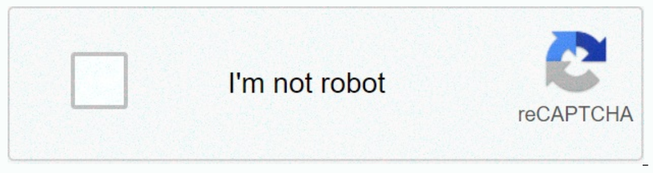

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Guideline hypertension acc aha 2017

High blood pressure is the leading cause of death and disability regulated in years of life worldwide (1, 2). In the United States, high blood pressure takes more deaths from cardiovascular disease (CVD) than any other modifiable risk factor, and for whatever reason, it ranks second only to smoking as a preventable cause of death (3). The American Heart Association (ACC)/American Heart Association (AHA) guidelines for prevention, diagnosis, evaluation, and management of high blood pressure in adults provide an evidence-based approach to reducing cvd risk through blood pressure reduction (BP) (4). In 1977, the National Heart, Lung and Blood Institute (NHLBI) began a series of high blood pressure guidelines, culminating in the release of the seventh report by the Joint National Committee on Prevention, Diagnosis, Evaluation and Treatment of Hypertension (JNC 7) (5) in 2003. In 2013, the NHLBI transferred responsibility to the ACC and AHA (6) for supporting clinical practice guidelines for CVD prevention. In 2014, the ACC and AHA worked with nine other professional associations to develop a new high blood pressure clinical practice guideline. A 21-member panel of multidisciplinary experts (doctors, nurses, pharmacists and patient representatives) developed the 2017 directive without industry ties associated with B.P. The Writing Committee conducted a detailed review of the literature and commissioned 4 systematic reviews (and meta-analysis when possible) of an independent evidence review committee to address the following: 1) self-directed blood pressure monitoring and/or abolatorial compared to office-based BP measurements to prevent adverse outcomes and achieve better blood pressure control, 2) The optimal goal for lowering blood pressure during antihy hypertension treatment, 3) whether different classes of antihytherapy drugs vary in their comparative benefits and/or damage as first-line treatment, and 4) whether starting treatment with 1 antihy high blood pressure drug (single therapy) is more or less beneficial than starting with 2 drugs (7). The Writing Committee used acc/AHA working group methods in clinical practice guidelines (8) to provide 106 recommendations, each with class (strength) recommendations (an estimate of the magnitude and certainty of profit relative to risk) and the level (quality) of evidence (ranking of type, quantity, and consistency of data from clinical trials and other sources). Five official arbitrators from the ACC and AHA, 9 institutional arbitrators representing professional partner organizations, and 38 content arbitrators with expertise in hypertension review recommendations before approval by the governing bodies of the ACC, AHA, American Preventive Cardiology Association, Preventive Cardiovascular Nurses Association, American Physician Assistants Academy, Black Cardiovascular Association, American Pharmacists Association, American College of Preventive Medicine, USA of Hypertension, the American Geriatrics Society, and the National Medical Association. A full description of the methods, evidence reviews, and recommendations www.acc.org/latest-in-cardiology/ten-points-to-remember/2017/11/09/11/41/2017-guideline-for-high-blood-pressure-in-adults. This summary summarizes major recommendations for GPs. Table 1 shows 1 SOUGHT classifications. Although the definition of normal blood pressure remains the same definition in JNC 7 (average systolic blood pressure [SBP] <120 mm Hg and average diastolic blood pressure [DBP] <80 mm Hg), the 2017 directive replaces the term pre-hypertension with blood pressure. High blood pressure (average SBP from 120 to 129 mmHg and average DBP <80 mm Hg) and stage 1 hypertension (average SBP from 130 to 139 mmHg or average DBP from 80 to 89 mm Hg). Stage 2 blood pressure is defined as at least 140 mm Hg or DBP on average at least 90 mm Hg instead of blood pressure of at least 160/100 mm Hg. The upper end of the prehy high blood pressure was again classified as stage 1 hypertension because adults with hypertension in this range have almost twice as high cvd risk compared to adults with normal BP, and recent randomized clinical trials have shown their benefit with SBP below 130 mm Hg (9 to 13). This change in bp classification is estimated to lead to an increase of about 14% in the prevalence of hypertension in the United States, but only a 1.9% increase in adults requiring antihyal hypertension medication (14). Table 1. Classification of appropriate BP measurement methods detailed in directive (4) are fundamental to blood pressure classification, BP-related CVD risk measurement, and high blood pressure management. The directive requires doctors to obtain accurate measurements and base their estimates of blood pressure on average at least 2 readings obtained in at least two separate occasions (Table 2). Table 2. Recommendations for BP*guidelines recommend greater use of out-of-office blood pressure measurements to confirm the diagnosis of high blood pressure and titerat medication. Adults who do not use antihythalm, aulator blood pressure monitoring (ABPM) or home BP monitoring (HBPM) should be used to detect white coat high blood pressure (high office blood pressure but normal OUT-of-office BP) and masked blood pressure (normal office blood pressure but high office blood pressure) (Fig 1). White coat hypertension is associated with a CVD risk in normal blood pressure approximation, while masked blood pressure carries a CVD risk similar to stable blood pressure. In adults currently using antihymenhythm medications, the guideline recommends screening for unmanalized unmanalized blood pressure if BP's office is on target but there is an increased risk of CVD or target organ damage. If BP's office is more than 5 to 10 mm Hg above target in a patient using 3 or more antihy high blood pressure medications, the guidelines recommend HBPM to detect the effect of white coats (Fig 2). Figure 1. White blood pressure detection algorithm or masked blood pressure in patients who do not receive drug therapy . The colors match the recommendation class in the form of the appendix. (Reproduced with the permission of the American Heart College and the American Heart Association.) ABPM = monitoring a regulatory blood pressure; Blood pressure = blood pressure; HBPM = Home Blood Pressure Monitoring. Download Download Figure PowerPoint Figure 2. The algorithm detects the effect of white coat or untended controlled blood pressure in patients receiving pharmacotherapy. The colors match the recommendation class in the form of the appendix. (Reproduced with the permission of the American Heart College and the American Heart Association.) ABPM = monitoring a regulatory blood pressure; Blood pressure = blood pressure; CVD = Cardiovascular disease; HBPM = Home Blood Pressure Monitoring. Download The PowerPoint Shape Appendix Download. Applying recommendation class and evidence level to clinical strategies, interventions, treatments, or diagnostic testing in patient care. COR and LOE are independently determined (each COR may be paired with any LOE). Recommending with LOE C does not mean that the recommendation is weak. Many of the important clinical questions addressed in the guidelines do not lend themselves to clinical trials. Although RCTs are not available, there may be a very clear clinical consensus that a specific trial or treatment is beneficial or effective. (Reproduced with the permission of the American Heart College and the American Heart Association.) COR = Class (strength) recommendation; EO = expert opinion; LD = limited data; LOE = level (quality) of evidence; NR = nonrandomized; R = Randomized; The outcome or outcome of the intervention should be determined (an improved clinical outcome or increased diagnostic accuracy or inso enhanced prognosis information).† for comparative recommendations-effectiveness (COR I and IIa; LOE A and B only), studies that support the use of comparing verbs Should direct comparisons of treatments or strategies being evaluated include .‡ the quality assessment method is evolving, including standard use, widely used, and preferably validate the evidence grading tool and, for systematic review, the composition of the evidence review committee. Downloading the download figure PowerPoint A secondary cause of high blood pressure can be identified by about 10% of adults with high blood pressure, and specific treatment of the cause reduces the risk of CVD. Screening is recommended for a secondary cause in the conditions listed in Table 3, by referring to a clinical specialist with relevant expertise when screening results are positive. Table 3. Screening for secondary blood pressure*Lifestyle changes alone are recommended for most newly classified adults as having stage 1 hypertension (130 to 139/80 to 89 mm Hg), and lifestyle changes plus medication are recommended for those with an existing CVD or an increased risk of CVD. Recommended lifestyle interventions are listed in Table 4.Table 4. Recommendations for And pharmacological treatment and blood pressure goals figure 3 show blood pressure thresholds and recommendations for the follow-up and treatment of normal blood pressure, high blood pressure and stages 1 and 2 of high blood pressure. Intensive hypotensing treatments should be directed towards patients with the highest risk of atherosclerotic cardiovascular disease (ASCVD). Although BP-based drug treatment alone is cost effective, basic treatment decisions about the absolute risk of ASCVD combined with BP are even more efficient and cost-effective in reducing cvd risk. The advantages of using a hybrid approach to guide drug treatment include focusing treatment on patients likely to have CVD events and reducing the risk of larger absolute CVD, preventing more CVD events, and saving years of more adjusted quality living. Figure 3. BP thresholds and recommendations for treatment and follow-up. The colors match the recommendation class in the form of the appendix. (Reproduced with the permission of the American Heart College and the American Heart Association.) ASCVD = atherosclerotic cardiovascular disease; Blood pressure = blood pressure; CVD = Cardiovascular Disease.* Using the American College of Cardiology/American Heart Association Pool Cohort Equations. Patients with diabetes mellitus or chronic kidney disease automatically fall into the high-risk category. To start using the renine angiotensin inhibitor or adversal therapy, doctors should evaluate blood tests for electrolytes and renal function of 2 to 4 wk after treatment begins.† Doctors should consider starting pharmacological treatment for stage 2 blood pressure with 2 anti-hypertension factors from different classes. Patients with stage 2 hypertension and blood pressure ≥160/100 mm Hg should be treated promptly, carefully monitored, and subject to adjusting the dose of the drug upward if necessary to control blood pressure. Reassessment includes measuring blood pressure, detecting orthostatic hypotension in selected patients (e.k., older patients or those with postural symptoms), identifying white coat high blood pressure or white coat effect, documenting adherence, monitoring response to treatment, strengthening the importance of adherence, strengthening the importance of treatment, and helping treatment to achieve BP's goal. Download the download form of PowerPoint for high-risk adults with stage 1 blood pressure that CVD al advances there or is estimated to be a 10-year ASCVD risk of at least 10%, the guideline recommends starting drug treatment for those with an average blood pressure of 130/80 mm Hg or higher (I-class recommendation, high-quality evidence). For more low-risk adults there is no CVD before and an estimated 10-year risk of ASCVD is less than 10%, BP threshold for drug treatment 140/90 mm Hg or higher (first class recommendation, low quality evidence) (Table 4). ACC/AHA Pooled Cohort equations (, which are based on age, race, sex, cholesterol levels (total, low-density lipoprotein, and high-density lipoprotein), statin use, SBP, For high blood pressure, a history of diabetes mellitus (DM), current smoking, and the use of aspirin, it is recommended to estimate a 10-year risk for ASCVD, which is defined as the first non-fatal heart attack, coronary heart disease death, or fatal or non-fatal stroke among adults without CVD (15). Adults with DM, those with chronic kidney disease (CKD), and people aged 65 or over are in the high-risk category of ASCVD. Table 4 summarizes recommendations on blood pressure thresholds and treatment goals for adults with high blood pressure. After starting anti-hypertension treatment, regardless of the risk of ASCVD, the recommended blood pressure target is less than 130/80 mm Hg. The quality of evidence supporting this target is stronger for patients with known CVD or an estimated 10-year risk of ASCVD of at least 10% than patients without a high risk. A recent systematic review and network meta-analysis showed a steady reduction in CVD risk (major cardiovascular events, stroke, coronary heart disease, and all-cause mortality) at gradually lower levels than obtained SBP (13). A sensitivity analysis showed a similar pattern when sprint results (systolic blood pressure intervention trial) were de-ranked (13). A review of the evidence conducted to inform the recommendations found some differences, but the general similarity in the effectiveness and safety of medications has traditionally been considered first-line factors, emphasizing the importance of lowering blood pressure higher than drug choice (7). Recommendations on primary factors are summarized in Table 4. For adults without a convincing indication to use a specific drug, doctors should begin treatment with thiazid diodes, calcium channel blockers, angiotensin-converting enzyme inhibitors, or angiotensin receptor blockers. Thiazid diuretics (especially chlorthalidone) and calcium channel blockers are preferred options for first-line treatment in most American adults because of their effectiveness. In black patients, including patients with DM, thiazid medics and calcium channel blockers are recommended as first-line agents, while β-blockers and inhibitors of the Renin-angiotensin system are less effective at lowering blood pressure. For patients with stage 2 hypertension, starting 2 antihytensants from different classes is recommended when the average SBP and DBP are more than 20 and 10 mm Hg above target, respectively. Patients with stage 2 hypertension and an average blood pressure of 160/100 mm Hg or higher should be treated promptly, should be carefully monitored, and should adjust their regimen quickly until control is achieved. After starting drug treatment, management should include monthly evaluation of adherence and treatment response until the control is achieved. Interventions to promote control, such as HBPM, team-based care, and remote health, are helpful in improving BP control. Although the guideline encourages ASCVD risk assessments in all adults with high blood pressure, including those with DM, doctors can assume sake That most adults with DM and hypertension have a 10-year ASCVD risk of at least 10%, putting them in a high-risk category that requires the onset of drug therapy at blood pressure of 130/80 mm Hg or higher. Although the ACCORD trial (action to control cardiovascular risk in diabetes) did not document a statistically significant decrease in the initial result (CVD composite) with intensive reduction versus BP standard, the trial was wrapped up to detect differences between treatment groups, and interpret results using a factorial design (16). SPRINT showed CVD benefited from intensive treatment to target SBP of less than 120 mm Hg but did not include patients with DM (17). Meta-analysis of SPRINT and ACCORD results indicated that the findings of both trials were consistent (18). A post hoc analysis of SPRINT showed that patients with prediabetes gain similar benefits compared to normoglycemic patients (19). Therefore, the guidelines recommend that the treatment of antihytensant drugs should begin at blood pressure of 130/80 mm Hg or higher in adults with DM, and the treatment target should be less than 130/80 mm Hg (Table 4). High blood pressure has been reported in 67% to 92% of patients with CKD, with an increase in prevalence as kidney function decreases. High blood pressure may occur as a result of kidney disease, but even in this context, its existence is likely to lead to acceleration in further kidney damage. Similar to patients with DM, those with CKD and high blood pressure are automatically assigned to the high-risk category for ASCVD, with BP threshold for pharmacological treatment at 130/80 mm Hg or higher. Given that most patients with CKD die from CVD complications, evidence from SPRINT supports a BP target of less than 130.80 mm Hg for patients with CKD (Table 4) (17). Hypertension is a leading cause of disease and preventable mortality in older adults and is a major contribute to their premature disability and institutionalization. Isolated systolic blood pressure forms mainly high blood pressure in older adults. Randomized trials of antihyretic therapy have included a large number of older adults, and in each instance, including when the target for SBP treatment was less than 120 mm Hg, more intensive treatment of lowering blood pressure safely reduced the risk of CVD events for people older than 65, 75, and 80 years old. Both HYVET (high blood pressure in highly elderly court) and SPRINT included older people who were weak but still living independently in society, and both found significant benefit in those treating more intensive blood pressure (17, 20). Blood pressure reduction therapy is one of several interventions that have been shown to reduce the risk of death in older adults. Starting a blood pressure reduction treatment, especially with 2 medications, should be done with caution in older people, and careful monitoring is essential for adverse effects, including orthostatic blood pressure reduction. Although the risk assessment guideline encourages ASCVD in Adults with high blood pressure, including older people, doctors can assume for convenience that adults aged 65 or older with high blood pressure have at least a 10% risk of 10-year-old ASCVD, putting them in a high-risk category that requires starting medication in SBP 130 mm babes or older. Treatment of high blood pressure with the aim of SBP less than 130 mm Hg is recommended for non-therapeutic adults, aholators, resident community 65 years or older with an average SBP of 130 mm Hg or higher (Table 4). Accurate titration of blood pressure reduction drugs and close monitoring is especially important in older adults with high capacity loads as large trials have sidelined many of these people. For older adults (≥65 years old) with high blood pressure, high burden of hospitality, and limited life expectancy, clinical judgment, patient preference, and a team-based approach to assess risk-benefit transactions a reasonable treatment for decisions about drug choice and severity of blood pressure control (Table 4). Office blood pressure resistant averages 130/80 mm Hg or higher in sticky patients defined to 3 or more antihyphalviral agents from different classes in optimal doses, including dilants, or in those who need 4 or more antihyretic drugs. Using the former BP target of less than 140/90 mm Hg, the prevalence of resistant blood pressure among adults of hypertension is estimated at 13 percent. Estimates suggest that the prevalence of resistant blood pressure will be about 4% higher with bp's new target of less than 130.80 mm Hg (4). The risk of myocardial infarction, stroke, end-stage kidney disease, and death in adults with hypertension (using the previous definition) is 2 to 6 times higher than adults with high blood pressure who are not resistant to treatment. Doctors taking care of patients who meet resistant blood pressure criteria should ensure that the diagnosis is based on rigorous administrative blood pressure measurements, assess nonconformity with prescribed antihythm medications, and obtain home-based BP readings or a regulatory to rule out the effect of white coats. Lifestyle-assisting factors should be identified and addressed. The use of substances that interfere with antihyretic therapy, such as nonsteroidal anti-inflammatory drugs, stimulants, and oral contraception should be discontinued or minimized and secondary causes of high blood pressure are out of order. Treatment of resistant blood pressure includes maximizing diuretic therapy (chlorthalidone or indopamide instead of hydrochlorothiazide), the addition of a caniocorticoid receptor antagonist (spironolactone or eplernone), the addition of other factors with different mechanisms of action, the use of ring moor in patients with CKD, and referral to a high blood pressure specialist if blood pressure remains uncontrolled (Table 5). Table 5. Recommendations for managing resistant blood pressure and improving the management of high blood pressure*Every adult with high blood pressure It has an evidence-based care plan that promotes treatment and self-management goals, effective management of comorbid conditions, timely follow-up, and CVD guidance management guidelines (Table 5). Up to 25 percent of patients do not fill their initial prescription for antihy high blood pressure drug treatment, and only 1 in 5 patients have high adherence enough to achieve the benefits observed in randomized controlled trials (21). Taking an anti-hypertension drug daily and using combination pills can improve adherence. A team-based care approach is recommended for adults with high blood pressure. In addition, the use of electronic health history and patient registration is useful in recognizing untended blood pressure and leading initiatives to improve quality in controlling high blood pressure. Unhealthy remote strategies can also be helpful to interventions shown to lower blood pressure for adults with high blood pressure. High blood pressure is a leading risk factor for regulated death and disability in years of life around the world. Blood pressure of 120.80 mm Hg or higher is linearly related to the risk of fatal and non-fatal stroke, ischemic heart disease, and noncardiology vascular disease, and each increase of 10.20 mm Hg doubles the risk of a fatal CVD event. The ACC/AHA Guidelines for prevention, diagnosis, evaluation and management of hypertension in adults (4) are the first comprehensive guidelines for clinical practice of hypertension since 2003. The 2017 directive uses a different classification system for BP than previous guidelines; Advocates of team-based care and use of electronic health history and remote health strategies to improve care; recommend non-pharmacological interventions; and recommends in addition to the drug's antihypatensive treatment based on a combination of average blood pressure, ASCVD risk, and associated conditions. Paul K. Whelton, MB, MD, MPH, Chair*Robert M. Carey, MD, Vice Chair Wilbert S. Aronow, MD†Donald E. Casey, MD, MPH, MBA†Karen J. 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SPRINT Research Group. اثر درمان فشرده در مقابل استاندارد فشار خون با توجه به وضعیت پیش دیابت پایه: یک تجزیه و تحلیل پس از hoc 2017 از یک کارآزمایی تصادفی. مراقبت از دیابت. [PMID: 28793997] doi:10.2337/dc17-0885 CrossrefMedlineGoogle Warwick J, Falaschetti E, Rockwood K, Mitnitski A, Thijs L, Beckett N, et al. There is no evidence to correct the positive effect of antihy high blood pressure therapy in very older adults: to investigate the effect of failure on blood pressure in a very elderly trial study (HYVET) that is a double-blind, placebo-controlled study in people with hypertension aged 80 and over. BMC Med. 2015;13:78. [PMID: 25880068] doi:10.1186/s12916-015-0328-1 CrossrefMedlineGoogle Scholar21. Berra E, Azizi M, Capron A, Høieggen A, Rabbia F, Kjeldsen SE, et al. Adherence assessment should become an integral part of the assessment of patients with apparently refractory hypertension. Hypertension. 2016;68:297-306. [PMID: 27296995] doi:10.1161/HYPERTENSIONAHA.116.07464 CrossrefMedlineGoogle ScholarPage 2Hypertension is the leading risk factor for death and disability worldwide (1, 2). The American Heart Association (ACC) Guide to Prevention, Diagnosis, Evaluation, and Management of Hypertension in Adults (3) is the first comprehensive clinical practice guideline for hypertension since the 7th Report of the Joint National Committee on Prevention, Diagnosis, Evaluation, and Treatment of Hypertension (JNC 7) in 2003 (4). The ACC/AHA guidelines provide an evidence-based approach to reduce the risk of cardiovascular disease (CVD) by controlling blood pressure (BP) (3). Four of the main recommendations to reduce the risk of CVD ... Resources1. Lim SS , Vos T , Flaxman AD , Danaei G , Shibuya K , Adair-Rohani H , et al. 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Whelton PK , Carey RM , Aronow WS , Casey DE Jr , Collins KJ , Dennison Himmelfarb C , et al. 2017 ACC/AHA/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Prevention, Detection, Evaluation, and Management of High Blood Pressure in Adults: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. 2017 فشارخون. [PMID: 29133354] doi:10.1161/HYP.0000000000000066 CrossrefMedlineGoogle Scholar7. کنترل از راه دور کری و Whelton PK ; 2017 ACC/AHA Hypertension Guideline Writing Committee. خلاصه داستان کالج قلب آمریکا/دستورالعمل انجمن قلب پیشگیری، تشخیص، ارزیابی، و مدیریت فشار خون بالا در بزرگسالان: آمریکا در سال ۲۰۱۷. Ann Intern Med. 2018;168:351-8. doi:10.7326/M17-3203 LinkGoogle Scholar8. گرینلند پی. شک و تردید دستورالعمل قلبی عروقی در مقابل رئالیسم سبک زندگی؟ JAMA. ۲۰۱۷. [PMID: 29242938] doi:10.1001/jama.2017.19675 CrossrefMedlineGoogle Scholar Page 3Frailty, one of the key syndromes of aging, is defined as a state of decreased physiologic reserve and increased vulnerability to stressors, such as acute disease, injury, or surgery. به همین دلیل، توسعه مداخلات برای (1) شکست در بزرگسالان مسن تر شناخته شده است. در طول چند دهه گذشته، شکست به طور فزاینده ای به عنوان پیش بینی کننده قوی پیامدهای ضعیف، از جمله استفاده از مراقبت حاد، ناتوانی، و مرگ، در بزرگسالان مسن تر شناخته شده است. جلوگیری یا به تاخیر انداختن شکست و پیامدهای نامطلوب مرتبط با آن، منطقه ای نوظهور از تحقیقات سالمندان است. با وجود این تمرکز رو به رشد، هیچ تعریف واحد، پذیرفته شده جهانی از شکست وجود دارد. بلکه تعاریف متعددی معمولاً مورد استفاده قرار می گیرند که هر کدام ... منابع1 شکننده در 62-381:752;2013 . افراد مسن. لانست. [PMID: 23395245] doi:10.1016/S0140-6736(12)62167-9 CrossrefMedlineGoogle Scholar2. Rockwood K and Mitnitski A. شکست در رابطه با تجمع کسری ها. 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Gene insegenization by epigenetic silencing, For functional loss of activity, the result was an alternative to mutant inso activation. It was then revealed that other genes that have mutated repeatedly... Resources1. Ashijima T and Asada K. Indiscriminate DNA methylation versus mutations. Cancer Sci. 2010;101:300-5. [PMID: 19958364] doi:10.1111/j.1349-7006.2009.01434.x CrossrefMedlineGoogle Scholar2. Greger V , Passarge E , Höpping W , Messmer E , and Horsthemke B . Epigenetic changes may contribute to the formation and self-regression of retinoblastoma. homegent . 1989;83:155-8. [PMID: 2550354] CrossrefMedlineGoogle Scholar3. Bianco T, Chenevix-Trench G, Walsh DC, Cooper JE, and Dobrovic A. Specific distribution of brca1 promoter tumors supports pathogenic role in breast and ovarian cancer. carcinogen . 2000;21:147-51. [PMID: 10657950] CrossrefMedlineGoogle Scholar4. Esteller M , Silva JM , Dominguez G , Bonilla F , Matias-Guiu X , Lerma E , et al. 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[PMID: 21205738] doi:10.1158/1940-6207.CAPR-10-0348 CrossrefMedlineGoogle Scholar Page 6Mechanical closure of a patent foramen ovale (PFO) without surgery has been possible since 1992 (1). Very common (2) but usually clinically silent, PFO can let go Blood hunting deoxygenated and even worse, allowing the thromboemboli venous system to cross the attrial septum into systemic circulation. A significant proportion of apparently cryptic strokes may result from such an event (3). Should the PFO be closed if it appears to have caused a stroke? Sensible as this approach sounds, (as always) there are risks, costs, and benefits to balance. The closing method is aggressive, expensive, and not risk-free. ... Resources1. Bridges ND , Hellenbrand W , Latson L , Filiano J , Newburger JW , and Lock JE . Transcatheter's closure of the foramen ovale patent is assumed after a paradoxical embolism. Circulation. 1992;86:1902-8. [PMID: 1451261] CrossrefMedlineGoogle Scholar2. 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Long-term Complications After Transcatheter Atrial Septal Defect Closure: A Review of the Medical Literature. Can Jay Cardiol. 2016;32:1315. [PMID: 27179546] doi:10.1016/j.cjca.2016.02.068 CrossrefMedlineGoogle Scholar Page Scholar 7The recent High Blood Pressure Directive from the American College of Cardiology (ACC), the American Heart Association (AHA), and partner organizations—summarizes that in this issue (1)—it raises important questions about the diagnosis of high blood pressure and treatment. The directive differs substantially from other organizations, including the American College of Physicians (ACP) and the American Academy of Family Physicians (AAFP) (2). Here we examine these differences by focusing on pharmacological treatment for adults older than 60 years of age. The strengths of the ACC/AHA guidelines include its emphasis on the importance of the technique of measuring blood pressure and lifestyle changes. However, the instruction falls short on ... Resources1. 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N Engl J Med. 2003;348:1556-64. [PMID: 12700376] CrossrefMedlineGoogle Scholar Page 8On Being a Doctor6 March 2018Author, Article and Disclosure Information Visual AbstractDear J,Thank you for your thoughtful e-mail. I wish we could have a personal conversation on a cup of coffee, but I understand that time is tight and you've probably moved to the hospital and another spin by now. Your message caused me to reflect not only on our recent interaction but also in my similar connections with residents and helpers over the years. More importantly, it led me to think a lot of conversations I didn't have because I was too busy, often running into a session that rarely left a long-term effect...

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