portable machines that record blood pressure at regular intervals over 12 to 24 hours while patients go about their normal activities and while they are sleeping. Measurements are typically taken at 20- to 30-minute intervals. Home blood pressure measurement devices are fully automated oscillometric devices that record measurements taken from the patient's brachial artery. Many of these devices are available for retail purchase, and some have undergone technical validation according to recommended protocols.

The USPSTF found convincing evidence that ABPM is the best method for diagnosing hypertension. Although the criteria for establishing hypertension varied across studies, there was significant discordance between the office diagnosis of hypertension and 12- and 24-hour average blood pressures using ABPM, with significantly fewer patients requiring treatment based on ABPM (Figure 1).³⁰ Elevated ambulatory systolic blood pressure was consistently and significantly associated with increased risk for fatal and nonfatal stroke and cardiovascular events, independent of office blood pressure (Figure 2).³⁰ For these reasons, the USPSTF recommends ABPM as the reference standard for confirming the diagnosis of hypertension.

Good-quality evidence suggests that confirmation of hypertension with HBPM may be acceptable. Several studies showed that elevated home blood pressure was significantly associated with increased risk for cardiovascular events, stroke, and all-cause mortality, independent of office blood pressure (Figure 3).³⁸⁻⁴¹ However, fewer studies have compared HBPM with office blood pressure measurement, so the evidence is not as substantial as it is for ABPM.¹ Therefore, the USPSTF considers ABPM to be the reference standard for confirming the diagnosis of hypertension. However, the USPSTF acknowledges that the use of ABPM may be problematic in some situations. Home blood pressure monitoring using appropriate protocols is an alternative method of confirmation if ABPM is not available. Measurements from the office, HBPM, and ABPM all must be interpreted with care and in the context of the individual patient. Patients with very high blood pressure or signs of end-organ damage may need immediate treatment.

Screening Interval

The USPSTF recommends annual screening for adults aged 40 years or older and for those who are at increased risk for high blood pressure. Persons at increased risk include those who have high-normal blood pressure (130 to 139/85 to 89 mm Hg), those who are overweight or obese, and African Americans. Adults aged 18 to 39 years with normal blood pressure (<130/85 mm Hg) who do not have other risk factors should be rescreened every 3 to 5 years. The USPSTF recommends rescreening with properly measured office blood pressure and, if blood pressure is elevated, confirming the diagnosis of hypertension with ABPM.

Treatment

The benefits of treatment of hypertension in preventing important health outcomes are well-documented. Moderate- to high-quality randomized, controlled trials (RCTs) demonstrate the efficacy of treatment of the general population of persons aged 60 years or older to a target blood pressure of 150/90 mm Hg in reducing the incidence of stroke, heart failure, and coronary heart disease events. Similarly, RCTs demonstrate the efficacy of treatment of younger adults to a target diastolic blood pressure of less than 90 mm Hg in reducing cerebrovascular events, heart failure, and overall mortality.⁴² In the absence of sufficient RCT data, expert opinion has been used to establish a target systolic blood pressure of 140 mm Hg in adults younger than 60 years.⁴² and some experts believe that this should also be maintained in those aged 60 years or older.⁴³ However, published results from a recently completed large RCT, the Systolic Blood Pressure Intervention Trial, are not yet available to inform current treatment goals. Clinicians should consult updated blood pressure treatment guidelines informed by this trial as they become available.

For nonblack patients, initial treatment consists of a thiazide diuretic, calcium-channel blocker, angiotensin-converting enzyme inhibitor, or angiotensin-receptor blocker. For black patients, initial treatment is thiazide or a calcium-channel blocker. Initial or add-on treatment for patients with chronic kidney disease consists of either an angiotensin-converting enzyme inhibitor or an angiotensin-receptor blocker (not both).

Other Considerations

Suggestions for Implementation

Screening for high blood pressure may be done in the office setting by using the proper methods described previously. However, the USPSTF recommends confirmation outside of the clinical setting before a diagnosis of hypertension is made and treatment is started. Confirmation may be done by using HBPM or ABPM. Because blood pressure is a continuous value with natural variations throughout the day, repeated measurements over time are generally more accurate in establishing a diagnosis of hypertension. The USPSTF did not find evidence for a single gold standard protocol for HBPM or ABPM. However, both may be used in conjunction with proper office measurement to make a diagnosis and guide management and treatment options. Blood pressure cuffs used for HBPM should be compliant with sphygmomanometer standards set by the Association for the Advancement of Medical Instrumentation.⁴⁴

Research Needs and Gaps

Most of the evidence supports ABPM as the best method for confirming a diagnosis of hypertension. More research is needed on the accuracy of HBPM versus ABPM and the best HBPM protocols for follow-up of elevated office blood pressure. The diagnostic accuracy of blood pressure measurements taken by a visiting nurse or another health care worker in the home setting also merits more research. Self-use blood pressure measurement kiosks in community settings, such as pharmacies and grocery stores, may be frequently used by the public but are not regulated by the U.S. Food and Drug Administration. More research on the accuracy of kiosk measurements is needed. New technology has been developed that uses a wireless brachial blood pressure monitor that connects to a smartphone, a desktop computer, or the Internet for recording and analysis. More research is needed on the accuracy of these monitors, their use in primary prevention, and their association with long-term health outcomes.

Discussion

Burden of Disease

Hypertension is a prevalent condition, affecting 29.1% of U.S. adults in 2011 to 2012.⁴⁵ Prevalence rates increase with age, from 7.3% in persons aged 18 to 39 years to 32.4% in those aged 40 to 59 years and to 65.0% in those aged 60 years or older. Non-Hispanic black adults have the highest prevalence (42.1%) compared with white (28.0%), Hispanic (26.0%), and Asian (24.7%) Americans. Uncontrolled hypertension is a risk factor for heart attack, stroke, and congestive heart failure and a major contributing factor to cardiovascular and all-cause mortality in the United States.⁴⁶ Persons with high blood pressure often have no signs or symptoms of the condition; however, once diagnosed, it is usually amenable to treatment.

Scope of Review

In its previous evidence reviews, the USPSTF found substantial indirect evidence to support the effectiveness of screening for high blood pressure in adults.^{2,3} For the current recommendation statement, the USPSTF examined the diagnostic accuracy of different methods for confirming a diagnosis of hypertension after initial screening. The USPSTF also examined data to determine the optimal rescreening interval for diagnosing hypertension.

Effectiveness of Early Detection

The USPSTF found 1 new study that directly assessed screening for high blood pressure in an adult population.⁴⁷ This study was a good-quality cluster RCT of community-based pharmacy screening in adults aged 65 years or older living in Ontario, Canada. Results showed 3 fewer annual cardiovascular-related hospitalizations per 1000 persons in the intervention group compared with the no-screening group (rate ratio, 0.91 [95% CI, 0.86 to 0.97]). However, because this study was limited to adults aged 65 years or older, the USPSTF concluded that there is still inadequate direct evidence about the benefits and harms of screening for hypertension in younger adults. Substantial indirect evidence continues to support the net benefit of screening for high blood pressure in adults aged 18 years or older.^{2,3}

Accuracy of Screening Tests

Office Blood Pressure Measurement

The USPSTF did not find evidence suggesting that a particular office blood pressure measurement protocol is more accurate than any other.¹ Data comparing manual (auscultatory) versus automated office blood pressure measurement with a reference standard, such as ABPM, are lacking.

The USPSTF found that office blood pressure variably predicted true hypertension, as defined by the reference standard of ABPM. Isolated elevated clinic blood pressure was not confirmed after ABPM in approximately 5% to 65% of study participants (Figure 1).¹ Positive predictive values (with ABPM as the reference standard) increased with the following factors: patient population characteristics, such as age; blood pressure; and the number of abnormal screening results before confirmation. Given the variability of office blood pressure in predicting sustained, true hypertension, confirmatory measurement is needed for patients with elevated blood pressure at the initial office screening.

Ambulatory and Home Blood Pressure Monitoring

The USPSTF found that elevated 24-hour ambulatory systolic blood pressure was consistently and significantly associated with stroke and other cardiovascular outcomes, independent of office blood pressure and with greater predictive value. Because of its large evidence base, ABPM is considered the best confirmatory test for hypertension. The USPSTF found 9 studies that evaluated the predictive value of 24-hour ABPM on long-term health outcomes.¹ Four studies found that each 10-mm Hg increment in ambulatory blood pressure (adjusted for office measurements) was significantly associated with increased risk for fatal and nonfatal stroke (Figure 2).³¹⁻³⁴ Six studies found that each 10-mm Hg increment was associated with increased risk for fatal and nonfatal cardiovascular events, with hazard ratios ranging from 1.11 to 1.42 (Figure 2).^{31-33, 35-37}

Home blood pressure monitoring may also be a reasonable confirmatory method but has less evidence to support its use. Four good-quality studies found that elevated blood pressure with HBPM showed a significant association with increased risk for cardiovascular outcomes, with hazard ratios ranging from 1.17 to 1.39 (Figure 3).³⁸⁻⁴¹

Screening Interval

No clinical trials randomly assigned patients to different rescreening intervals and evaluated clinical outcomes. Many observational studies have followed patients over time to determine how many develop hypertension at intervals of 1 to 5 years.¹ These data are summarized in the Table.

The percentage of patients who are diagnosed with hypertension after confirmatory monitoring is significantly higher among African Americans, persons with an initial high-normal blood pressure (130 to 139/85 to 89 mm Hg), those who are obese or overweight, and those older than 40 years.¹ In most studies, the risk for hypertension exceeded 20% at 3 to 5 years in persons with at least 1 of these risk factors. Given the higher incidence of hypertension in populations with these risk factors, annual screening may be warranted for persons aged 40 years or older, African Americans of any age, and persons who are overweight or obese. Blood pressure exceeding the optimal level of less than 120/80 mm Hg may confer a graded risk; persons with blood pressure closest to the threshold for a diagnosis of hypertension have a higher incidence of hypertension at rescreening. Adults aged 18 to 39 years with no other risk factors have a low incidence of hypertension (about 1% to 6% at 2 years).

The USPSTF recommends rescreening with adequate office blood pressure measurement using the techniques described previously and, if indicated, confirmation with ABPM. Ambulatory blood pressure monitoring can be performed every year in high-risk persons and every 3 to 5 years in those at low risk (adults aged 18 to 39 years with no risk factors).

Potential Harms of Screening

The USPSTF found 9 studies that evaluated the harms of screening for high blood pressure.¹ Four studies found no significant differences in psychological distress or quality of life before versus after participants were labeled with hypertension or prehypertension.⁴⁸⁻⁵¹ Four studies addressed harms associated with ABPM and found that use of the monitoring device was associated with sleep disturbances, discomfort, and restrictions in daily activities.⁵²⁻⁵⁵ These studies suggest that the harms of screening may be relatively minor and short-term in nature. However, persons with isolated elevated clinic blood pressure who do not receive confirmatory ABPM or HBPM may be misdiagnosed with hypertension and could subsequently experience the more serious harms of unnecessary drug treatment. Misdiagnosis of hypertension is an area that warrants future research.

Estimate of Magnitude of Net Benefit

The USPSTF determined that the benefits of screening for high blood pressure in adults to prevent cardiovascular morbidity and mortality are substantial and that the harms of screening are small. The USPSTF concludes with high certainty that the net benefit of screening is substantial.

Response to Public Comment

A draft version of this recommendation statement was posted for public comment on the USPSTF Web site from 23 December 2014 to 26 January 2015. The USPSTF reviewed all public comments received in response. The USPSTF acknowledges the current barriers to implementation of its recommendation, including the availability and affordability of ABPM. In response, it revised the final recommendation to include HBPM as an alternative for confirming a diagnosis of hypertension when ABPM is not feasible. The USPSTF also provided more information on the implementation of diagnostic confirmation and industry standards for home blood pressure monitors.

Update of Previous USPSTF Recommendation

This recommendation updates the 2007 reaffirmation recommendation statement on screening for high blood pressure in adults. The current statement recommends screening for high blood pressure using office blood pressure measurement and confirming a diagnosis of hypertension with ABPM. In addition, the USPSTF recommends optimal screening intervals for diagnosing hypertension in adults.

Recommendations of Others

The Eighth Joint National Committee does not address the diagnosis of hypertension in its 2014 guidelines.⁴² The Seventh Joint National Committee recommends screening for high blood pressure at least once every 2 years in adults with blood pressure less than 120/80 mm Hg and every year in adults with blood pressure of 120 to 139/80 to 89 mm Hg.⁵⁶ The American Heart Association recommends blood pressure measurement at each regular health care visit or at least once every 2 years in adults with blood pressure less than 120/80 mm Hg.⁵⁷ The American Academy of Family Physicians' recommendation is similar to that of the USPSTF.⁵⁸ The American Congress of Obstetricians and Gynecologists recommends blood pressure screening as part of women's annual health care visits.⁵⁹

Members of the U.S. Preventive Services Task Force

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† For a list of current USPSTF members, go to www.uspreventiveservicestaskforce.org/Page/Name/our-members.

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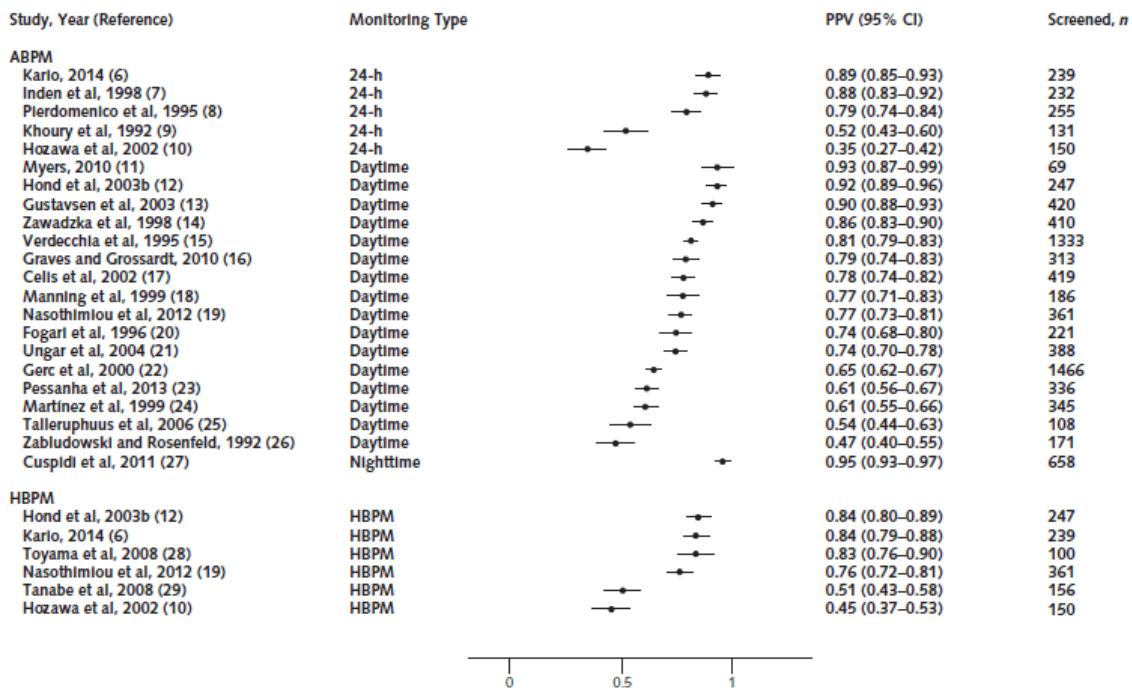
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References:

- Piper MA, Evans CV, Burda BU, Margolis KL, O'Connor E, Smith N, et al. Screening for High Blood Pressure in Adults: A Systematic Evidence Review for the U.S. Preventive Services Task Force. Evidence Synthesis No. 121. AHRQ Publication No. 13-05194-EF-1. Rockville, MD: Agency for Healthcare Research and Quality; 2014.
- Sheridan S, Pignone M, Donahue K. Screening for high blood pressure: a review of the evidence for the U.S. Preventive Services Task Force. *Am J Prev Med*. 2003;25:151-8.
- Wolff T, Miller T. Evidence for the reaffirmation of the U.S. Preventive Services Task Force recommendation on screening for high blood pressure. *Ann Intern Med*. 2007;147:787-91.
- Myers MG, Valdivieso M, Kiss A. Consistent relationship between automated office blood pressure recorded in different settings. *Blood Press Monit*. 2009;14:108-11.
- Myers MG, Kaczorowski J, Dawes M, Godwin M. Automated office blood pressure measurement in primary care. *Can Fam Physician*. 2014;60:127-32.
- Kario K. Diagnosis of true uncontrolled hypertension using both home and ambulatory blood pressure monitoring. *J Hum Hypertens*. 2014;28:176-9.
- Inden Y, Tsuda M, Hayashi H, Takezawa H, Iino S, Kondo T, et al. Relationship between Joint National Committee-VI classification of hypertension and ambulatory blood pressure in patients with hypertension diagnosed by casual blood pressure. *Clin Cardiol*. 1998;21:801-6.
- Pierdomenico SD, Mezzetti A, Lapenna D, Guglielmi MD, Mancini M, Salvatore L, et al. 'White-coat' hypertension in patients with newly diagnosed hypertension: evaluation of prevalence by ambulatory monitoring and impact on cost of health care. *Eur Heart J*. 1995;16:692-7.
- Khoury S, Yarows SA, O'Brien T, Sowers JR. Ambulatory blood pressure monitoring in a nonacademic setting. Effects of age and sex. *Am J Hypertens*. 1992;5:616-23.
- Hozawa A, Ohkubo T, Kikuya M, Yamaguchi J, Ohmori K, Fujiwara T, et al. Blood pressure control assessed by home, ambulatory and conventional blood pressure measurements in the Japanese general population: the Ohasama study. *Hypertens Res*. 2002;25:57-63.
- Myers MG. A proposed algorithm for diagnosing hypertension using automated office blood pressure measurement. *J Hypertens*. 2010;28:703-8.
- Hond ED, Celis H, Fagard R, Keary L, Leeman M, O'Brien E, et al; THOP Investigators. Self-measured versus ambulatory blood pressure in the diagnosis of hypertension. *J Hypertens*. 2003;21:717-22.
- Gustavsen PH, Høegholm A, Bang LE, Kristensen KS. White coat hypertension is a cardiovascular risk factor: a 10-year follow-up study. *J Hum Hypertens*. 2003;17:811-7.
- Zawadzka A, Bird R, Casadei B, Conway J. Audit of ambulatory blood pressure monitoring in the diagnosis and management of hypertension in practice. *J Hum Hypertens*. 1998;12:249-52.
- Verdecchia P, Schillaci G, Borgioni C, Ciucci A, Zampi I, Gattobigio R, et al. White coat hypertension and white coat effect. Similarities and differences. *Am J Hypertens*. 1995;8:790-8.
- Graves JW, Grossardt BR. Discarding the first of three nurse-auscultatory or oscillometric blood pressure measurements does not improve the association of office blood pressure with ABPM. *Blood Press Monit*. 2010;15:146-51.
- Celis H, Staessen JA, Thijs L, Buntinx F, De Buyzere M, Den Hond E, et al; Ambulatory Blood Pressure and Treatment of Hypertension Trial Investigators. Cardiovascular risk in white-coat and sustained hypertensive patients. *Blood Press*. 2002;11:352-6.
- Manning G, Rushton L, Millar-Craig MW. Clinical implications of white coat hypertension: an ambulatory blood pressure monitoring study. *J Hum Hypertens*. 1999;13:817-22.
- Nasothimiou EG, Tzamouranis D, Rarra V, Roussias LG, Stergiou GS. Diagnostic accuracy of home vs. ambulatory blood pressure monitoring in untreated and treated hypertension. *Hypertens Res*. 2012;35:750-5.
- Fogari R, Corradi L, Zoppi A, Lusardi P, Poletti L. Repeated office blood pressure controls reduce the prevalence of white-coat hypertension and detect a group of white-coat normotensive patients. *Blood Press Monit*. 1996;1:51-54.
- Ungar A, Pepe G, Monami M, Lambertucci L, Torrini M, Baldasseroni S, et al. Isolated ambulatory hypertension is common in outpatients referred to a hypertension centre. *J Hum Hypertens*. 2004;18:897-903.
- Gerc V, Favrat B, Brunner HR, Burnier M. Is nurse-measured blood pressure a valid substitute for ambulatory blood pressure monitoring? *Blood Press Monit*. 2000;5:203-9.
- Pessanha P, Viana M, Ferreira P, Bertoquini S, Polónia J. Diagnostic value and cost-benefit analysis of 24 hours ambulatory blood pressure monitoring in primary care in Portugal. *BMC Cardiovasc Disord*. 2013;13:57.
- Martínez MA, García-Puig J, Martín JC, Guallar-Castillón P, Aguirre de Cárcer A, Torre A, et al; Monitorización Ambulatoria de la Presión Arterial (MAPA)-Area 5 Working Group. Frequency and determinants of white coat hypertension in mild to moderate hypertension: a primary care-based study. *Am J Hypertens*. 1999;12:251-9.
- Talleruphuus U, Bang LE, Wiinberg N, Mehlsen J, Svendsen TL, Bentzen MW. Isolated systolic hypertension in an elderly Danish population. Prevalence and daytime ambulatory blood pressure. *Blood Press*. 2006;15:347-53.
- Zabludowski JR, Rosenfeld JB. Evaluation of clinic blood pressure measurements: assessment by daytime ambulatory blood pressure monitoring. *Isr J Med Sci*. 1992;28:345-8.
- Cuspidi C, Sala C, Valerio C, Negri F, Mancina G. Nocturnal blood pressure in untreated essential hypertensives. *Blood Press*. 2011;20:335-41.
- Toyama H, Hasegawa Y, Ejima Y, Kurosawa S, Sanada S, Hatano R, et al. Characteristics of young-onset white coat hypertension identified by targeted screening for hypertension at a university health check-up. *Hypertens Res*. 2008;31:1063-8.
- Tanabe P, Persell SD, Adams JG, McCormick JC, Martinovich Z, Baker DW. Increased blood pressure in the emergency department: pain, anxiety, or undiagnosed

- hypertension? *Ann Emerg Med*. 2008;51:221-9.
30. Piper MA, Evans CV, Burda BU, Margolis KL, O'Connor E, Whitlock EP. Diagnostic and predictive accuracy of blood pressure screening methods with consideration of rescreening intervals: a systematic review for the U.S. Preventive Services Task Force. *Ann Intern Med*. 2015;162:192-204.
31. Ohkubo T, Kikuya M, Metoki H, Asayama K, Obara T, Hashimoto J, et al. Prognosis of "masked" hypertension and "white-coat" hypertension detected by 24-h ambulatory blood pressure monitoring 10-year follow-up from the Ohasama study. *J Am Coll Cardiol*. 2005;46:508-15.
32. Staessen JA, Thijs L, Fagard R, O'Brien ET, Clement D, de Leeuw PW, et al. Predicting cardiovascular risk using conventional vs ambulatory blood pressure in older patients with systolic hypertension. Systolic Hypertension in Europe Trial Investigators. *JAMA*. 1999;282:539-46.
33. Dolan E, Stanton A, Thijs L, Hinedi K, Atkins N, McClory S, et al. Superiority of ambulatory over clinic blood pressure measurement in predicting mortality: the Dublin Outcome Study. *Hypertension*. 2005;46:156-61.
34. Mesquita-Bastos J, Bertoquini S, Polónia J. Cardiovascular prognostic value of ambulatory blood pressure monitoring in a Portuguese hypertensive population followed up for 8.2 years. *Blood Press Monit*. 2010;15:240-6.
35. Clement DL, De Buyzere ML, De Bacquer DA, de Leeuw PW, Duprez DA, Fagard RH, et al; Office versus Ambulatory Pressure Study Investigators. Prognostic value of ambulatory blood-pressure recordings in patients with treated hypertension. *N Engl J Med*. 2003;348:2407-15.
36. Hermida RC, Ayala DE, Mojón A, Fernández JR. Decreasing sleep-time blood pressure determined by ambulatory monitoring reduces cardiovascular risk. *J Am Coll Cardiol*. 2011;58:1165-73.
37. Gasowski J, Li Y, Kuznetsova T, Richart T, Thijs L, Grodzicki T, et al. Is "usual" blood pressure a proxy for 24-h ambulatory blood pressure in predicting cardiovascular outcomes? *Am J Hypertens*. 2008;21:994-1000.
38. Fagard RH, Van Den Broeke C, De Cort P. Prognostic significance of blood pressure measured in the office, at home and during ambulatory monitoring in older patients in general practice. *J Hum Hypertens*. 2005;19:801-7.
39. Ohkubo T, Imai Y, Tsuji I, Nagai K, Kato J, Kikuchi N, et al. Home blood pressure measurement has a stronger predictive power for mortality than does screening blood pressure measurement: a population-based observation in Ohasama, Japan. *J Hypertens*. 1998;16:971-5.
40. Asayama K, Ohkubo T, Kikuya M, Obara T, Metoki H, Inoue R, et al. Prediction of stroke by home "morning" versus "evening" blood pressure values: the Ohasama study. *Hypertension*. 2006;48:737-43.
41. Niiranen TJ, Hänninen MR, Johansson J, Reunanen A, Jula AM. Home-measured blood pressure is a stronger predictor of cardiovascular risk than office blood pressure: the Finn-Home study. *Hypertension*. 2010;55:1346-51.
42. James PA, Oparil S, Carter BL, Cushman WC, Dennison-Himmelfarb C, Handler J, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). *JAMA*. 2014;311:507-20.
43. Wright JT Jr, Fine LJ, Lackland DT, Ogedegbe G, Dennison Himmelfarb CR. Evidence supporting a systolic blood pressure goal of less than 150 mm Hg in patients aged 60 years or older: the minority view. *Ann Intern Med*. 2014;160:499-503.
44. International Organization for Standardization. IEC 80601-2-30:2009. Medical electrical equipment—part 2-30: particular requirements for basic safety and essential performance of automated non-invasive sphygmomanometers. Geneva: International Organization for Standardization; 2009 (amended 2013).
45. Nwankwo T, Yoon SS, Burt V, Gu Q. Hypertension among adults in the United States: National Health and Nutrition Examination Survey, 2011-2012. *NCHS Data Brief*. 2013;1-8.
46. Yang Q, Cogswell ME, Flanders WD, Hong Y, Zhang Z, Loustalot F, et al. Trends in cardiovascular health metrics and associations with all-cause and CVD mortality among US adults. *JAMA*. 2012;307:1273-83.
47. Kaczorowski J, Chambers LW, Dolovich L, Paterson JM, Karwalajtys T, Gierman T, et al. Improving cardiovascular health at population level: 39 community cluster randomised trial of Cardiovascular Health Awareness Program (CHAP). *BMJ*. 2011;342:d442.
48. Spruill TM, Feltheimer SD, Harlapur M, Schwartz JE, Ogedegbe G, Park Y, et al. Are there consequences of labeling patients with prehypertension? An experimental study of effects on blood pressure and quality of life. *J Psychosom Res*. 2013;74:433-8.
49. Ameling EH, de Korte DF, Man in 't Veld A. Impact of diagnosis and treatment of hypertension on quality of life: a double-blind, randomized, placebo-controlled, cross-over study of betaxolol. *J Cardiovasc Pharmacol*. 1991;18:752-60.
50. Mann AH. The psychological effect of a screening programme and clinical trial for hypertension upon the participants. *Psychol Med*. 1977;7:431-8.
51. Viera AJ, Lingley K, Esserman D. Effects of labeling patients as prehypertensive. *J Am Board Fam Med*. 2010;23:571-83.
52. Verdecchia P, Angeli F, Borgioni C, Gattobigio R, Reboldi G. Ambulatory blood pressure and cardiovascular outcome in relation to perceived sleep deprivation. *Hypertension*. 2007;49:777-83.
53. Manning G, Rushton L, Donnelly R, Millar-Craig MW. Variability of diurnal changes in ambulatory blood pressure and nocturnal dipping status in untreated hypertensive and normotensive subjects. *Am J Hypertens*. 2000;13:1035-8.
54. Viera AJ, Lingley K, Hinderliter AL. Tolerability of the Oscar 2 ambulatory blood pressure monitor among research participants: a cross-sectional repeated measures study. *BMC Med Res Methodol*. 2011;11:59.
55. Nasothimiou EG, Karpettas N, Dafni MG, Stergiou GS. Patients' preference for ambulatory versus home blood pressure monitoring. *J Hum Hypertens*. 2014;28:224-9.
56. Chobanian AV, Bakris GL, Black HR, Cushman WC, Green LA, Izzo JL Jr, et al; Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. National Heart, Lung, and Blood Institute. Seventh report of the Joint National Committee on . Prevention, Detection, Evaluation, and Treatment of High Blood Pressure. *Hypertension*. 2003;42:1206-52.
57. American Heart Association. Understanding Blood Pressure Readings. Dallas, TX: American Heart Association; 2014. Accessed at www.heart.org/HEARTORG/Conditions/HighBloodPressure/AboutHighBloodPressure/Understanding-Blood-Pressure-Readings_UCM_301764_Article.jspThis link goes offsite. Click to read the external link disclaimer on 20 November 2014.
58. American Academy of Family Physicians. Clinical Preventive Service Recommendation: Hypertension. Leawood, KS: American Academy of Family Physicians; 2007. Accessed at www.aafp.org/patient-care/clinical-recommendations/all/hypertension.htmlThis link goes offsite. Click to read the external link disclaimer on 20 November 2014.
59. American Congress of Obstetricians and Gynecologists. Well-Woman Recommendations. Washington, DC: American Congress of Obstetricians and Gynecologists; 2013. Accessed at www.acog.org/About-ACOG/ACOG-Departments/Annual-Womens-Health-Care/Well-Woman-RecommendationsThis link goes offsite. Click to read the external link disclaimer on 20 November 2014.

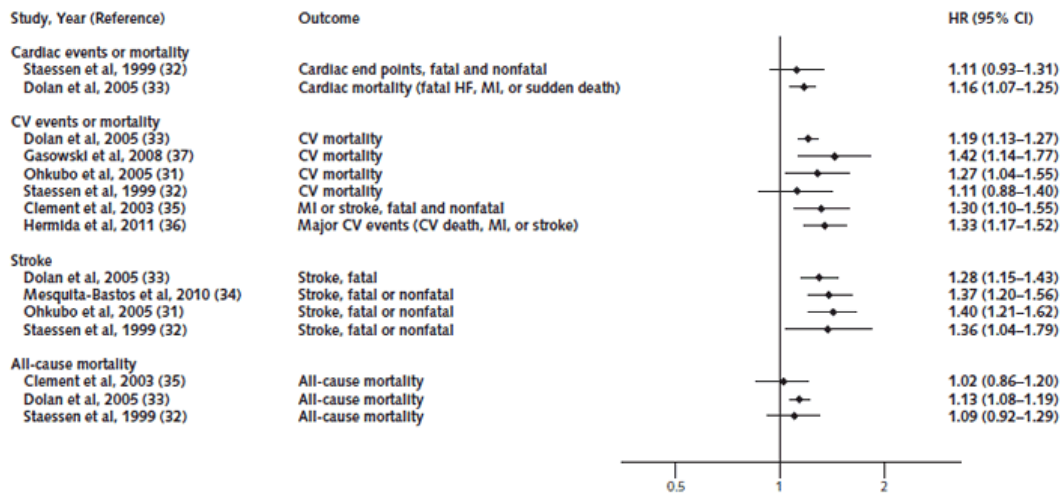
Figure 1. Proportion of Elevated Office Blood Pressure Readings That Are Confirmed as Hypertension by ABPM or HBPM



ABPM = ambulatory blood pressure monitoring; HBPM = home blood pressure monitoring; PPV = positive predictive value.

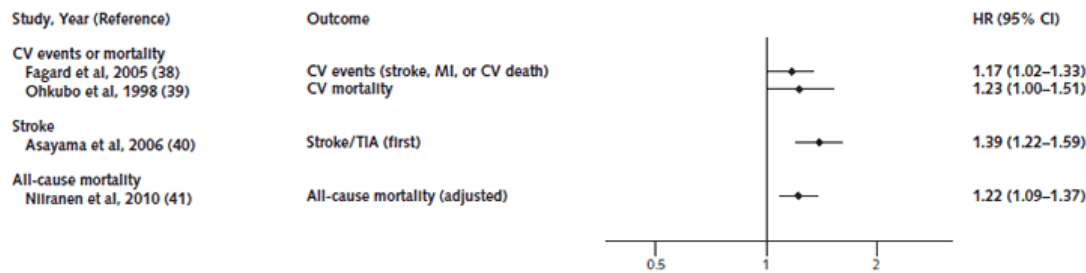
[Text Description.](#)

Figure 2. Risk for Cardiovascular Outcomes and Death: 24-h Ambulatory Monitoring of Systolic Blood Pressure, Adjusted for Office Blood Pressure



Weights are from random-effects analysis. CV = cardiovascular; HF = heart failure; HR = hazard ratio; MI = myocardial infarction.

[Text Description.](#)

Figure 3. Risk for Cardiovascular Outcomes and Death: Home Monitoring of Systolic Blood Pressure, Adjusted for Office Blood Pressure

Weights are from random-effects analysis. CV = cardiovascular; HR = hazard ratio; MI = myocardial infarction; TIA = transient ischemic attack.

[Text Description.](#)

Table. Hypertension Incidence, by Rescreening Interval

Variable	Rescreening Interval				
	1 y	2 y	3 y	4 y	5 y
Weighted mean incidence of hypertension (range), %	2.5 (2.5–4.4)	7.7 (1.2–12.3)	14.2 (6.6–24.9)	12.4 (2.1–23.7)	13.8 (2.1–28.4)
Studies (participants), <i>n</i>	2 (17,740)	6 (76,753)	6 (25,443)	5 (25,778)	16 (54,240)

Current as of: October 2015

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