



# Guidelines

Volume 45

October 2011

Welcome to the 45th edition of **Guidelines**, the three-times yearly handbook summarising clinical guidelines for primary and shared care. Our aim is to provide those involved in developing and implementing practice or locality guidelines with a valuable reference source in a convenient, easy-to-use, working handbook. Due to the continual development and revision of national guidelines, **Guidelines** is updated and published in February, June and October each year.

National and European clinical guidelines, developed by clinicians and sponsored by the relevant independent professional bodies, are summarised and included within **Guidelines**.

Systematic reviews and guidelines published by the National Institute for Health and Clinical Excellence or the Department of Health are highlighted in blue (■). National guidelines produced by independent professional bodies are highlighted in green (■).

The NHS Evidence Accreditation Scheme recognises organisations that achieve high standards in producing health or social care guidance. Organisations that successfully pass the rigorous evaluation of the independent Advisory Committee are able to display the Accreditation Mark (D) on all guidance produced using the accredited process for the term of the award.

There are a number of areas not covered by the NICE and independent professional body guidelines. Consideration also needs to be given to the place of newer interventions omitted from national guidelines that have not been recently updated. For these reasons, summaries of working party guidelines are also included within **Guidelines**. These guidelines are highlighted in yellow (■). They are required to meet the following criteria:

1. They must be drawn up by a multidisciplinary group including at least one general practitioner;
2. The members of the group should be drawn from several geographical locations;
3. The content of the guidelines must be independent of and not influenced by commercial sponsorship of the working party.

An index of clinical areas covered is located at the end of the publication.

We hope that you find **Guidelines** of help when drawing up your local guidelines, recommendations and policies, and look forward to receiving your feedback as to how it may be further developed to meet your needs.

*Gastrointestinal**Cardiovascular**Respiratory**Central Nervous System**Infection**Endocrine**Obstetrics, Gynaecology  
& Urology**Malignant Disease**Nutrition**Musculoskeletal & Joints**Eye, Ear, Nose & Throat**Skin**Immunisation &  
Vaccination**General*

## Hypertension: clinical management of primary hypertension in adults

*National Institute for Health and Clinical Excellence*

### Definitions

- **Stage 1 hypertension:** clinic blood pressure is 140/90 mmHg or higher **and** subsequent ambulatory blood pressure monitoring (ABPM) daytime average or home blood pressure monitoring (HBPM) average blood pressure is 135/85 mmHg or higher
- **Stage 2 hypertension:** clinic blood pressure is 160/100 mmHg or higher **and** subsequent ABPM daytime average or HBPM average blood pressure is 150/95 mmHg or higher
- **Severe hypertension:** clinic systolic blood pressure is 180 mmHg or higher, **or** clinic diastolic blood pressure is 110 mmHg or higher

### Measuring blood pressure

- Healthcare professionals taking blood pressure measurements need adequate initial training and should have their performance reviewed periodically
- Devices for measuring blood pressure must be properly validated, maintained and regularly recalibrated according to manufacturers' instructions
- If using an automated blood pressure monitoring device, ensure that the device is validated and an appropriate cuff size for the person's arm is used
- When measuring blood pressure in the clinic or in the home, standardise the environment and provide a relaxed, temperate setting, with the person quiet and seated, and their arm outstretched and supported

- Palpate the radial or brachial pulse before measuring blood pressure, since automated devices may not measure blood pressure accurately if there is pulse irregularity (for example, due to atrial fibrillation). If pulse irregularity is present, measure blood pressure manually, using direct auscultation over the brachial artery

### Postural hypotension

- In people with symptoms of postural hypotension (falls or postural dizziness):
  - measure blood pressure with the person either supine or seated
  - measure blood pressure again with the person standing for at least 1 minute prior to measurement
- If the systolic blood pressure falls by 20 mmHg or more when the person is standing:
  - review medication
  - measure subsequent blood pressures with the person standing
  - consider referral to specialist care if symptoms of postural hypotension persist

### Diagnosing hypertension

#### Measuring the clinic blood pressure

- Measure blood pressure in both arms:
  - if the difference in readings between arms is more than 20 mmHg, repeat the measurements
  - if the difference in readings between arms remains more than 20 mmHg on the second measurement, measure subsequent blood pressures in the arm with the higher reading

**Emergency contraception**

• Faculty of Sexual & Reproductive Healthcare •

**Summary of key recommendations**

**What methods should be offered to women requesting emergency contraception?**

- Health professionals should discuss individual need for emergency contraception (EC) and inform women about the different methods with regard to efficacy, adverse effects, interactions, medical eligibility and need for additional contraceptive precautions
- The copper-bearing intrauterine device (Cu-IUD) can be inserted up to 120 hours after the first episode of unprotected sexual intercourse (UPSI) or within 5 days of the earliest expected date of ovulation
- The efficacy of ulipristal acetate (UPA) has been demonstrated up to 120 hours and can be offered to all eligible women requesting EC during this time period. It is the only oral EC licensed for use between 72 and 120 hours
- The efficacy of levonorgestrel (LNG) has been demonstrated up to 96 hours; between 96 and 120 hours efficacy is unknown. Use of LNG beyond 72 hours is outside the product licence
- If a service or health professional is unable to provide a method of EC, local referral mechanisms should facilitate timely access to a service that can provide the woman's preferred method
- Ideally an emergency intrauterine device (IUD) should be inserted at first presentation, but where this is not possible oral EC can be given in the interim, and the woman advised to return at the earliest appropriate time

**Future/ongoing contraception**

- Women should be advised that oral EC methods do not provide contraceptive

cover for subsequent UPSI and that they will need to use contraception or refrain from sex to avoid further risk of pregnancy

- If a woman is likely to continue to be at risk of pregnancy or has expressed a preference to start contraception immediately after EC, a health professional may 'quick start' combined hormonal contraception (excluding co-cyprindiol), the progestogen-only pill (POP) or implant, providing the woman has been appropriately informed and advised to have a pregnancy test in  $\geq 3$  weeks
- Women requesting the progestogen-only injectable after EC should ideally be offered an alternative method until pregnancy can be excluded. The injectable should be started immediately only if other methods are not appropriate or acceptable and the woman has been appropriately informed and advised to have a pregnancy test in  $\geq 3$  weeks
- Following administration of LNG, women continuing to use a hormonal method of contraception should be advised to use additional contraceptive precautions for 7 days (2 days for POP, 9 days for estradiol valerate with dienogest)
- Following administration of UPA, women continuing to use a hormonal method of contraception should be advised to use additional contraceptive precautions for 14 days (9 days for POP, 16 days for estradiol valerate with dienogest)

**Drug interactions**

- Women taking liver enzyme-inducing drugs (or who have stopped taking this medication within the last 28 days) should be advised that a copper-bearing intrauterine device (Cu-IUD) is the only method of EC not affected by these drugs

## Prostate cancer: diagnosis and treatment ◉

*National Institute for Health and Clinical Excellence*

### Diagnosing prostate cancer

- Before referral to specialist care, men with suspected prostate cancer should have been offered a digital rectal examination (DRE) and prostate-specific antigen (PSA) test as set out in 'Referral guidelines for suspected cancer' (NICE clinical guideline 27)

### Biopsy

- Provide information, support and allow sufficient time for the man to decide whether to have a biopsy
- Discuss:
  - the risks and benefits of biopsy
  - their individual risk factors (including increasing age and black African or black Caribbean ethnicity)
  - their estimated prostate size, DRE findings and PSA level
  - any comorbidities
  - any previous negative biopsy
- Use nomograms to help with decision making and to predict the biopsy results. Explain their reliability and limitations
- Do not biopsy:
  - on the basis of serum PSA level alone
  - if suspicion of prostate cancer is high because of PSA level and evidence of bone metastases, unless required as part of a clinical trial

### Before starting treatment

- Discuss all relevant management options
- Inform men that treatment may result in:
  - altered physical appearance

- altered sexual experience
- possible loss of sexual function, ejaculation, and fertility
- changes in urinary function
- Support men in making treatment decisions, taking into account survival and quality of life benefits
- Advise men about the potential long-term adverse effects of treatment and when and how to report them

### Localised prostate cancer

#### Watchful waiting

- If men choose watchful waiting and show evidence of disease progression, they should be reviewed by a member of the urological cancer multidisciplinary team (MDT)

#### Active surveillance

- Active surveillance is the preferred option for low-risk men who are candidates for radical treatment. It is particularly suitable for men with clinical stage T1c, Gleason score 3+3 and PSA density <0.15 ng/ml/ml who have cancer in less than 50% of their biopsy cores, with <10 mm of any core involved.
- Candidates for active surveillance should:
  - have had at least 10 biopsy cores taken
  - have at least one re-biopsy which may be performed according to the ProSTART protocol\*
- If men on active surveillance show evidence of disease progression, offer radical treatment. Treatment decisions should be