

Jnc 8 summary

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Compared to previous guidelines for the treatment of hypertension, the Guidelines of the Joint National Committee (JNC 8) recommend higher blood pressure targets and less use of multiple types of antihypertensive drugs. Patients will be asked about the new JNC 8 hypertension guidelines, which were published in the Journal of the American Medical Association on December 18, 2013.¹ The new guidelines emphasize the control of systolic blood pressure (SBP) and diastolic blood pressure (DBP) with age and related treatment. The new guidelines also introduce new recommendations aimed at promoting safer use of enzyme angiotensin enzyme (ACE) inhibitors and angiotensin receptor blockers (ARBs). Important changes from the JNC 7 guidelines include: In patients 60 years of age or older who do not have diabetes or chronic kidney disease, the blood pressure target is currently 150/90 mmHg. In patients between the ages of 18 and 59, patients between the ages of 18 and 59, without serious comorbidities, as well as patients 60 years of age or older with diabetes, chronic kidney disease (CKD), or both conditions, both conditions, a new blood pressure level of the target of $\leq 140/90$ mm Hg. Art. - The first line and later treatment lines should now be limited to 4 classes of drugs: diuretics such as thiazide, calcium channel blockers (CCB), ACE inhibitors and ARB. Several drugs are now labeled as alternatives to the later line, including: beta-blockers, alpha-blockers, alpha1/beta-blockers (e.g. carvedilol), vasodilators (e.g. nebivolol), central alpha2/adrenergic agonists (e.g. clonidine), direct vasodilators (e.g. hydralazine), loop diuretics (e.g. furosemide), aldosterone antagonists (e.g. spironolactone) and peripheral adrenergic antagonists (e.g., antagonists), in all patients with CKD, regardless of ethnic origin, either as a first-line therapy or in addition to first-line therapy, an increase in creatinine, and further renal disorders. Changing the milder systolic blood pressure target can mislead many patients who are used to lower JNC 7 goals, including 140/90 mmHg. Art goal for most patients and 130/80 mm Hg, a target for patients with hypertension and major comorbidities. The guidelines were informed of the results of 5 key trials: The Hypertension And Follow-up Detection Program (HDFP), The Hypertension-Stroke Cooperative, the Medical Research Council (MRC) Trial, the Australian National Blood Pressure (ANBP) Trial, and the Co-op Of Veterans Administration (VA). In these studies, patients between the ages of 30 and 69 received drugs to reduce DBP to a level of 90 mmHg. The results showed a decrease in cerebrovascular events, heart failure and overall mortality in patients treated to the target level of DBP. The data was so compelling that some members of the JNC 8 group wanted to keep the DBP 90 mm Hg. Art as the only goal among young patients, citing insufficient evidence of the benefits of the SBP target below 140 mmHg. Art. in patients under the age of 60. However, the more conservative panelists insisted on maintaining the SBP's target as well as the DBP's goal. In young patients without serious comorbidities, elevated DBP is a more important cardiovascular risk factor than elevated SBP. The JNC 8 panelists are not the first authors of the guidelines to be recognized in this regard. The authors of the JNC 7 guideline also recognized that DBP control is more important than SBP control to reduce cardiovascular risk in patients under the age of 60. However, in patients 60 years and older, SBP control remains the most important factor. Other recent data suggest that the target of SBP is 140 mmHg. the JNC 7 guidelines recommended for most patients may have been unreasonably low. The authors of the JNC 8 manual refer to 2 studies that have found no improvement in cardiovascular outcomes with the goal of SBP ≤ 140 mmHg, compared to the target level of SBP ≤ 160 mm Hg. art. or 150 mm Hg. Despite this finding, the new guidelines do not suggest that the treatment targeted SBP ≤ 140 mm Hg, but it is recommended to be careful that low levels of SBP do not affect quality of life or lead to adverse events. Moving to a DBP-based goal may mean that young patients will be prescribed fewer medications if they are diagnosed with hypertension; It can improve adherence and minimize adverse events associated with low SBP, such as sexual dysfunction. Patients with kidney disease As 1 post-special analysis showed a possible benefit in kidney outcomes with a lower goal of 130/80 mm Hg. 2 other primary analyses did not support this conclusion. In addition, 3 more tests did not show an advantage with the goal of 130/80 mm Hg. 140/90 mm Hg. Art. for patients with chronic kidney disease. As a result, the new guidelines recommend that patients with chronic kidney disease receive drugs sufficient to reach a higher level of 140/90 mmHg. However, in exception to this goal level, guidelines suggest that patients with chronic kidney disease or albuminuria 70 years old should receive treatment based on comorbidities, frailty, and other patient-specific factors. The evidence was to support the target, blood pressure is 140/90 mm Hg. Age in patients over 70 years of age with CKD or albuminuria. Patients with diabetes In diabetes and hypertension reduced mortality, as well as improved cardiovascular and cerebrovascular outcomes with treatment of the target SBP ≤ 150 mm Hg. art, but not randomized randomized Tests support the target of 140/90 mm Hg. Despite this, the group chose a conservative recommendation in patients with diabetes and hypertension, choosing for the goal a level of 140/90 mm Hg. Art. in adult patients with diabetes and hypertension, rather than the pro-evidence target of 150/90 mm Hg. The subsequent authors of the JNC 8 guidelines simplified the complex recommendation for follow-up in patients with hypertension. The JNC Group 7 recommended that after initial high blood pressure reading, a followup with a confirming reading of blood pressure should occur not by the limits of seven days to two months, depending on how high the original reading was and whether the patient had a kidney disease or end-organ injury as a result of hypertension. According to JNC 8, in all cases, the goal of blood pressure goals must be achieved within a month of starting treatment either by increasing the dose of the original drug or by using a combination of medications. Treatment As JNC 7 panel, the JNC 8 panel recommended thiazid-type diuretics as an initial therapy for most patients. Although ACE, ARB and calcium channel blockers (CCB) are acceptable alternatives, diuretics such as thiazide still have the best evidence of efficacy. The JNC 8 panel does not recommend first-line therapy with beta-blockers and alpha blockers because of one trial that showed a higher rate of cardiovascular events using beta-adrenolators compared to the use of ARB, and another trial in which alpha blockers resulted in lower cardiovascular outcomes compared to diuretic use. In addition, the lack of evidence comparing the four first-line therapies with the disease, nebivolol, clonidine, hydralazine, reserpine, furosemide, spironolactone, and other similar medications excludes the use of any drugs other than ACE, ARB inhibitors, CCBs, and thiazide-type diuretics in the vast majority of patients. Before receiving alpha blockers, beta blockers, or any of several different agents, according to JNC 8 guidelines, patients will receive a dosage adjustment and a combination of 4 first-line therapies. Triple therapy with an ACE/ARB inhibitor, CDC and a diuretic such as thi would precede the use of alpha blockers, beta-blockers or any of several other agents. These new guidelines virtually exclude the use of beta-blockers (including nebivolol), alpha blockers, diuretics, alpha-1/beta-adrenolators, central alpha2/adrenergic agonists, direct vasodilators, antagonists of aldosterone and peripheral adrenergic antagonists in patients newly diagnosed with hypertension. Caution is justified in patients who are already stable on these treatments. Special therapeutic inhibitors and ARB may not be ideal patients of African descent. The results of an analysis of subgroups in antihypertensive and lipid reduction treatment to prevent heart attack Trial (ALLHAT) found that ACE inhibitors led to worse cardiovascular outcomes than thiazide-type diuretics or CCBs in patients of African descent. Despite the ALLHAT subgroup analysis, results from the African-American Kidney and Hypertension Study (AASK) support the use of the first line or supplement ACEIs to improve kidney-related outcomes in patients of African descent with hypertension, CKD, and proteinuria. As a result, JNC 8 experts recommend that all patients with chronic kidney disease and hypertension, regardless of ethnicity, should receive treatment with an ACE inhibitor or ARB to protect kidney function, either as an initial therapy or add-on therapy. One exception to the use of ACE or ARB inhibitors to protect kidney function is in patients over 75 years of age. The team pointed to the potential for ACE inhibitors and ARBs to increase serum creatinine and produce hyperkalemia. As a result, for patients over 75 years of age with reduced kidney function, diuretics such as thiazide or CCB are an acceptable alternative to ACEIs or ARBs. In addition, the panel expressly prohibits the simultaneous use of the ACE inhibitor and ARB in the same patient. This combination has not been shown to improve results. Although 2 drugs work at different points in the renin-angiotensin-aldosterone system, other drug combinations are better options, and the simultaneous use of ACEIs and ARBs is not supported by evidence. Lifestyle Changes In JNC 7, JNC 8 guidelines also recommend lifestyle changes as an important component of therapy. Lifestyle activities include using Dietary Approaches to Stop Hypertension (DASH) Nutrition Plan, Weight Loss, Reducing Sodium Intake to Less Than 2.4 Grams per Day, and at least 30 minutes of aerobic activity most days a week. In addition, to delay the development of hypertension, increase blood pressure - to reduce the effect of existing drugs and reduce the risk of cardiovascular disease, alcohol consumption should be limited to 2 drinks per day in men and 1 drink per day in women. Note that 1 drink is 12 ounces of beer, 5 ounces of wine, or 1.5 ounces of 80-proof liquor. Smoking cessation also reduces the risk of cardiovascular disease. ConclusionThe JNC 8 guidelines move away from the assumption that lower blood pressure levels will improve results, regardless of the type of agent used to reach lower levels. Instead, JNC 8 guidelines encourage the use of agents with better evidence of cardiovascular risk reduction. In addition, the guidelines may lead to less use of antihypertensive drugs in young patients, which will produce equivalent results in terms of cardiovascular events with less potential for adverse events that limit compliance. Michael R. Page, PharmD, RPh., is clinical editor of Pharmacy Times. This story first appeared online in Times January 6, 2014.References1. 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