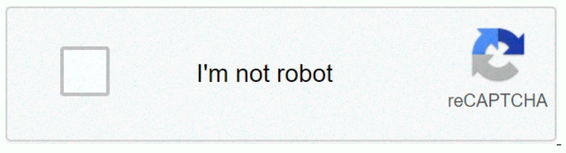

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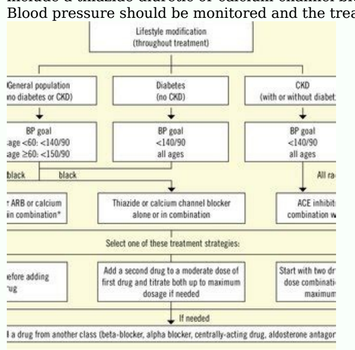
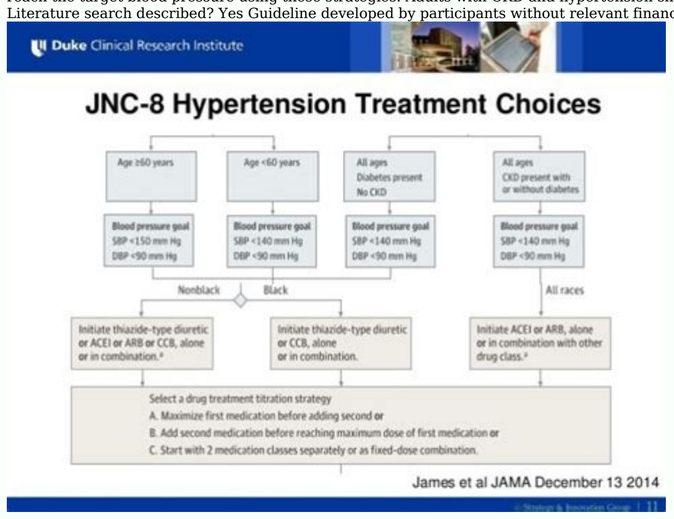
Jnc 9 guidelines pdf

• In the general population, pharmacologic treatment should be initiated when blood pressure is 150/90 mm Hg or higher in adults 60 years and older, or 140/90 mm Hg or higher in adults younger than 60 years. • In patients with hypertension and diabetes, pharmacologic treatment should be initiated when blood pressure is 140/90 mm Hg or higher, regardless of age. • Initial antihypertensive treatment should include a thiazide diuretic, calcium channel blocker, ACE inhibitor, or ARB in the general nonblack population or a thiazide diuretic or calcium channel blocker in the general black population. • If the target blood pressure is not reached within one month after initiating therapy, the dosage of the initial medication should be increased, or a second medication should be added. Hypertension is one of the most important preventable contributors to disease and death in the United States, leading to myocardial infarction, stroke, and renal failure when it is not detected early and treated appropriately. The Eighth Joint National Committee (JNC 8) recently released evidence-based recommendations on treatment thresholds, goals, and medications in the management of hypertension in adults. In the general population of adults 60 years and older, pharmacologic treatment should be initiated when the systolic pressure is 150 mm Hg or higher, or when the diastolic pressure is 90 mm Hg or higher.

Patients should be treated to a target systolic pressure of less than 150 mm Hg and a target diastolic pressure of less than 90 mm Hg. Treatment does not need to be adjusted if it results in a systolic pressure lower than 140 mm Hg, as long as it is not associated with adverse effects on health or quality of life. In the general population younger than 60 years, pharmacologic treatment should be initiated when the systolic pressure is 140 mm Hg or higher, or when the diastolic pressure is 90 mm Hg or higher. The target systolic pressure in this population is less than 140 mm Hg, and the target diastolic pressure is less than 90 mm Hg. Hypertension in Patients with CKD or Diabetes For persons 18 years or older with chronic kidney disease (CKD) or diabetes mellitus, the treatment threshold and target blood pressures are the same as those for the general population younger than 60 years (i.e., threshold systolic pressure of 140 mm Hg or threshold diastolic pressure of 90 mm Hg; target systolic pressure of less than 140 mm Hg; target diastolic pressure of less than 90 mm Hg). There is no evidence that treating patients with CKD to a lower blood pressure goal slows the progression of the disease. Similarly, there is no evidence from randomized controlled trials showing that treatment to a systolic pressure of less than 140 mm Hg improves health outcomes in adults with diabetes and hypertension. In the general nonblack population, including those with diabetes, initial anti-hypertensive treatment should include a thiazide diuretic, calcium channel blocker, angiotensin-converting enzyme (ACE) inhibitor, or angiotensin receptor blocker (ARB). In the general black population, including those with diabetes, initial treatment should include a thiazide diuretic or calcium channel blocker. If the target blood pressure is not reached within one month after initiating therapy, the dosage of the initial medication should be increased or a second medication should be added (thiazide diuretic, calcium channel blocker, ACE inhibitor, or ARB; do not combine an ACE inhibitor with an ARB). Blood pressure should be monitored and the treatment regimen adjusted until the target blood pressure is reached.



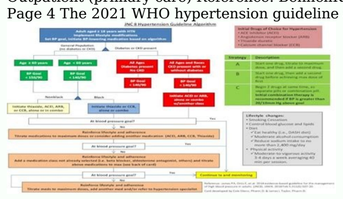
A third drug should be added if necessary; however, if the target blood pressure cannot be achieved using only the drug classes listed above, antihypertensive drugs from other classes can be used (e.g., beta blockers, aldosterone antagonists). Referral to a physician with expertise in treating hypertension may be necessary for patients who do not reach the target blood pressure using these strategies. Adults with CKD and hypertension should receive an ACE inhibitor or ARB as initial or add-on therapy, based on moderate evidence that these medications improve kidney-related outcomes in these patients. Guideline source: Eighth Joint National Committee Evidence rating system used? Yes Literature search described? Yes Guideline developed by participants without relevant financial ties to industry? No Published source: Journal of the American Medical Association, December 18, 2013 Page 2 Dyspareunia (DIS-puh-ROO-nee-uh) is pain that occurs during sex.



The pain may begin the first time you have sex, or it can begin later. The pain may be near or in the opening of the vagina or deep inside your pelvis. It may feel like a muscle spasm that makes entry into the vagina difficult. Anxiety or fear of the pain may also occur. Many conditions can cause it. Infections, skin conditions, and scar tissue in the vagina can all cause pain during sex. Normal changes after childbirth or after menopause can make sex painful. Other conditions of the uterus, bladder, or colon also can cause pain during sex. What can I expect when I see my doctor? Your doctor will ask questions about your pain, such as where it is, what makes it worse, and if you have other symptoms. Your doctor will do a pelvic exam. You may need to have other tests, such as an ultrasound or a blood draw, to help your doctor find the cause. Your doctor will find out what is causing your pain. The treatment will depend on the diagnosis. You may need to see a physical therapist. Your doctor may recommend using lubrication during sex. For some causes, your doctor may recommend surgery. Where can I get more information? AAFP's Patient Education Resource American College of Obstetricians and Gynecologists Page 3 Is physical therapy useful for reducing pain and improving function in adults with hip osteoarthritis?

In this study, physical therapy was no more effective than sham therapy in reducing pain and improving function in adults with hip osteoarthritis. (Level of Evidence = 1b) These investigators identified adults 50 years or older who met the standard criteria for hip osteoarthritis, with an average pain intensity of at least 40 (on a 100-mm visual analog scale) and at least moderate difficulty with daily activities. Eligible patients (N = 102) randomly received (concealed allocation assignment) active physical therapy or sham physical therapy. All participants attended 10 individual therapy sessions: two during the first week, one weekly for six weeks, and then one every other week. Active intervention consisted of manual therapy techniques, including manipulation, mobilization, massage, and stretches; home exercises; education and advice; and a walking stick, if appropriate. The sham intervention included inactive ultrasonography and light application of inert gel to the hip region, but no exercise instructions or manual therapy. The study was 80% powered to detect a predetermined clinically significant difference between the two treatment groups, if one existed. Complete follow-up occurred for 94% of participants at 13 weeks and 81% at 36 weeks. Although the treating therapists were not masked to treatment group assignment, a single masked assessor evaluated outcomes using standard scoring tools based on patient self-reports at 13 and 36 weeks. Statistical analysis found no significant evidence that patients could reliably tell to which intervention group they were assigned. Using intention-to-treat and per-protocol analyses, no significant between-group differences were found for changes in pain or physical function. Likewise, medication use and co-interventions were similar for both groups. Adverse events occurred significantly more often in the active intervention group (41% vs. 14%), including increased hip pain, back pain, stiffness, and pain in other regions. Study design: Randomized controlled trial (double-blinded) Funding source: Government Setting: Outpatient (primary care) Reference: BennellKLEgertonTMartinJet alEffect of physical therapy on pain and function in patients with hip osteoarthritis: a randomized clinical trial. JAMA2014; 311(19): 1987– 1997.

Page 4 The 2021 WHO hypertension guideline aims to provide the most current and relevant evidencebased global public health guidance on the initiation of treatment (with pharmacological agents) for hypertension in adults.



The recommendations target the general adult, non-pregnant, hypertensive population.Guideline for the pharmacological treatment of hypertension in adults. Geneva: World Health Organization; 2021. Licence: CC BY-NC-SA 3.0 IGO.General disclaimers. The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of WHO concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted and dashed lines on maps represent approximate border lines for which there may not yet be full agreement.The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by WHO in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.All reasonable precautions have been taken by WHO to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either expressed or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall WHO be liable for damages arising from its use.