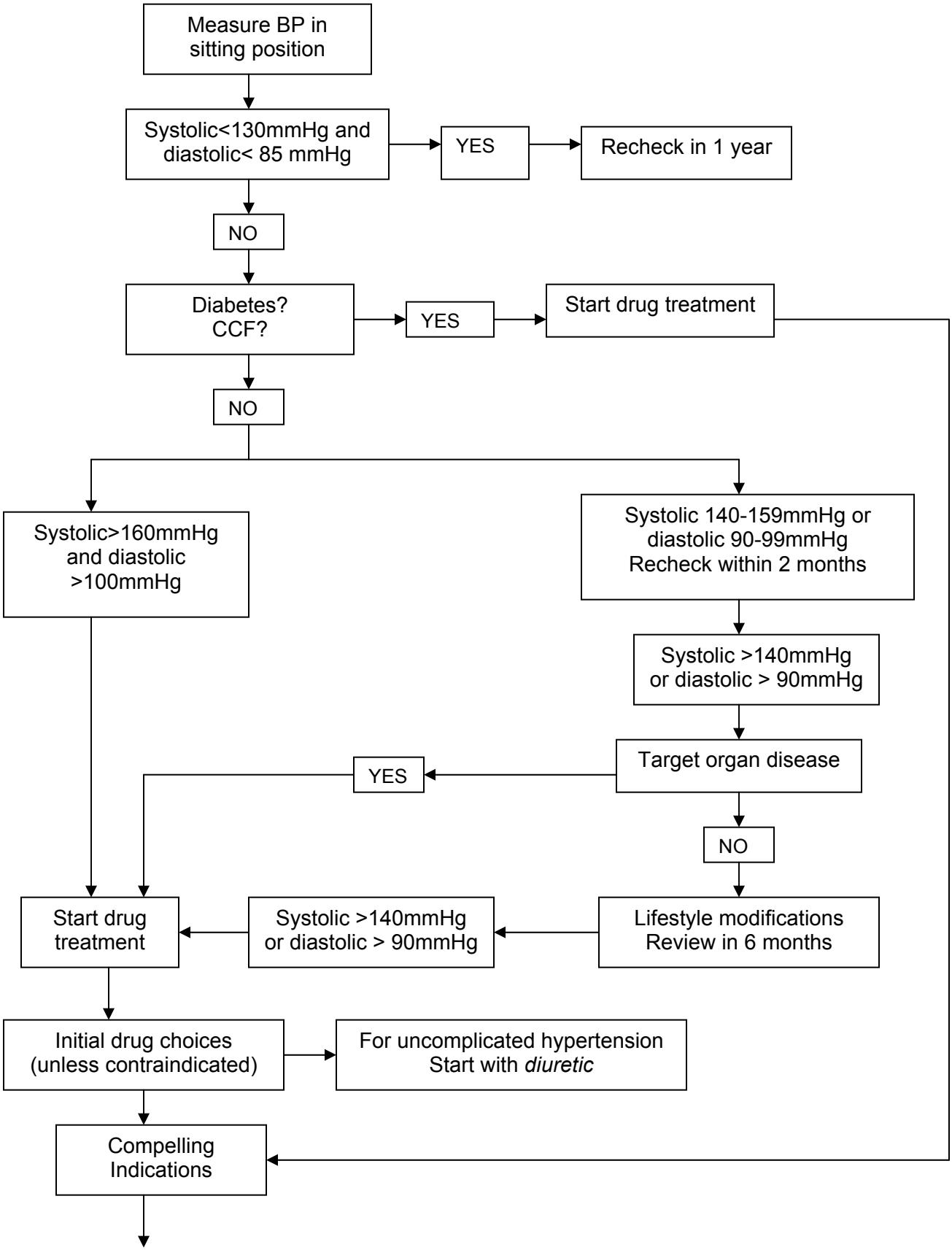
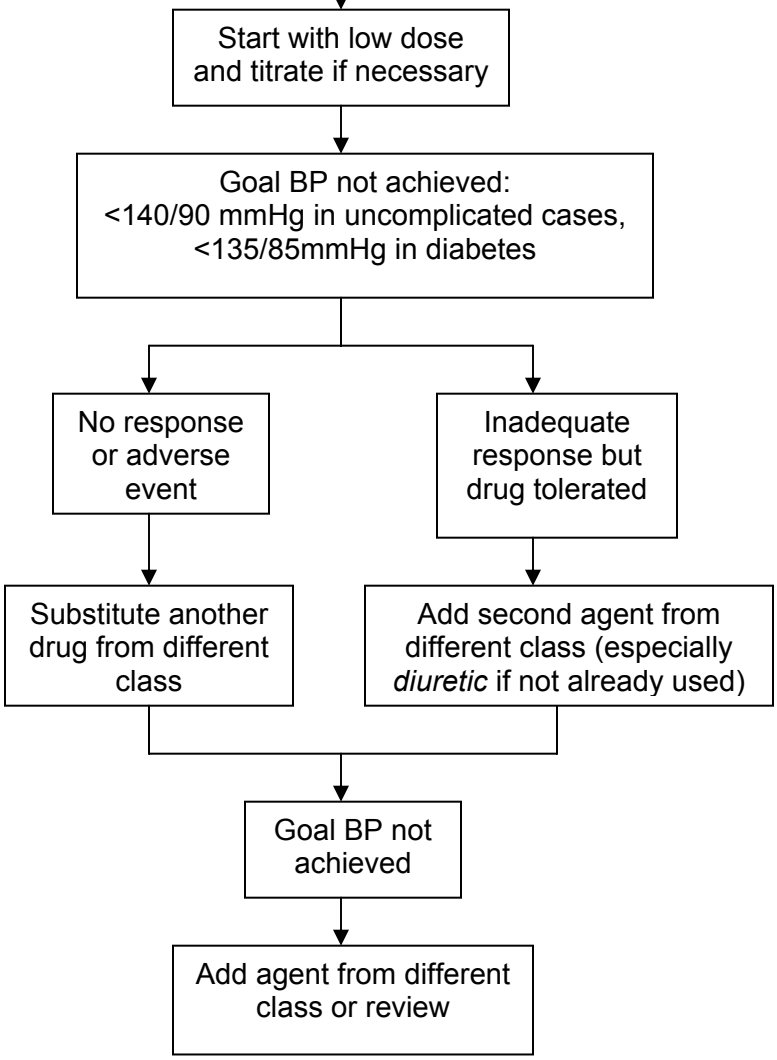
HYPERTENSION



- Angina: *β-blocker, CCB*
- Prior myocardial infarct or CAD: *β-blocker* and *ACE inhibitor*
- Post MI: *β-blocker* or *ACE inhibitor* (in patients with systolic dysfunction)
- Heart Failure: *ACE inhibitor*, *β-blocker*, diuretics (*furosemide* or *spironolactone*)
- Left ventricular hypertrophy: *ACE inhibitor*
- Stroke: Low dose diuretic, *ACE inhibitor*
- Type 1 Diabetes with proteinuria: *ACE inhibitor*, usually in combination with *diuretic*
- Type 2 Diabetes with microalbuminuria: *ACE inhibitor* or *ARB*, usually in combination with *diuretic*
- Type 2 Diabetes without proteinuria: *ACE inhibitor*, usually in combination with a *diuretic*
- Type 2 Diabetes with proteinuria: *ACE inhibitor* or *ARB* usually in combination with *diuretic*
- Isolated systolic hypertension (elderly): *diuretic* preferred (low dose *thiazides*), long-acting *CCB*
- Prostatism: *α-blocker* (this should not be used as monotherapy)



Glossary:

- *α-blocker* – Alpha-receptor blocker
- *ACE inhibitor* – Angiotensin converting enzyme inhibitor
- *ARB* – Angiotensin receptor blocker
- BP – Blood pressure
- *β-blocker* – Beta-receptor blocker
- *CCB* – Calcium channel blocker
- CCF – Chronic / Congestive cardiac failure
- CAD – Coronary artery disease
- LV – Left ventricular
- MI – Myocardial infarct

Applicable ICD 10 Coding:

- I10 Essential (primary) hypertension
- I11 Hypertensive heart disease
  - I11.0 Hypertensive heart disease with (congestive) heart failure
  - I11.9 Hypertensive heart disease without (congestive) heart failure
- I12 Hypertensive renal disease
  - I12.0 Hypertensive renal disease with renal failure
  - I12.9 Hypertensive renal disease without renal failure
- I13 Hypertensive heart and renal disease
  - I13.0 Hypertensive heart and renal disease with (congestive) heart failure
  - I13.1 Hypertensive heart and renal disease with renal failure
  - I13.2 Hypertensive heart and renal disease with both (congestive) heart failure and renal failure
  - I13.9 Hypertensive heart and renal disease, unspecified
- I15 Secondary hypertension
  - I15.0 Renovascular hypertension
  - I15.1 Hypertension secondary to other renal disorders
  - I15.2 Hypertension secondary to endocrine disorders
  - I15.8 Other secondary hypertension
  - I15.9 Secondary hypertension, unspecified
- O10 Pre-existing hypertension complicating pregnancy, childbirth and the puerperium
  - O10.0 Pre-existing essential hypertension complicating pregnancy, childbirth and the puerperium
  - O10.1 Pre-existing hypertensive heart disease complicating pregnancy, childbirth and the puerperium
  - O10.2 Pre-existing hypertensive renal disease complicating pregnancy, childbirth and the puerperium
  - O10.3 Pre-existing hypertensive heart and renal disease complicating pregnancy, childbirth and the puerperium
  - O10.4 Pre-existing secondary hypertension complicating pregnancy, childbirth and the puerperium
  - O10.9 Unspecified pre-existing hypertension complicating pregnancy, childbirth and the puerperium
- O11 Pre-existing hypertensive disorder with superimposed proteinuria

Note:

1. **Medical management reasonably necessary for the delivery of treatment described in this algorithm is included within this benefit, subject to the application of managed health care interventions by the relevant medical scheme.**

2. **To the extent that a medical scheme applies managed health care interventions in respect of this benefit, for example clinical protocols for diagnostic procedures or medical management, such interventions must –**
   a. **not be inconsistent with this algorithm;**
   b. **be developed on the basis of evidence-based medicine, taking into account considerations of cost-effectiveness and affordability; and**
   c. **comply with all other applicable regulations made in terms of the Medical Schemes Act, 131 of 1998**

3. **This algorithm may not necessarily always be clinically appropriate for the treatment of children. If this is the case, alternative paediatric clinical management is included within this benefit if it is supported by evidence-based medicine, taking into account considerations of cost-effectiveness and affordability.**