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rateHBPMhome blood pressure increasedEHRelectronic health recordHFheart failureHFpEFheart failure with preserved ejection fractionHFrEFheart failure with reduced ejection fractionICHintracerebral hemorrhageJNCJoint National CommissionLVleft ventricularLVHleft ventricular hypertrophyMImyocardial infarctionMRImagnetic resonance imagingPADperipheral artery diseaseARASrenin-angiotensin systemRCTrandomized controlled trialSBPsystolic blood pressureSIHDstable ischemic heart diseaseITLtransient ischemic attack2. BP and CVD Risk2.1. Observational RelationshipObservational studies have demonstrated graded associations between higher systolic blood pressure (SBP) and diastolic blood pressure (DBP) and increased CVD risk.S2.1-1,S2.1-2 In a meta-analysis of 61 prospective studies, the risk of CVD increased in a log-linear fashion from SBP levels 180 mm Hg and from DBP levels 105 mm Hg.S2.1-1 In that analysis, 20 mm Hg higher SBP and 10 mm Hg higher DBP were each associated with a doubling in the risk of death from stroke, heart disease, or other vascular disease. In a separate observational study including >1 million adult patients ≥30 years of age, higher SBP and DBP were associated with increased risk of CVD incidence and angina, myocardial infarction (MI), HF, stroke, peripheral artery disease (PAD), and abdominal aortic aneurysm, each evaluated separately.S2.1-2 An increased risk of CVD associated with higher SBP and DBP has been reported across a broad age spectrum, from 30 years to >80 years of age. Although the relative risk of incident CVD associated with higher SBP and DBP is smaller at older ages, the corresponding high BP-related increase in absolute risk is larger in older persons (≥65 years) given the higher absolute risk of CVD at an older age.S2.1-12.2. BP ComponentsEpidemiological studies have evaluated associations of SBP and DBP, as well as derived components of BP measurements (including pulse pressure, mean BP, and mid-BP), with CVD outcomes (Table 4). When considered separately, higher levels of both SBP and DBP have been associated with increased CVD risk.S2.2-1,S2.2-2 Higher SBP has consistently been associated with increased CVD risk after adjustment for, or within strata of, DBP.S2.2-3–S2.2-5 In contrast, after consideration of SBP through adjustment or stratification, DBP has not been consistently associated with CVD risk.S2.2-6,S2.2-7 Although pulse pressure and mid-BP have been associated with increased CVD risk independent of SBP and DBP in some studies, SBP (especially) and DBP are prioritized in the present document because of the robust evidence base for these measures in both observational studies and clinical trials and because of their ease of measurement in practice settings.S2.2-3–S2.2-11Table 4. BP Measurement DefinitionsBP MeasurementDefinitionSBPFirst Korotkoff sound*DBPFifth Korotkoff sound*Pulse pressureSBP minus DBPMean arterial pressureDBP plus one third pulse pressure†Mid-BPSum of SBP and DBP, divided by 22.3. Population RiskIn 2010, high BP was the leading cause of death and disability-adjusted life years worldwide.S2.3-1,S2.3-2 In the United States, hypertension (see Section 3.1 for definition) accounted for more CVD deaths than any other modifiable CVD risk factor and was second only to cigarette smoking as a preventable cause of death for any reason.S2.3-3 In a follow-up study of 23 272 US NHANES (National Health and Nutrition Examination Survey) participants, >50% of deaths from coronary heart disease (CHD) and stroke occurred among individuals with hypertension.S2.3-4 Because of the high prevalence of hypertension and its associated increased risk of CHD, stroke, and end-stage renal disease (ESRD), the population-attributable risk of these outcomes associated with hypertension is high.S2.3-4,S2.3-5 In the population-based ARIC (Atherosclerosis Risk in Communities) study, 25% of the cardiovascular events (CHD, coronary revascularization, stroke, or HF) were attributable to hypertension. In the Northern Manhattan study, the percentage of events attributable to hypertension was higher in women (32%) than in men (19%) and higher in blacks (36%) than in whites (21%).S2.3-6 In 2012, hypertension was the second leading assigned cause of ESRD, behind diabetes mellitus (DM), and accounted for 34% of incident ESRD cases in the US population.S2.3-72.4. Coexistence of Hypertension and Related Chronic ConditionsRecommendation for Coexistence of Hypertension and Related Chronic ConditionsReferences that support the recommendation are summarized in Online Data Supplement 1.CORLOERecommendationIB-NR1.Screening for and management of other modifiable CVD risk factors are recommended in adults with hypertension.S2.4-1,S2.4-2SynopsisMany adult patients with hypertension have other CVD risk factors; a list of such modifiable and relatively fixed risk factors is provided in Table 5. Among US adults with hypertension between 2009 and 2012, 15.5% were current smokers, 49.5% were obese, 63.2% had hypercholesterolemia, 27.2% had DM, and 15.8% had chronic kidney disease (CKD; defined as estimated glomerular filtration rate [eGFR] 20%, 40.9% had a risk of 10% to 20%, and only 18.4% had a risk

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