

Figure. Screening for high blood pressure: clinical summary of U.S. Preventive Services Task Force (USPSTF) Recommendation.

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Screening for High Blood Pressure: Clinical Summary of U.S. Preventive Services Task Force Recommendation

Population	Adult General Population*
Recommendation	Screen for high blood pressure Grade: A
Screening Tests	High blood pressure (hypertension) is usually defined in adults as: systolic blood pressure (SBP) of 140 mm Hg or higher, or diastolic blood pressure (DBP) of 90 mm Hg or higher. Due to variability in individual blood pressure measurements, it is recommended that hypertension be diagnosed only after 2 or more elevated readings are obtained on at least 2 visits over a period of 1 to several weeks.
Screening Intervals	The optimal interval for screening adults for hypertension is not known. The Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC 7) recommends: <ul style="list-style-type: none"> • Screening every 2 years with BP <120/80 mm Hg • Screening every year with SBP of 120–139 mm Hg or DBP of 80–90 mm Hg
Suggestions for Practice	A variety of pharmacologic agents are available to treat hypertension. JNC 7 guidelines for treatment of hypertension can be accessed at www.nhlbi.nih.gov/guidelines/hypertension/jncintro.htm . The following nonpharmacologic therapies are associated with reductions in blood pressure: <ul style="list-style-type: none"> • Reduction of dietary sodium intake • Potassium supplementation • Increased physical activity, weight loss • Stress management • Reduction of alcohol intake
Other Relevant Recommendations from the USPSTF	Adults with hypertension should be screened for diabetes. Adults should be screened for hyperlipidemia (depending on age, sex, risk factors) and smoking. Clinicians should discuss aspirin chemoprevention with patients at increased risk for cardiovascular disease. These recommendations and related evidence are available at www.preventiveservices.ahrq.gov .

*This recommendation applies to adults without known hypertension. For the full recommendation statement and supporting documents, go to www.preventiveservices.ahrq.gov.

Table 1. What the U.S. Preventive Services Task Force Grades Mean and Suggestions for Practice*

Grade	Definition	Suggestions for Practice
A	The USPSTF recommends the service. There is high certainty that the net benefit is substantial.	Offer or provide this service.
B	The USPSTF recommends the service. There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.	Offer or provide this service.
C	The USPSTF recommends against routinely providing the service. There may be considerations that support providing the service in an individual patient. There is moderate or high certainty that the net benefit is small.	Offer or provide this service only if other considerations support offering or providing the service in an individual patient.
D	The USPSTF recommends against the service. There is moderate or high certainty that the service has no net benefit or that the harms outweigh the benefits.	Discourage the use of this service.
I statement	The USPSTF concludes that the current evidence is insufficient to assess the balance of benefits and harms of the service. Evidence is lacking, of poor quality, or conflicting, and the balance of benefits and harms cannot be determined.	Read the clinical considerations section of USPSTF Recommendation Statement. If the service is offered, patients should understand the uncertainty about the balance of benefits and harms.

* USPSTF = U.S. Preventive Services Task Force.

Table 2. U.S. Preventive Services Task Force Levels of Certainty Regarding Net Benefit

Level of Certainty*	Description
High	The available evidence usually includes consistent results from well-designed, well-conducted studies in representative primary care populations. These studies assess the effects of the preventive service on health outcomes. This conclusion is therefore unlikely to be strongly affected by the results of future studies.
Moderate	The available evidence is sufficient to determine the effects of the preventive service on health outcomes, but confidence in the estimate is constrained by such factors as: <ul style="list-style-type: none"> the number, size, or quality of individual studies inconsistency of findings across individual studies limited generalizability of findings to routine primary care practice lack of coherence in the chain of evidence. As more information becomes available, the magnitude or direction of the observed effect could change, and this change may be large enough to alter the conclusion.
Low	The available evidence is insufficient to assess effects on health outcomes. Evidence is insufficient because of: <ul style="list-style-type: none"> the limited number or size of studies important flaws in study design or methods inconsistency of findings across individual studies gaps in the chain of evidence findings that are not generalizable to routine primary care practice a lack of information on important health outcomes. More information may allow an estimation of effects on health outcomes.

* The U.S. Preventive Services Task Force (USPSTF) defines *certainty* as “likelihood that the USPSTF assessment of the net benefit of a preventive service is correct.” The net benefit is defined as benefit minus harm of the preventive service as implemented in a general, primary care population. The USPSTF assigns a certainty level based on the nature of the overall evidence available to assess the net benefit of a preventive service.