

2016 European Society of Hypertension guidelines for the management of high blood pressure in children and adolescents

Empar Lurbe^{a,b}, Enrico Agabiti-Rosei^c, J. Kennedy Cruickshank^d, Anna Dominiczak^e, Serap Erdine^f, Asle Hirth^g, Cecilia Invitti^h, Mieczyslaw Litwinⁱ, Giuseppe Mancia^j, Denes Pall^k, Wolfgang Rascher^l, Josep Redon^{b,m,n}, Franz Schaefer^o, Tomas Seeman^p, Manish Sinha^q, Stella Stabouli^r, Nicholas J. Webb^s, Elke Wühl^t, and Alberto Zanchetti^u

Increasing prevalence of hypertension (HTN) in children and adolescents has become a significant public health issue driving a considerable amount of research. Aspects discussed in this document include advances in the definition of HTN in 16 year or older, clinical significance of isolated systolic HTN in youth, the importance of out of office and central blood pressure measurement, new risk factors for HTN, methods to assess vascular phenotypes, clustering of cardiovascular risk factors and treatment strategies among others. The recommendations of the present document synthesize a considerable amount of scientific data and clinical experience and represent the best clinical wisdom upon which physicians, nurses and families should base their decisions. In addition, as they call attention to the burden of HTN in children and adolescents, and its contribution to the current epidemic of cardiovascular disease, these guidelines should encourage public policy makers to develop a global effort to improve identification and treatment of high blood pressure among children and adolescents.

Keywords: adolescents, central blood pressure, children, European, management of high blood pressure, out of office blood pressure, recommendations, society of hypertension

Abbreviations: ABPM, ambulatory blood pressure measurement; ACE, angiotensin-converting enzyme; ACEi, angiotensin-converting enzyme inhibitor; ACTH, adrenocorticotropic hormone; ARB, AT1 blocker; BP, blood pressure; cIMT, carotid intima-media thickness; CKD, chronic kidney disease; CoA, coarctation of aorta; CPAP, continuous positive airway pressure; cPP, central pulse pressure; CS, Cushing syndrome; cSPB, central or aortic SBP; CT, computed tomography; CV, cardiovascular; DIH, drug-induced hypertension; DM1, type 1 diabetes; DM2, type 2 diabetes; EM, ethnic minorities; ENaC, epithelial sodium channel; ESC, European Society of Cardiology; ESCAPE, Effect of Strict Blood Pressure Control and ACE Inhibition on Progression of Chronic Renal Failure in Pediatric Patients; ESH, European Society of Hypertension; ESRD, end stage renal disease; EU, European Union; FH-1,2,3, familial hyperaldosteronism type 1,2,3; GFR,

glomerular filtration rate; HTN, hypertension; HTNR, hypertensive retinopathy; ISH, isolated systolic hypertension; LDL-C, LDL cholesterol; LV, left ventricle; LVH, left ventricular hypertrophy; LVM, left ventricular mass; LVMI, left ventricular mass index; MR, mineralocorticoid receptor; OSA, obstructive sleep apnea; PRES, posterior reversible encephalopathy syndrome; PUMA, pediatric use marketing authorization; PWV, pulse wave velocity; RAS, renin-angiotensin system; SNP, single nucleotide polymorphism; SPRINT, SBP Intervention Trial; TOD, target organ damage; UAE, urinary albumin excretion; VEGF, vascular endothelial growth factor

Journal of Hypertension 2016, 34:1887–1920

^aPediatric Department, Consorcio Hospital General, University of Valencia, Valencia, ^bCIBER Fisiopatología Obesidad y Nutrición (CB06/03), Instituto de Salud Carlos III, Madrid, Spain, ^cClinica Medica, Department of Clinical and Experimental Sciences, University of Brescia, Italy, ^dDiabetes and Nutritional Science Division, Kings College, London, ^eCollege of Medical, Veterinary and Life Sciences, University of Glasgow, Glasgow, UK, ^fCardiology Department, Cerrahpasa School of Medicine, Istanbul University, Istanbul, Turkey, ^gDepartment of Pediatrics, Haukeland University Hospital, Bergen, Norway, ^hDepartment of Medical Sciences and Rehabilitation, IRCCS Istituto Auxologico Italiano, Milan, Italy, ⁱDepartment of Nephrology and Arterial Hypertension, The Children's Memorial Health Institute, Warsaw, Poland, ^jCenter of Epidemiology and Clinical Trials, IRCCS Istituto Auxologico Italiano, Milan, Italy, ^kDepartment of Medicine and Coordination Centre for Drug Development, University of Debrecen, Debrecen, Hungary, ^lDepartment of Pediatrics and Adolescent Medicine, University of Erlangen-Nürnberg, Erlangen, Germany, ^mDepartment of Internal Medicine, Hospital Clinico de Valencia, University of Valencia, ⁿINCLIVA Research Institute, Valencia, Spain, ^oDivision of Pediatric Nephrology, Center for Pediatrics and Adolescent Medicine, University of Heidelberg, Heidelberg, Germany, ^pDepartment of Paediatrics, 2nd Faculty of Medicine, Charles University in Prague and Motol University Hospital, Prague, Czech Republic, ^qDepartment of Paediatric Nephrology, Evelina London Children's Hospital, Guys and St Thomas' NHS Foundation Trust, London, UK, ^r1st Department of Pediatrics, Aristotle University of Thessaloniki, Hippokratia Hospital, Thessaloniki, Greece, ^sDepartment of Paediatric Nephrology and NIHR/Wellcome Clinical Research Facility, University of Manchester, Manchester Academic Health Science Centre, Royal Manchester Children's Hospital, Manchester, UK, ^tDivision of Pediatric Nephrology, Center for Pediatrics and Adolescent Medicine, University of Heidelberg, Heidelberg, Germany and ^uIstituto Auxologico Italiano IRCCS, and Centro Interuniversitario di Fisiologia Clinica e ipertensione, University of Milan, Milan, Italy

Correspondence to Empar Lurbe, Prof, MD, PhD, Pediatrics Department, Consorcio Hospital General, Universitario de Valencia, Avenida Tres Cruces s/n, Valencia 46014, Spain. Tel: +34 963 131 800; e-mail: empar.lurbe@uv.es

Received 8 June 2016 Accepted 15 June 2016

J Hypertens 34:1887–1920 Copyright © 2016 Wolters Kluwer Health, Inc. All rights reserved.

DOI:10.1097/HJH.0000000000001039

INTRODUCTION AND PURPOSE

Purpose

The European Society of Hypertension (ESH) Guidelines on High Blood Pressure in Children and Adolescents published in 2009 [1] were undertaken because of growing evidence that mild blood pressure (BP) elevations are much more common among children and adolescents than previously thought, and BP abnormalities in youth frequently translate into adult hypertension (HTN), what is known as the tracking phenomenon.

The Scientific Council and the Working Group on Hypertension in Children and Adolescents of the ESH acknowledged the importance of diagnosis, management and treatment of high BP in this age group and recognized the need for an update of the 2009 guidelines because over the 7 years elapsed from their publication, a large body of new knowledge had been acquired, making modifications and expansion of the previous recommendations necessary.

It is hoped that the new knowledge summarized in these guidelines will lead to increased efforts toward prevention and management of HTN in the pediatric age, thus also helping relieving the burden of cardiovascular disease in adults.

What is new?

Increasing prevalence of HTN in children and adolescents has become a significant public health issue driving a considerable amount of research. Aspects discussed in this document include advances in the definition of HTN in 16 year or older, clinical significance of isolated systolic HTN (ISH) in youth, the importance of out of office and central BP measurement, new risk factors for HTN, methods to assess vascular phenotypes, clustering of cardiovascular risk factors and treatment strategies among others.

How the document has been prepared

The European members in charge of the 2016 guidelines were appointed by the ESH Council, on the basis of their recognized interest and experience in the area. Each member was assigned a specific writing task according to their expertise, and each contribution was reviewed by all the coauthors. The text was finalized over approximately 12 months, during which the members corresponded intensively. It can thus be confidently stated that the recommendations issued by the 2016 ESH guidelines largely reflect the state of the art on HTN, as viewed by pediatricians and HTN experts in Europe.

The document has 14 sections containing 19 tables, four figures and six boxes which summarize the most relevant recommendations providing an easy access to the readers. The data upon which recommendations are based are referenced at the end of the document.

How to detect hypertension in children: pros and cons of screening

The early recognition of BP abnormalities is crucial if there are to be early interventions that may reduce cardiovascular morbidity and mortality later in life. The current guidelines

clearly state that a child should not be diagnosed with HTN until he or she has shown evidence of sustained BP elevation [1]. Several prominent medical organizations, including the National High Blood Pressure Education Program, the American Academy of Pediatrics and the American Heart Association, recommend routine measurement of BP in children and adolescents. However, these recommendations are not deeply grounded, and controversy has been raised about benefits and costs of routine screening [2,3]. In 2013, the US Preventive Services Task Force concluded that the 'current evidence is insufficient to assess the balance of benefits and harms of screening for primary hypertension in asymptomatic children and adolescents to prevent subsequent CV disease in childhood or adulthood' [2]. The pros and cons of screening have been widely debated, recently [4–6]. The group responsible for these guidelines has considered that lack of evidence does not necessarily justify inaction; that opportunistic BP screening in children is associated with minimal cost and time inputs and does not include invasive and expensive tests. It may also lead to further actions improving health outcomes [3]. Therefore, the consensus of the present guidelines is that BP should be measured in children starting from the age of 3 years. Once BP is measured, children considered that normotensive should be reevaluated every 2 years, whereas those with high-normal BP and no organ damage should be seen again after 1 year. This recommendation was already given in the 2009 Guidelines here reconfirmed. Also reconfirmed is the advice that, once a diagnosis of HTN has been established, children should be referred to units with expertise in managing this condition in the pediatric age.

DEFINITION AND CLASSIFICATION OF HYPERTENSION

Classification of hypertension

On the contrary to what happens for adults, the definition of HTN in children is arbitrary and is based on the normal distribution of BP in healthy children and not on the cardiovascular morbidity and mortality associated with a certain level of BP. Diagnostic criteria for elevated BP in children are based on the concept that BP in children increases with age and body size, making it impossible to utilize a single-BP level to define HTN, as done in adults. Because of the persisting lack of European reference values that incorporate age, sex and height, throughout the entire pediatric age range, we confirm the decision of the 2009 ESH Guidelines [1] to use the normative data on auscultatory clinic measurements provided by the US Task Force [7], providing BP percentiles for each sex, ages from 1 to 17 years and for seven height percentile categories.

As in the previous guidelines, HTN in children is defined as SBP and/or DBP persistently at least 95th percentile for sex, age and height measured on at least three separate occasions, as outlined in Fig. 1. Children with average SBP and/or DBP at least 90th, but less than 95th are classified as having high-normal BP. In the present document, the definitions have been revised for older adolescents. Considering the 95th percentile for age, sex and height as the definition of HTN, a 16-year-old boy in the 95th percentile

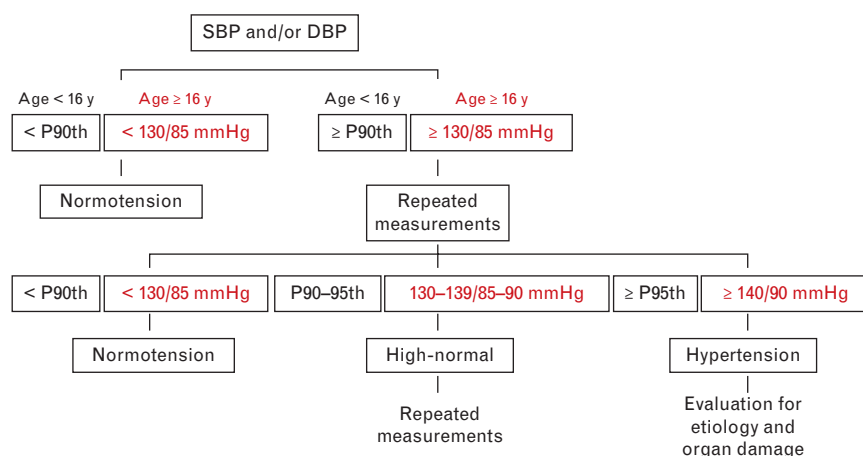


FIGURE 1 Flowchart for the diagnosis of hypertension based on percentile distribution of age, sex and height. Less than 16 years and on defined threshold at least 16 years. P, percentile.

for height would be defined as hypertensive by an office SBP of 137–140 mmHg, whereas a 16-year-old girl in the same height percentile by an office SBP of only 132 mmHg. One–two years later, no longer seen by a pediatrician, the girl will now be diagnosed as normotensive or high normal by the family physician on the basis of adult guidelines. Even greater differences in diagnosis will occur in adolescents shorter than the 95th height percentile. Due to these differences in diagnosis, a consensus in the present guidelines is given that for boys and girls aged 16 or older, the definition of HTN should no longer be based on the 95th percentile but on the absolute cutoff used for adults, which defines high-normal (130–139/85–89 mmHg) and HTN ($\geq 140/90$ mmHg) (Fig. 1 and Table 1).

In addition, HTN is further classified as grade 1 (95th percentile to the 99th percentile and 5 mmHg) and grade 2 (>99 th percentile plus 5 mmHg). In the case of patients, 16 years or older HTN should be graded as for adults. Tables 2 and 3 report the BP percentiles for boys and girls, aged 1–15 years, adapted from the Fourth Report of the US Task Force [7].

Systolic blood pressure vs diastolic blood pressure

Elasticity of the great vessels is particularly relevant in youth and causes SBP to be considerably higher in upper limb arteries than in the ascending aorta, increasing the presence of so-called ISH. This condition in youth is defined as SBP at least 95th percentile specific for sex, age and height,

with DBP less than 90th percentile [8]. In 16 years and older SBP at least 140 mmHg and DBP less than 90 mmHg, see Table 1. The clinical significance of ISH in youth is still debated, as discussed in Section entitled ‘Central blood pressure’ below.

Risk of hypertension in adult life

Previous studies have demonstrated that elevated BP in childhood is the strongest predictor of HTN in the adult, and the increment of risk of HTN in adult life results from adolescents in the highest BP percentiles [9–12]. Increments in SBP of 15 or 30 mmHg above 90 mmHg in 15-year olds represent probabilities of having HTN at 35 years of 0.18 and 0.33, respectively, for boys. These probabilities are lower for girls, 0.04 and 0.08, respectively, with 4.25 more risk for boys than for girls [13]. In a longitudinal study, BP at adolescence, even in the low-normotensive range, linearly predicted progression to HTN in young adulthood [11]. This progression was shown to be sex dependent and was three to four times higher among men than women in all BP categories.

BP values in adolescence can also be predictors of cardiovascular risk other than HTN. After 17 years of follow-up, BP values in young individuals show a significant association with cardiometabolic risk [14] and may also predict coronary artery disease in adult life [15]. Likewise, BP values at adolescence are independent predictors of end stage renal disease in middle-aged men [16].

TABLE 1. Classification of hypertension in children and adolescents

Category	0–15 years SBP and/or DBP percentile	16 years and older SBP and/or DBP values (mmHg)
Normal	<90th	<130/85
High-normal	≥ 90 th to <95th percentile	130–139/85–89
Hypertension	≥ 95 th percentile	$\geq 140/90$
Stage 1 hypertension	95th percentile to the 99th percentile and 5 mmHg	140–159/90–99
Stage 2 hypertension	>99 th percentile plus 5 mmHg	160–179/100–109
ISH	SBP ≥ 95 th percentile and DBP <90th percentile	$\geq 140/<90$

ISH, isolated systolic hypertension.

TABLE 2. Blood pressure for boys by age and height percentiles

Age (years)	BP percentile	SBP (mmHg) percentile of height							DBP (mmHg) percentile of height						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	90th	94	95	97	99	100	102	103	49	50	51	52	53	53	54
	95th	98	99	101	103	104	106	106	54	54	55	56	57	58	58
	99th	105	106	108	110	112	113	114	61	62	63	64	65	66	66
2	90th	97	99	100	102	104	105	106	54	55	56	57	58	58	59
	95th	101	102	104	106	108	109	110	59	59	60	61	62	63	63
	99th	109	110	111	113	115	117	117	66	67	68	69	70	71	71
3	90th	100	101	103	105	107	108	109	59	59	60	61	62	63	63
	95th	104	105	107	109	110	112	113	63	63	64	65	66	67	67
	99th	111	112	114	116	118	119	120	71	71	72	73	74	75	75
4	90th	102	103	105	107	109	110	111	62	63	64	65	66	66	67
	95th	106	107	109	111	112	114	115	66	67	68	69	70	71	71
	99th	113	114	116	118	120	121	122	74	75	76	77	78	78	79
5	90th	104	105	106	108	110	111	112	65	66	67	68	69	69	70
	95th	108	109	110	112	114	115	116	69	70	71	72	73	74	74
	99th	115	116	118	120	121	123	123	77	78	79	80	81	81	82
6	90th	105	106	108	110	111	113	113	68	68	69	70	71	72	72
	95th	109	110	112	114	115	117	117	72	72	73	74	75	76	76
	99th	116	117	119	121	123	124	125	80	80	81	82	83	84	84
7	90th	106	107	109	111	113	114	115	70	70	71	72	73	74	74
	95th	110	111	113	115	117	118	119	74	74	75	76	77	78	78
	99th	117	118	120	122	124	125	126	82	82	83	84	85	86	86
8	90th	107	109	110	112	114	115	116	71	72	72	73	74	75	76
	95th	111	112	114	116	118	119	120	75	76	77	78	79	79	80
	99th	119	120	122	123	125	127	127	83	84	85	86	87	87	88
9	90th	109	110	112	114	115	117	118	72	73	74	75	76	76	77
	95th	113	114	116	118	119	121	121	76	77	78	79	80	81	81
	99th	120	121	123	125	127	128	129	84	85	86	87	88	88	89
10	90th	111	112	114	115	117	119	119	73	73	74	75	76	77	78
	95th	115	116	117	119	121	122	123	77	78	79	80	81	81	82
	99th	122	123	125	127	128	130	130	85	86	86	88	88	89	90
11	90th	113	114	115	117	119	120	121	74	74	75	76	77	78	78
	95th	117	118	119	121	123	124	125	78	78	79	80	81	82	82
	99th	124	125	127	129	130	132	132	86	86	87	88	89	90	90
12	90th	115	116	118	120	121	123	123	74	75	75	76	77	78	79
	95th	119	120	122	123	125	127	127	78	79	80	81	82	82	83
	99th	126	127	129	131	133	134	135	86	87	88	89	90	90	91
13	90th	117	118	120	122	124	125	126	75	75	76	77	78	79	79
	95th	121	122	124	126	128	129	130	79	79	80	81	82	83	83
	99th	128	130	131	133	135	136	137	87	87	88	89	90	91	91
14	90th	120	121	123	125	126	128	128	75	76	77	78	79	79	80
	95th	124	125	127	128	130	132	132	80	80	81	82	83	84	84
	99th	131	132	134	136	138	139	140	87	88	89	90	91	92	92
15	90th	122	124	125	127	129	130	131	76	77	78	79	80	80	81
	95th	126	127	129	131	133	134	135	81	81	82	83	84	85	85
	99th	134	135	136	138	140	142	142	88	89	90	91	92	93	93
16	90th	125	126	128	130	131	133	134	78	78	79	80	81	82	82
	95th	129	130	132	134	135	137	137	82	83	83	84	85	86	87
	99th	136	137	139	141	143	144	145	90	90	91	92	93	94	94
17	90th	127	128	130	132	134	135	136	80	80	81	82	83	84	84
	95th	131	132	134	136	138	139	140	84	85	86	87	87	88	89
	99th	139	140	141	143	145	146	147	92	93	93	94	95	96	97

BP, blood pressure. Modified from Task Force on High Blood Pressure in Children and Adolescents [7]. Boxed area corresponds to reference values of boys 16 years or older in which the reference values for adults are recommended.

Relative cardiovascular and renal risk

HTN impacts on the heart, kidney, central nervous system and vessels producing early functional or structural changes that can be detected by using appropriate assessment methods. Among children and adolescents with primary HTN, 30–40% had a left ventricular mass index (LVMI) above the 95th percentile and 10–15% of them had severe left ventricular hypertrophy (LVH) defined as LVMI above

51 g/height^{2.7} [17–19]. Renal damage is rarely observed in essential hypertensive children, but these patients have greater albuminuria and excrete more *N*-acetyl glucosamine than their normotensive counterparts. The severity of albuminuria correlates with LVH [20,21]. On the other hand, antihypertensive treatment, when successful in reducing BP, also leads to regression of LVH, decrease in carotid intima-media thickness (cIMT) and normalization of

TABLE 3. Blood pressure for girls by age and height percentiles

Age (years)	BP percentile	SBP (mmHg) percentile of height							DBP (mmHg) percentile of height						
		5th	10th	25th	50th	75th	90th	95th	5th	10th	25th	50th	75th	90th	95th
1	90th	97	97	98	100	101	102	103	52	53	53	54	55	55	56
	95th	100	101	102	104	105	106	107	56	57	57	58	59	59	60
	99th	108	108	109	111	112	113	114	64	64	65	65	66	67	67
2	90th	98	99	100	101	103	104	105	57	58	58	59	60	61	61
	95th	102	103	104	105	107	108	109	61	62	62	63	64	65	65
	99th	109	110	111	112	114	115	116	69	69	70	70	71	72	72
3	90th	100	100	102	103	104	106	106	61	62	62	63	64	64	65
	95th	104	104	105	107	108	109	110	65	66	66	67	68	68	69
	99th	111	111	113	114	115	116	117	73	73	74	74	75	76	76
4	90th	101	102	103	104	106	107	108	64	64	65	66	67	67	68
	95th	105	106	107	108	110	111	112	68	68	69	70	71	71	72
	99th	112	113	114	115	117	118	119	76	76	76	77	78	79	79
5	90th	103	103	105	106	107	109	109	66	67	67	68	69	69	70
	95th	107	107	108	110	111	112	113	70	71	71	72	73	73	74
	99th	114	114	116	117	118	120	120	78	78	79	79	80	81	81
6	90th	104	105	106	108	109	110	111	68	68	69	70	70	71	72
	95th	108	109	110	111	113	114	115	72	72	73	74	74	75	76
	99th	115	116	117	119	120	121	122	80	80	80	81	82	83	83
7	90th	106	107	108	109	111	112	113	69	70	70	71	72	72	73
	95th	110	111	112	113	115	116	116	73	74	74	75	76	76	77
	99th	117	118	119	120	122	123	124	81	81	82	82	83	84	84
8	90th	108	109	110	111	113	114	114	71	71	71	72	73	74	74
	95th	112	112	114	115	116	118	118	75	75	75	76	77	78	78
	99th	119	120	121	122	123	125	125	82	82	83	83	84	85	86
9	90th	110	110	112	113	114	116	116	72	72	72	73	74	75	75
	95th	114	114	115	117	118	119	120	76	76	76	77	78	79	79
	99th	121	121	123	124	125	127	127	83	83	84	84	85	86	87
10	90th	112	112	114	115	116	118	118	73	73	73	74	75	76	76
	95th	116	116	117	119	120	121	122	77	77	77	78	79	80	80
	99th	123	123	125	126	127	129	129	84	84	85	86	86	87	88
11	90th	114	114	116	117	118	119	120	74	74	74	75	76	77	77
	95th	118	118	119	121	122	123	124	78	78	78	79	80	81	81
	99th	125	125	126	128	129	130	131	85	85	86	87	87	88	89
12	90th	116	116	117	119	120	121	122	75	75	75	76	77	78	78
	95th	119	120	121	123	124	125	126	79	79	79	80	81	82	82
	99th	127	127	128	130	131	132	133	86	86	87	88	88	89	90
13	90th	117	118	119	121	122	123	124	76	76	76	77	78	79	79
	95th	121	122	123	124	126	127	128	80	80	80	81	82	83	83
	99th	128	129	130	132	133	134	135	87	87	88	89	89	90	91
14	90th	119	120	121	122	124	125	125	77	77	77	78	79	80	80
	95th	123	123	125	126	127	129	129	81	81	81	82	83	84	84
	99th	130	131	132	133	135	136	136	88	88	89	90	90	91	92
15	90th	120	121	122	123	125	126	127	78	78	78	79	80	81	81
	95th	124	125	126	127	129	130	131	82	82	82	83	84	85	85
	99th	131	132	133	134	136	137	138	89	89	90	91	91	92	93
16	90th	121	122	123	124	126	127	128	78	78	79	80	81	81	82
	95th	125	126	127	128	130	131	132	82	82	83	84	85	85	86
	99th	132	133	134	135	137	138	139	90	90	90	91	92	93	93
17	90th	122	122	123	125	126	127	128	78	79	79	80	81	81	82
	95th	125	126	127	129	130	131	132	82	83	83	84	85	85	86
	99th	133	133	134	136	137	138	139	90	90	91	91	92	93	93

Modified from Task Force on High Blood Pressure in Children and Adolescents [7]. Boxed area corresponds to reference values of boys 16 years or older in which the reference values for adults are recommended. BP, blood pressure.

microalbuminuria [22–24]. Likewise, in children with chronic kidney disease (CKD) proteinuria correlates with BP, and strict BP control leads to a decrease in proteinuria and a slowing of the progression of CKD [25]. Therefore, assessment of early organ damage, as a measurement of the clinical consequences of increased BP, is essential for HTN management in youth (the Searching for target organ damage section).

Monitoring organ damage in children and adolescents with elevated BP is even more important as the cardiovascular/renal sequelae of childhood-onset HTN may not become clinically relevant before adulthood. Prospective studies have shown that elevated BP in adolescence is associated with both subclinical dysfunction of the left ventricle (LV) in the fifth decade of life and increased arterial stiffness [26–29]. Similarly, young adults with

greater pulse wave velocity (PWV) had steeper increases of BP and visceral obesity from the age of 13 years [30].

EPIDEMIOLOGY

Prevalence

As the definition of HTN in children is based on BP values greater than the 95th percentile in normal healthy individuals, the prevalence of HTN should be around 5%. This rarely happens, however, probably because the normative values used are limited to the USA and may not exactly apply to other part of the world, or because the normative data are more than 20 years old, and the current epidemics of overweight and obesity may have changed the matter. Furthermore, despite the number of studies that have been performed, the prevalence of pediatric HTN worldwide is difficult to establish also because of the regional differences in the definition, the distribution of reference BP data and the methods of BP measurement. Central-European studies showed the prevalence of HTN in adolescents to be 2.2% in Switzerland, 2.5% in Hungary and 4.9% in Poland [31–33]. The data from Southern Europe identified higher prevalence; adolescent HTN was estimated as 9% in Turkey, 12% in Greece and 13% in Portugal [34–36]. After the age of 10, primary HTN is the predominant form [37], and in the majority of the adolescent hypertensive patients, 81% were ISH [31]. For European prevalence, see Table 4.

The obesity epidemic in children and adolescents makes it plausible that prevalence rates of HTN are increasing overtime [38]. HTN was found in 1.4% of normal weight, 7.1% of overweight and 25% of obese adolescents [39]. The relative risk of HTN for overweight patients is 3.26 (CI: 2.5–4.2) [40] and based on a multiple regression model – apart from sex – BMI is the strongest determining factor of adolescent BP [32]. A recent study reported the prevalence of HTN in overweight or obese 6–18-year-old patients, to range between 27 and 47%, according to different reference values [41].

Incidence

Reports on incidence of HTN in childhood are mainly concerned with progression from high-normal BP to HTN among adolescents and on the incidence of HTN in children from groups at risk of cardiovascular disease, such as masked HTN, type 2 diabetes mellitus (DM2), obesity or repaired coarctation of aorta (CoA). In a general population

of adolescents, 10–19 years, the rate of progression from normotension to HTN was 0.4/100 patients/year, and among those who had high-normal BP, it was 1.1/100 patients/year [42]. In another study on normotensive children with a mean follow-up of 35 months, the incidence of sustained HTN was 0.6/100 patients/year [43]. In the same study, masked hypertensive patients had an incidence of sustained HTN of 7/100 patients/year, the risk being higher in boys than in girls [43]. The incidence in adolescents with T2D was estimated at 4/100 patients/year [44]. Obese children aged 3–11 had a two-fold increased risk of developing HTN than normal weight children, whereas those with severe obesity had a more than four-fold increased risk [45]. After successful repair of CoA, the incidence rate was found to be 1.3/100 patients/year [46].

Family aggregation and genetics

There is extensive evidence from family studies that BP is moderately heritable with 15–40% of office SBP and 15–30% of office DBP explained by variation in genetic factors [47]. Ambulatory BP appears more heritable with 69 and 51% for the ambulatory night-time systolic and DBP, respectively [48]. A recent analysis of BP heritability in families of the Gubbio population followed-up for 25 years shows that also the SBP/DBP variation with aging has a genetic component (33–43% for SBP and 24–25% for DBP) with a much smaller component (4–17%) because of shared environment [49]. These findings suggest that BP is a complex, polygenic trait with no single gene exerting a predominant effect on the trait. However, we are also aware of several rare syndromes with classic Mendelian inheritance, which present with very high or low BP early in life [50]. The discovery of genes responsible for these monogenic syndromes has highlighted the importance of the kidneys and the adrenal glands in BP regulation as well as indicating efficacious treatments driven by the understanding of molecular pathophysiology of each of these rare syndromes. Furthermore, family screening is now available in national reference laboratories. In summary, HTN is a polygenic trait with the rare syndromes representing the extreme end of the BP distribution [51].

Ethnic minorities

Childhood BP, particularly ambulatory BP measurement (ABPM), remains seriously understudied in ‘ethnic minorities’, meaning descendants of ‘non-Europeans’,

TABLE 4. European studies of hypertension prevalence in children and adolescents

Reference	Patients (n)	Origin	Age range and/or mean age (years)	Methods	Readings (n)	Prevalence (%)
Chiolero et al. [31]	5207	Region of Switzerland	12.3	Oscillometric	Three visits to confirm high blood pressure	2.2
Katona et al. [32]	10 194	Debrecen, Hungary	15–18, 16.6	Oscillometric	Three visits to confirm high blood pressure	2.5
Ostrowska-Nawarycz and Nawarycz [33]	25 309	Tódz, Poland	7–18	Auscultatory method	Separate visits to confirm high blood pressure	4.9
Akgun et al. [34]	1963	Van, Turkey	7–16	N/A	Single visit	9
Maldonado et al. [36]	5381	Portugal	4–18, 12.5	Oscillometric	Single visit	13
Flechtner-Mors et al. [41]	57 915 (overweight or obese)	A total of 188 centers from Germany, Austria and Switzerland	6–18	Oscillometric or auscultatory method	Median blood pressure of 6 weeks	22

generally South Asian, sub-Saharan African or African-Caribbean by origin in Europe, as well as among refugee children [52]. Despite the lack of direct evidence, the latter are likely to have higher or potentially much higher BP values. Without evidence, the standard guidelines have to apply to ethnic minorities children, with safeguards for generational time since (parental) migration. Ethnic minority children may well have been born smaller, possibly from more frequent hypertensive/preeclamptic pregnancies, so at greater cardiovascular risk themselves.

DIAGNOSTIC EVALUATION

Blood pressure measurement

Office BP measurement has provided the basis for the present knowledge of the potential risk associated with HTN and has guided patient management for many years. Although office BP should be used as a reference, BP values obtained out-of-office may improve the evaluation in untreated and treated patients. In addition, in the last years, the assessment of central BP has been introduced.

Office blood pressure

The main issue about how to measure BP in children is whether to use the auscultatory or the oscillometric method. In the auscultatory method, Korotkoff sounds are used to assess SBP (K1) and DBP (K5) while deflating the cuff [1]. Oscillometric devices measure mean BP directly from the point of maximum oscillation; neither SBP nor DBP are measured directly, but are calculated using an algorithm-based on a putative relationship between the oscillations. If an oscillometric method is applied, the monitor should have passed the validation procedure recommended by the British Hypertension Society [53], the American Association for the Advancement of Medical Instrumentation [54] or the ESH International Protocol [55]. Few oscillometric devices for office, home or ambulatory BP monitoring have been successfully validated using an established protocol in children. Continuously updated information on monitor validation for children is found at www.dableducational.org. It should be noted, however, that available reference values for defining BP categories (Tables 2 and 3) have been obtained by the auscultatory method. Values obtained with oscillometric equipment are considerably higher than the auscultatory ones. Therefore, if HTN is detected by the oscillometric method, it must be confirmed by the auscultatory one. After the recommendations of the 2009 ESH Guidelines, recent studies have been conducted to develop reference values using oscillometric devices [56–58]. Unfortunately, the heterogeneity of the studies does not allow pooling of the information. The specific recommendations for office BP measurement in children and adolescents are shown in Table 5.

Ambulatory blood pressure

ABPM is now increasingly recognized as providing extremely useful information for the diagnosis and management of HTN and has contributed significantly to our understanding of HTN by ‘unmasking’ BP phenomena that were not readily apparent using office BP. BP measurement in the more meaningful context of daily real-life conditions,

TABLE 5. Recommendations for office blood pressure measurement

To make sure the patient is sitting or relaxed for 3–5 min before beginning blood pressure measurements
To use the appropriate cuff size according to bladder width (40% of the arm circumference) and length (4 cm × 8 cm, 6 cm × 12 cm, 9 cm × 18 cm, 10 cm × 24 cm), to cover 80–100% of the individual's arm circumference
To measure blood pressure three times with an interval of 3 min between measurements and use the average of the last two
The auscultatory method is recommended and phase I and V (disappearance) Korotkoff sounds are used to identify SBP and DBP, respectively
If the oscillometric method is used, the model used needs to be validated. If hypertension is detected by the oscillometric method, it needs to be confirmed using the auscultatory method
Children from 3 years of age who are seen in a medical setting should have their blood pressure measured. In younger children, blood pressure should be measured under special circumstances that increase the risk for hypertension: under neonatal conditions requiring intensive care, congenital heart disease, renal disease, treatment with drugs known to raise blood pressure and evidence of elevated intracranial pressure
To measure blood pressure in both arms at first visit to detect possible differences. In this instance, take the arm with the higher value as the reference

not just in the artificial environment of the physician's office and clinic, has allowed much more in-depth investigation of BP. Values obtained using 24-h ABPM have some better relationship with the presence of organ damage and a higher reproducibility than those obtained using office BP [59].

Average daytime and night-time BP can be calculated on the basis of the reported times of getting up and going to bed, or using fixed time periods (daytime from 0800 to 2200 h, night-time from midnight to 0600 h), in which the rising and retiring periods – which differ from individual to individual – are eliminated. For recommended methodology, the reader is referred to the guidelines of ABPM of the ESH [60].

A positive correlation exists between ambulatory and office BP for both systolic and DBP in normotensive children, even though ambulatory BP values are generally higher than their office BP counterparts. The higher ambulatory BP in normotensive children is reversed when monitoring hypertensive patients [61], a behavior similar to that observed in the adult population, in which the difference between office and ambulatory BP gradually diminishes the lower is office BP, until for SBP values of about 120 mmHg also in adults ambulatory becomes higher than office BP [61,62]. Although the higher ambulatory than office BP in normotensive children has been attributed, at least in part, to physical activity, additional reasons may reside in the different method of measuring BP [61], the algorithm used to calculate systolic and DBP from the maximal amplitude [63] and the phenomenon of regression to the mean [61].

The clinical interpretation of 24-h ABPM depends on the use of normal BP ranges as reference values. These have now been obtained from different European populations (Tables 6–9) but were not obtained in parallel with the office BP values available, as they come from different populations, countries and years. Based on the arguments discussed in the ‘Classification of hypertension’ section, the consensus of the present Guidelines is that the 95th percentile can be used as a threshold for HTN in children and

TABLE 6. Systolic and diastolic ambulatory blood pressure (SBP/DBP) values for age (boys)

Age (years)	Boys											
	24-h				Day				Night			
	50th	75th	90th	95th	50th	75th	90th	95th	50th	75th	90th	95th
5	105/65	109/69	113/72	116/74	111/72	116/76	120/79	123/81	95/55	99/59	103/62	106/65
6	106/66	110/69	115/73	118/75	112/72	116/76	121/79	124/81	96/55	100/59	105/63	108/66
7	106/66	111/70	116/73	119/75	112/73	117/76	122/80	125/82	96/56	101/60	106/64	110/67
8	107/66	112/70	117/73	120/75	112/73	117/76	122/80	125/82	97/56	102/60	108/64	111/67
9	108/67	113/70	118/73	121/75	113/72	118/76	123/80	126/82	97/56	103/60	109/64	112/67
10	109/67	114/70	119/73	123/75	113/72	119/76	124/80	127/82	98/56	104/60	110/64	113/67
11	110/67	116/71	121/74	125/76	115/72	121/76	126/80	129/82	99/56	105/60	111/64	115/67
12	113/67	118/71	124/74	127/76	117/72	123/76	128/80	132/82	101/56	107/60	113/64	116/67
13	115/67	121/71	126/74	130/76	120/72	126/76	131/80	135/82	103/56	109/60	115/64	119/67
14	118/68	124/71	129/75	133/77	122/73	129/77	134/80	138/82	106/57	112/61	118/64	121/67
15	121/68	127/72	132/75	136/77	125/73	132/77	137/81	141/83	108/57	114/61	120/64	123/66
16	123/69	129/72	135/76	138/78	128/74	135/78	140/81	144/84	111/57	117/61	123/64	126/66

The values are in mmHg. Data from [183].

TABLE 7. Systolic and diastolic ambulatory blood pressure (SBP/DBP) values for age (girls)

Age (years)	Girls											
	24-h				Day				Night			
	50th	75th	90th	95th	50th	75th	90th	95th	50th	75th	90th	95th
5	103/66	108/69	112/72	115/74	108/73	114/77	118/80	121/82	95/56	100/61	105/66	108/69
6	104/66	109/69	114/72	116/74	110/73	115/77	120/80	122/82	96/56	101/61	106/65	110/68
7	105/66	110/69	115/72	118/74	111/72	116/77	121/80	123/82	96/56	102/60	107/65	111/67
8	107/66	112/69	116/72	119/74	112/72	117/76	122/80	124/82	97/55	103/60	108/64	112/67
9	108/66	113/70	117/73	120/74	112/72	118/76	122/80	125/82	98/55	103/59	109/64	112/67
10	109/66	114/70	118/73	121/75	113/72	119/76	123/79	126/81	98/55	104/59	110/64	113/67
11	110/66	115/70	119/73	122/75	114/72	120/76	124/79	127/81	99/54	105/59	110/63	114/66
12	111/67	116/70	120/74	123/76	115/72	121/76	125/80	128/82	100/54	105/59	110/63	114/66
13	112/67	117/71	121/74	124/76	116/72	122/77	126/80	129/82	101/54	106/59	111/63	114/66
14	113/67	118/71	122/74	125/76	118/73	123/77	127/80	130/82	101/55	106/59	111/63	114/65
15	114/68	118/71	123/75	125/77	119/73	124/77	128/80	130/82	102/55	107/59	111/63	114/65
16	115/68	119/71	123/75	126/77	120/74	124/77	129/80	131/82	103/55	107/59	111/63	114/65

The values are in mmHg. Data from [183].

TABLE 8. Systolic and diastolic ambulatory blood pressure (SBP/DBP) values for height (boys)

Height (cm)	Boys											
	24-h				Day				Night			
	50th	75th	90th	95th	50th	75th	90th	95th	50th	75th	90th	95th
120	105/66	109/70	114/74	117/77	111/72	116/77	122/80	125/82	94/54	99/58	103/61	106/63
125	105/66	110/70	115/74	118/77	111/72	117/76	122/80	125/82	95/55	100/58	105/61	108/63
130	106/66	111/70	116/74	119/77	112/72	117/76	122/80	126/82	96/55	101/59	106/62	110/64
135	107/66	112/70	117/74	120/77	112/72	117/76	123/80	126/82	97/56	102/59	108/63	111/65
140	108/67	113/71	118/75	121/77	113/72	118/76	123/80	126/82	98/56	104/60	109/63	113/65
145	110/67	115/71	120/75	123/77	114/72	119/76	124/79	127/81	99/56	105/60	111/64	114/66
150	111/67	116/71	121/75	124/77	115/72	120/76	125/79	128/81	100/56	106/60	112/64	116/66
155	113/67	118/71	123/75	126/77	117/72	122/76	127/79	130/81	101/56	107/60	113/64	117/66
160	114/67	120/71	124/75	127/77	119/72	124/76	129/79	133/81	103/56	108/60	114/64	118/66
165	116/68	121/71	126/75	129/78	121/72	126/76	132/80	135/82	104/57	110/60	116/64	119/66
170	118/68	123/72	128/75	131/78	123/73	128/77	134/80	138/82	106/57	112/61	117/64	121/66
175	120/68	125/72	130/75	133/78	124/73	130/77	136/81	140/83	107/57	113/61	119/64	122/66
180	122/68	127/72	131/76	134/78	126/73	132/77	138/81	142/83	109/57	115/61	120/64	124/66
185	123/68	128/72	133/76	136/78	128/73	134/78	140/81	144/84	110/57	116/61	122/64	125/66

The values are in mmHg. Data from [183].

TABLE 9. Systolic and diastolic ambulatory blood pressure (SBP/DBP) values for height (girls)

Height (cm)	Girls											
	24-h				Day				Night			
	50th	75th	90th	95th	50th	75th	90th	95th	50th	75th	90th	95th
120	104/66	108/69	112/71	114/72	110/73	114/77	118/80	120/82	95/55	99/60	103/63	106/65
125	105/66	109/69	113/71	116/73	111/73	115/77	119/80	121/82	96/55	100/60	104/63	107/66
130	106/66	110/69	114/72	117/73	111/72	116/76	120/80	122/82	96/55	101/59	106/63	108/66
135	107/66	111/70	115/72	118/74	112/72	116/76	120/80	123/82	97/55	102/59	107/63	109/66
140	108/66	112/70	116/73	119/75	112/72	117/76	121/80	124/82	98/55	103/59	108/63	110/66
145	109/66	113/70	117/73	120/75	113/72	118/76	123/80	125/82	98/54	103/59	109/63	112/66
150	110/67	115/70	119/74	121/76	114/72	119/76	124/80	127/82	99/54	104/59	110/63	113/66
155	111/67	116/71	120/74	123/76	116/72	121/76	125/80	128/82	100/54	106/59	111/63	114/66
160	112/67	117/71	121/74	123/76	117/72	122/76	126/80	129/82	101/55	106/59	111/63	114/66
165	114/67	118/71	122/74	124/76	118/73	123/77	127/80	130/82	102/55	107/59	112/63	114/66
170	115/68	119/71	123/74	125/76	120/74	124/77	128/80	131/82	103/55	108/61	112/67	115/71
175	116/69	120/72	124/75	126/76	121/75	125/78	129/81	131/82	105/55	109/59	113/63	115/66

The values are in mmHg. Data from [183].

adolescents as long as the values are inferior to the accepted criteria for adults (24-h 130/80 mmHg; daytime 135/85 mmHg, night-time 125/75 mmHg).

The night-to-day BP ratio represents circadian variability because of the physiological nocturnal BP fall. BP normally decreases during the night – defined as ‘dipping’. Although the degree of night-time dipping has a normal distribution in a population setting, it is generally agreed that the finding of a nocturnal BP fall of more than 10% of daytime values (night-to-day BP ratio <0.9) can be accepted as an arbitrary cutoff to define patients as ‘dippers’, although one should bear in mind that the reproducibility of the dipping pattern is limited. Possible reasons for absence of dipping are sleep disturbance, obstructive sleep apnea (OSA), obesity, high salt intake in salt-sensitive patients, orthostatic hypotension, autonomic dysfunction, CKD, DM1 and DM2.

Recommendations for the use of 24-h ABPM are given in Table 10. They include measurements made with the purpose of diagnosis, evaluation during treatment as well as in

clinical trials and other conditions, in which the presence of orthostatism or rapid and episodic elevation of BP are difficult to detect in the office. Especially in children, 24-h ABPM should be recommended before starting antihypertensive treatment, to avoid treating with drugs children with ‘white-coat’ HTN.

Home blood pressure

Feasibility of home BP monitoring in children and adolescents has been reported in different ethnic populations [64–66]. Home BP correlates closely with daytime ambulatory BP values and has superior reproducibility to office BP, similar to that of ABPM [67]. Home BP is lower than daytime ambulatory BP in children and adolescents [65,68–70]. Some preliminary evidence exists that home BP in children correlates with target organ damage (TOD) better than office BP [71], and that it may also better reflect the effect of risk factors on BP, such as family history or obesity [66,72–73]. Two research groups reported good performance of home BP to diagnose white-coat HTN, but a low sensitivity and positive predictive value to predict masked HTN compared with ABPM [68,74]. Methodological aspects and recommendations for use of home BP are shown in Table 11. Home BP monitoring for 6–7 days, with duplicate morning and evening measurements is recommended,

TABLE 10. Recommendations for 24-h ambulatory blood pressure monitoring

<i>During the process of diagnosis</i>	
Confirm hypertension before starting antihypertensive drug treatment to avoid treatment of white-coat hypertension	
Target organ damage (LVH and microalbuminuria) and office BP normal (masked hypertension)	
DM1 and DM2	
CKD	
Renal, liver or heart transplant	
Severe obesity with or without sleep-disordered breathing	
Hypertensive response during the treadmill test	
Discrepancy between office BP and home BP	
<i>During antihypertensive drug treatment</i>	
Evaluate for apparent drug-resistant hypertension	
Assessment of BP control in children with target organ damage	
Symptoms of hypotension	
<i>Clinical trials</i>	
<i>Other clinical conditions</i>	
Autonomic dysfunction	
Suspicion of catecholamine-secreting tumors	

BP, blood pressure; CKD, chronic kidney disease; DM1, type 1 diabetes; DM2, type 2 diabetes; LVH, left ventricular hypertrophy.

TABLE 11. Home blood pressure monitoring

<i>Methodological aspects</i>	
Measured daily on at least 3–4 days, preferably on 7 consecutive days in the mornings as well as in the evenings	
Measured in a quiet room, with the patient in the seated position, back and arm supported, after 5 min of rest	
Two measurements per occasion taken 1–2 min apart	
Home blood pressure is the average of these readings, with exclusion of the first monitoring day	
<i>Clinical indications for use</i>	
All patients receiving antihypertensive medication	
Suspicion of white-coat hypertension	
Conditions where strict blood pressure control is mandatory (high-risk patients)	
Clinical trials	

Methodological aspects and clinical indications for use.

TABLE 12. Systolic and diastolic home blood pressure values (SBP/DBP)

Height (cm)	Percentiles for boys (n = 347)		Percentiles for girls (n = 420)	
	50th	95th	50th	95th
120–129	105/64	119/76	101/64	119/74
130–139	108/64	121/77	103/64	120/76
140–149	110/65	125/77	105/65	122/77
150–159	112/65	126/78	108/66	123/77
160–169	115/65	128/78	110/66	124/78
170–179	117/66	132/78	112/66	125/79
180–189	121/67	134/79	114/67	128/80

The values are in mmHg. Data from [64].

as most available studies in children used a schedule of at least 6-day monitoring. A 3-day monitoring was found to be the minimum reliable schedule against 6-day readings [75].

One school-based study provided the only normalcy data for home BP in children and adolescents (Table 12) [64]. The criteria to define HTN based on home BP is BP being higher than or equal to 95th percentile for sex and height, as long as the values are inferior to the criteria accepted for adults (average 135/85 mmHg). Several issues about the clinical application of the method, including validated devices, remain underinvestigated.

White-coat and masked hypertension

White-coat HTN is defined as elevated BP in office, yet normal being elsewhere. The reported frequency of white-coat HTN varies, perhaps as a result of the criteria used to establish the diagnosis, ranging from 1 to 44% [76]. At present, no long-term follow-up data are available for children with white-coat HTN at initial assessment, to know the reproducibility and the real impact of this condition. Hence, it remains to be clarified whether white-coat HTN is an innocuous phenomenon or a prelude to future sustained HTN.

The inverse phenomenon, masked HTN, defined as normal BP in the office but elevated BP outside the office, occurs in approximately 10% of children and adolescents [74,77–80]. The persistence and clinical significance of the phenomenon has shown that in 40% of children, the abnormal elevation of the daytime ambulatory BP persisted over a minimum of 6 months [79]. Masked HTN has been linked with progression to HTN in youth, with the risk being higher in boys than in girls [43]. Masked HTN warrants follow-up, and if it persists, left ventricular mass (LVM) should be assessed.

Central blood pressure

Mean and DBP are nearly constant throughout the arterial tree, but SBP varies, with peripheral higher than central or aortic SBP (cSBP) [81]. Compared with adults, this phenomenon differs significantly in children, whose SBP amplification is substantial, a mean ~20 mmHg, almost twice as in adults [82]. If cSBP relates more closely than peripheral SBP to TOD, including LVH, as some claim in adults [83], it may be very useful clinically to estimate its values in children, but its benefit and independence from peripheral BP remains unknown. The recent publication of percentiles for cBP in children and adolescents, specific for sex and age

or height, has the potential for widespread clinical use and may provide additional information about vascular phenotype [84], if the method is correctly validated in children. Although a range of devices are now available to estimate cBP using different noninvasive techniques in adults, we need further data on agreement between these various devices.

The potential value of cSBP and central pulse pressure (cPP), in the assessment of adolescents with ISH, is a controversial issue. cBP may be especially relevant in asymptomatic children incidentally found to have isolated peripheral systolic HTN without TOD. In children and young adults at high risk of future adverse cardiovascular outcomes (e.g. with essential HTN or CKD), a research is needed on what factors determine systolic amplification as well as interventions that have differential impact on central rather than peripheral systolic pressure. Because of their high correlation, cBP will only offer incremental value over peripheral BP if cBP identifies TOD better.

Blood pressure during exercise

The BP response during physical exercise has been suggested for that diagnostic assessment of BP in children. Longitudinal studies have shown that SBP or the calculated heart rate and SBP product during exercise are positively associated with future resting BP, even independent of resting SBP and other cardiovascular risk factors [85,86]. An exaggerated BP response to treadmill exercise has been observed in children with white-coat HTN [87]. Likewise, an exaggerated SBP during exercise has also been reported in children at risk for early damage in vascular structure and functioning [88–90]. To establish the clinical usefulness of BP response to exercise testing in children and adolescents with HTN, a larger body of data is needed. Even though reference values for SBP during exercise are now available, they are restricted to the age range 12–16 years [91]. The ESH Guidelines in adults suggest performing 24-h ABPM in patients with a hypertensive response during the treadmill test searching for the possible presence of masked HTN [92]. Even though evidence in youth is lacking, this recommendation can be applied in adolescents.

Family and clinical history

Family and clinical history should precede further diagnostic evaluation of HTN in children and adolescents to allow a targeted-individualized approach and avoid inappropriate,

TABLE 13. Family and clinical history

<i>Family history</i>	
Hypertension	
Diabetes	
Dyslipidemia	
Cardiovascular disease	
Hereditary renal disease (polycystic kidney disease and Alport syndrome)	
Hereditary endocrine disease (adrenal tumors, glucocorticoid-remediable aldosteronism, multiple endocrine neoplasia type 2 and monogenic syndromes of hypertension)	
Syndromes associated with hypertension (neurofibromatosis)	
<i>Clinical history</i>	
1. History or symptoms of secondary hypertension	
Perinatal history: oligohydramnios, anoxia, umbilical artery catheterization and renal artery/vein thrombosis	
Underlying or concurrent diseases	
Renal or urologic disease, trauma, recurrent urinary tract infections, edema, weight loss, failure to thrive, thirst/polyuria, nocturia and hematuria	
Cardiac, endocrine, or neurological disease, cold extremities, intermittent claudication, palpitations, sweating, fever, pallor, flushing, muscle weakness, cramps, virilization, primary amenorrhea, male pseudo-hermaphroditism and skin abnormalities	
Systemic disease (lupus erythematosus)	
Drug/substance intake: steroids, calcineurin inhibitors, TCAs, decongestants, oral contraceptives, amphetamines and cocaine	
2. History or symptoms of target organ damage	
Headache, epistaxis, vertigo, visual impairment, facial palsy, seizures, strokes, low school performance, dyspnea, chest pain, palpitations and syncope	
<i>Risk factors</i>	
Diabetes mellitus	
Dyslipidemia	
Obesity and growth patterns	
Physical exercise and dietary habits	
Smoking and alcohol	
Birth weight and gestational age	
Snoring and sleep apnea history	
<i>Hypertension onset and management</i>	
Age at presentation	
Previous blood pressure measurements	
Past and current treatment	
Compliance-adverse effects	

expensive and invasive tests. Family history of HTN or cardiovascular disease may identify children and adolescents with essential HTN, but history of hereditary diseases associated with secondary forms of HTN should also be relevant [1,37]. Parental history of HTN has been associated with masked HTN, early TOD, changes in central and peripheral hemodynamics and can guide further evaluation [79,93–95]. A complete clinical history assessment may include information summarized in Table 13.

Birth weight

The importance of intrauterine and early life events in development of cardiometabolic disease in adult life has been underlined [96–100]. The time immediately before and after birth may be a sensitive period in which multiple interactions between hemodynamic and metabolic parameters foreshadow the clustering of cardiometabolic risk factors later in life [101,102]. A critical window of opportunity to modify programming may exist during pregnancy and throughout the first years of life when strategies aiming to reduce risk can be implemented. This is an expanding area for promising further investigation.

Physical examination

All children identified as having HTN should have their height and weight measured and classified by percentiles. Other than the findings of HTN itself and obesity, physical examination in children with HTN is mostly normal. Nevertheless, a careful examination is mandatory to identify features of disorders that may be the cause of secondary HTN as well as identifying evidence of end-organ damage (Table 14).

TABLE 14. Physical examination

Organ system/finding	Causative factor for hypertension	Sequelae of hypertension
General	Poor growth, pallor; CKD	
	Edema	
	Obesity	
	Cushingoid features	
	Features of Turner, William, Marfan, Klippel–Trenaunay–Weber, Feuerstein–Mims, von Hippel–Lindau and multiple endocrine neoplasia syndromes	
Skin	Rash; SLE, vasculitis	
	Neurofibromas, axillary freckling	
	Acanthosis nigricans	
	Pseudoxanthoma elasticum	
Eye	Congenital adrenal hyperplasia	
	Cataract; corticosteroids	Hypertensive retinopathy
	Hemangioblastoma; von Hippel–Lindau	
Abdomen	Proptosis; hyperthyroidism	
	Mass; Wilms tumor, neuroblastoma, pheochromocytoma, recessive or dominant polycystic kidney disease, multicystic dysplastic kidney, obstructive uropathy and acute renal venous thrombosis	
	Hepatosplenomegaly; recessive polycystic kidney disease	
Neurological		Cranial nerve palsy (particularly IIIrd and Vth cranial nerves)
Cardiovascular		Hemiparesis/other evidence of stroke
	Cardiac murmur (coarctation, aortic stenosis)	LV enlargement
	Bruit over flanks (renal artery), abdomen, back, neck and head	LV failure
	Weak femoral pulses, interscapular bruit (coarctation, mid-aortic syndrome)	
Genitalia	Tachycardia (pheochromocytoma)	
	Virilization (congenital adrenal hyperplasia)	

CKD, chronic kidney disease; LV, left ventricular; SLE, systemic lupus erythematosus.

TABLE 15. Laboratory investigation and imaging studies

Laboratory tests	Comments
<i>Routine laboratory tests to be performed in all children with hypertension</i>	
Plasma creatinine, urea, electrolytes and uric acid	
Fasting plasma glucose	
Plasma cholesterol (total, HDL and LDL) and triglycerides	
Urinalysis and culture	Microscopy for red cell casts indicative of glomerular disease; white cell casts indicative of interstitial disease
Quantification of albuminuria (albumin : creatinine ratio) proteinuria (protein : creatinine ratio)	
<i>Echocardiography</i>	
<i>Renal ultrasonography</i>	
<i>Additional laboratory tests in specific circumstances</i>	
PRA and aldosterone	Renovascular hypertension (high PRA), primary hyperaldosteronism (PRA is very low in mineralocorticoid-related diseases and there may be associated hypokalemia)
Urine and plasma catecholamines or metanephrines	Pheochromocytoma, extra-adrenal catecholamine producing tumors
Urinary free cortisol	Cushing syndrome
Urinary steroid profiles and more complex endocrine investigations	
Plasma cortisol, ACTH, 24 h urinary free cortisol	
Molecular genetic studies e.g. apparent mineralocorticoid excess*, Liddle syndrome*, glucocorticoid-remediable aldosteronism*, hypertensive forms of congenital adrenal hyperplasia (11 β -hydroxylase deficiency, 17 α -hydroxylase deficiency, neurofibromatosis, von Hippel–Lindau and multiple endocrine neoplasia syndromes)	*Monogenic causes of hypertension (suspect where low renin hypertension and family history of early onset severe hypertension/death from cerebrovascular events and refractory hypertension)
Thyroid function tests: FT4 and TSH	Thyrotoxicosis
Plasma deoxycorticosterone and corticosterone, 18-hydroxycorticosterone, 18-hydroxy deoxycorticosterone and 11 deoxycortisol	Congenital adrenal hyperplasia
Drug levels	Identify drugs that may cause hypertension e.g. amphetamines, ecstasy

ACTH, adrenocorticotropic hormone; FT4, thyroxine; PRA, Plasma renin activity; TSH, Thyroid-stimulating hormone.

Laboratory investigation

Routine laboratory tests and imaging studies must be performed in all children with HTN. Other additional tests are necessary in specific conditions (Table 15).

Genetic analysis

Genetic analysis merits a specific comment even if it has not yet been demonstrated to have a clear role to play in the routine assessment of children with HTN.

The human genome project in 2001 led the way to large-scale genomic studies in populations.

The current list of known variants contributing to genetic architecture of BP and HTN includes more than 25 rare mutations and 53 single nucleotide polymorphisms, as recently reviewed [51]. It is now possible to use whole genome DNA sequencing or exome sequencing to diagnose rare monogenic syndromes although more traditional single gene PCR-based tests are also used successfully.

Monogenic causes of HTN are rare, but they should be detected during the pediatric age, for successful treatment and avoidance of the HTN-associated morbidity and mortality. The monogenic HTN syndromes are good examples of perfect pharmacogenetic, in which the knowledge of the functional genetic mutation allows for targeted therapy. All currently known monogenic causes of HTN are characterized by abnormal sodium transport in the kidney, volume expansion and low renin. Among them, Liddle's syndrome, glucocorticoid-remediable aldosteronism, apparent mineralocorticoid excess, Gordon's syndrome, mineralocorticoid receptor hypersensitivity syndrome and hypertensive forms of congenital adrenal hyperplasia have been identified [1]. Monogenic diseases should be suspected in children with low renin HTN and a family history

of early-onset severe HTN, death from cerebral vascular accidents and heart failure or refractory HTN. Hypokalemia is a common feature of the majority of low renin HTN stated with the exception of Gordon's syndrome.

Searching for target organ damage

Once HTN is confirmed, organ-damage evaluation should be assessed due to the importance of subclinical organ damage as an intermediate stage in the continuum of vascular disease. Subsequently, evaluation of organ damage is also useful as an intermediate endpoint for monitoring treatment. A summary of the criteria to define HTN-induced organ damage can be found in Table 16.

Heart

Assessment of LVM and geometry remains a cornerstone when looking for end organ damage in sustained pediatric

TABLE 16. Criteria to define hypertension-induced organ damage

<i>LVH</i>	LVH should be defined as LVMI or RWT \geq 95th percentile by age and sex [107–109]
<i>Carotid intima thickness</i>	cIMT \geq 95th percentile by age and sex [113,114]
<i>PWV</i>	PWV \geq 95th percentile by age and sex [84,123,124]
<i>Kidney</i>	Albuminuria (as measured by urinary albumin/creatinine quotient $>$ 30 mg/g creatinine or $>$ 3 mg/mmol creatinine) or even proteinuria (as measured by urinary albumin/creatinine quotient ($>$ 300 mg/g creatinine or $>$ 30 mg/mmol creatinine) or by 24 h urinary protein excretion ($>$ 200 mg/m ² /day) [1]

cIMT, carotid intima media thickness; LVH, left ventricular hypertrophy; LVMI, left ventricular mass index; PWV, pulse wave velocity; RWT, relative wall thickness.

HTN [17,103]. Following the Joint European Association of Echocardiography and American Society of Echocardiography [104], LVM should be calculated using the cube formula [105] and indexed (LVMI) by height^{2.7} [106]. Traditionally, LVH has been defined as LVMI or relative wall thickness (RWT) at least 5th percentile by age and sex [107,108]. A recent article by Chinali *et al.* [109] suggest to use a simplified approach for the identification of LVH in infants, children and adolescents with a single-partition value across the whole age range. Using $LVM/[height]^{2.16}$ a single-partition value of $45\text{ g/m}^{2.16}$ and validated against a cohort of 130 healthy patients, no false positives for LVH were found.

The ratio of Doppler transmitral flow (E) and tissue Doppler derived early diastolic velocity (E'), reflecting diastolic function, independently predicts primary cardiac events in hypertensive adults [110]. Reference values of E/E' are poorly defined in children and adolescents. Nevertheless, if technically available, it is recommended to include it in the longitudinal follow-up of individual patients, and it most certainly should be included in future echocardiographic study protocols of hypertensive children and adolescents. A 12-lead ECG adds little to early detection of cardiac end-organ damage (LVH) because of its overall poor reliability in children [111,112].

Blood vessels

Improved imaging methods (high definition ultrasound and echotracking) have enhanced 'reference' values for cIMT and arterial distensibility in healthy children aged 3–18 years [113,114]. CIMT and distensibility, associated with age, anthropometry and BP are elevated in at-risk children with familial hypercholesterolemia [115,116], overweight [117,118], HTN [119,120] and type 1 diabetes (DM1) [121].

Arterial stiffening measured by PWV predicts cardiovascular events and mortality in adults [122]. Reference values for PWV are now available from three studies that have been performed in childhood [84,123,124]. Overall, the current data suggest childhood BP only variably predicts increased PWV [125–127]. The emerging data suggest that functional changes in large vessels are the earliest detectable findings in children, for example in those with familial hypercholesterolemia and CKD [128,129].

Routine assessment of arterial stiffness and central BP parameters are not currently recommended, and they should be maintained as a research area until further information is available.

Kidney

High BP itself may affect kidney function by inducing albuminuria (albumin/creatinine quotient $>30\text{ mg/g}$ creatinine or $>3\text{ mg/mmol}$ creatinine) or even proteinuria ($>300\text{ mg/g}$ creatinine or $>30\text{ mg/mmol}$ creatinine or 200 mg/m^2 per day) [130]. Hematuria, proteinuria and edema formation indicate glomerular damage, but also failure to thrive, polyuria and polydipsia are symptoms of renal disease.

Full blood count, plasma sodium, potassium and calcium, urea, creatinine, uric acid and urinalysis (hematuria, proteinuria and leukocyturia) and quantitative measurement of albuminuria and proteinuria should be

performed in all children with HTN [1,7]. Reduced glomerular filtration rate (GFR in ml/min per 1.73 m^2) should be estimated according to Schwartz formula and permanently (>3 months) reduced estimated GFR indicates renal damage.

Renal imaging by renal ultrasound is required in every child with HTN to exclude Wilms tumor, neuroblastoma and renal cystic diseases or dysplasia. Reduced renal perfusion by renal artery stenosis or by mid-aortic stenosis increases BP and can be detected by renal Doppler ultrasound, magnetic resonance tomography or direct renal angiography, the gold standard [131].

Fundoscopy

The data on incidence, findings and prognosis of hypertensive retinopathy (HTNR) in children are scarce [132]. American children with essential HTN had HTNR based on arteriolar narrowing in fundus photographs and fluorescein angiography in 51% of 97 children [133]. This was not the case when HTNR was examined by an ophthalmologist and assessed by dilated ophthalmoscopy; only three of 35 (8.6%) had mild HTNR [134]. In a British sample, seven of 39 children (18%) had HTNR, six with severe disease (hemorrhages, exudates and disc edema) and some with permanent visual reduction [135]. Fundoscopy should likely be limited to children with symptoms, encephalopathy or malignant HTN.

Brain

Sustained and severe high BP may affect the brain by various symptoms and signs (cerebral seizures, stroke, visual impairment and retinal vascular changes) [136]. Then, neurologic clinical evaluation and diagnostic procedures, for example electroencephalography, ultrasonography during infant age, and by cranial computed tomography (CT), to exclude intracranial hemorrhage, need to be performed. Severe acute HTN causes a hypertensive emergency with specific symptoms (headache, visual impairment, dizziness, impaired consciousness, seizures or neurological deficits, e.g. facial nerve paresis). In these cases, MRI is required, which is able to identify small silent brain infarcts, microbleeds, white matter lesions and posterior reversible encephalopathy syndrome (PRES) [137].

Biomarkers

Biomarkers could be considered as tools to stratify the risk of patients at an individual level and/or to serve as surrogate endpoints of cardiovascular events [138].

A biomarker should be tested against stringent criteria including a proof of concept, prospective validation, incremental value, clinical utility, clinical outcomes, cost-effectiveness and reference values [139]. Biomarkers which fulfill most of the above criteria currently are not available today.

The most likely scenario is that the emerging disruptive technologies such as genomics, proteomics and metabolomics would change the way we use biomarkers. Instead of a search for one perfect biomarker, we would rely on hundreds or even thousands of molecular markers considered jointly to pave the way for the development of precision medicine [140].

COMORBIDITIES

Obesity and metabolic syndrome

Childhood obesity is the most common nutritional problem in developed and developing countries, and its prevalence in children has doubled since the mid-1980s [141–143] reaching pandemic proportions and increasing not only in prevalence but also in severity. According to the WHO, 42 million children under the age of 5 were overweight or obese worldwide in 2013 [144]. The increasing tendency for obesity to appear during childhood and to track into adult life, as well as the firmly established relationships between obesity, DM2 and HTN in adults, means that obese children appear to be at particularly high risk of becoming diabetic and hypertensive as they age [145,146].

Identifying children most at risk for the development of future hypertensive disease is as important as assessing BP's association with other cardiometabolic risk factors. A process of clustering may occur when high BP acts together with one or more cardiometabolic risk factors, hyperinsulinemia and lipid abnormalities, producing TOD and cardiometabolic disease [6]. Although the clustering in adults has been labeled as 'the metabolic syndrome', a consensus definition has been difficult to reach also for the pediatric population. Several definitions of metabolic syndrome have been proposed using not only different parameters but also different cutoffs. Moreover, as insulin resistance, the major driver of metabolic syndrome, is influenced by pubertal stage, it is questionable to use definitions that do not take into account pubertal status in pediatric age. As a consequence, a widely variable prevalence of between 6 and 39% has been reported. High normal BP and HTN are frequently associated with one or more cardiometabolic risk factors [147]. Therefore, lifestyle changes, particularly weight loss and increased physical exercise, are recommended for all individuals. For antihypertensive treatment see the 'Metabolic syndrome' section for specific recommendations.

Diabetes mellitus

In young people, both DM1 and DM2 are increasing in prevalence. The correct diagnosis of DM1 and DM2, and monogenic diabetes mellitus is important because it helps to guide therapy; however, distinguishing between DM1 and DM2 in children can be difficult as autoantibodies and ketoacidosis may be present in patients with features of DM2 (including obesity and acanthosis nigricans) [148]. Compared with antibody negative, antibody positive DM2 are less overweight, have lower BP, better lipid profile and are more likely to be men [149]. Youth-onset DM2 occurs at a much greater prevalence in those of non-White European descent (Africans, native North Americans, Hispanics, Asians and Pacific islanders) and in Japan, Hong Kong and Taiwan where more than 60% of youth-onset diabetes is DM2. In contrast to the USA and Europe, where nearly all youths with DM2 are overweight/obese, in Asia they are often normal weight [149].

The prevalence of elevated BP is generally higher in youths with DM2 than DM1 (16–36% vs 4–16%) and reduced nocturnal dipping may also be identified. Higher BP levels predispose to the development of microalbuminuria, nephropathy, HTNR, and carotid thickening and

significant comorbidities may already be present at the time of DM2 diagnosis [150,151]. The determinants of BP levels in children with diabetes include poor diet, adiposity, diabetes-related autonomic imbalance and poor glucose control [152].

The Search for Diabetes in Youth Study described the prevalence of elevated BP, awareness, treatment, and control in 3691 children with DM1 and 410 with DM2, who attended a visit from 2001 to 2010 [150]. Compared with youths with DM1, those with DM2 were older and more likely women, had an older age at diagnosis, were more likely to be obese (26.5 vs 11.1%) and belong to ethnic minorities (19–76% vs 2.9%). Likewise, they had significantly higher SBP and DBP, lower glycosylated hemoglobin and higher prevalence of microalbuminuria, despite their shorter duration of diabetes mellitus. The percentage of youths receiving BP-lowering medication was very low, and children with DM2 were more likely to receive such treatment. The recent data confirm that HTN is underdiagnosed in youths with DM1 less than 13 years of age [153]. As a whole, awareness, screening, diagnosis and treatment of elevated BP in youths with diabetes mellitus are not yet satisfactory.

Chronic kidney disease and renal insufficiency

In contrast to adults, where CKD is mainly considered as TOD as a consequence of primary HTN, pediatric HTN occurs mostly (in at least 85% of cases) secondarily to an underlying renoparenchymal or renovascular disease. The prevalence of HTN in pediatric CKD ranges from 20 to 80% depending on the degree of renal dysfunction [154–157]. However, even children with CKD stage 2 (i.e. GFR 60–90 ml/min per 1.73 m²) may present with elevated BP [158].

Even though HTN may not be the primary cause of renal disease, BP affects the rate of renal failure progression. In adults, HTN is an independent risk factor for CKD progression [159–161] and also in a large prospective study of children with CKD, SBP greater than 120 mmHg has been associated with a faster decline of GFR [162].

CKD may additionally affect the physiological diurnal variation of BP. The integrity of the nocturnal fall of BP ('dipping') plays a significant role in renal failure progression, in addition to and independent of the absolute BP level. Nondipping is a well known and common characteristic of renal HTN and an independent cardiovascular risk factor [163] and is associated with faster progression of renal failure in adult CKD patients [164,165].

EVIDENCE FOR THERAPEUTIC MANAGEMENT OF HYPERTENSION

General overview

Numerous randomized clinical trials in hypertensive adults have provided evidence that antihypertensive treatment reduces the risk of death and major cardiovascular events such as stroke, myocardial infarction, heart failure and renal failure and improves life expectancy [166–170]. Major cardiovascular events are extremely uncommon in childhood, and their rarity has so far prevented the running of event-based randomized therapeutic trials. Despite this, clinical experience shows that reduction of high BP in

life-threatening conditions, such as acute heart failure, hypertensive encephalopathy and malignant HTN, improves survival and reduces sequelae in children. Because of the rarity of events, most of the limited evidence available so far is based on the use of organ-damage markers including LVH, urinary albumin excretion (UAE), CKD progression and increased intima-media thickness as endpoints.

Randomized trials based on intermediate endpoints

Heart

Antihypertensive treatment results in improved cardiac function and LVH regression, which in turn reduces the risk of major cardiovascular events in adults [171–173]. In children, information on the effects of antihypertensive treatment on cardiac end-organ damage is mostly limited to uncontrolled studies in heterogeneous populations with primary and secondary HTN. Nonetheless, there is pediatric evidence that effective antihypertensive treatment induces regression of LVH, ameliorates cardiac geometry and function [22,23,174–176]. In children with CKD receiving angiotensin-converting enzyme inhibitors (ACEi), improved BP control resulted in LVH regression and improved systolic function within 12 months of treatment. Lowering BP to the low-normal range, however, resulted in a slightly more marked improvement in myocardial function but not in LVMI [175].

Renal function and disease

The effects of BP-lowering treatment on renal function and disease in adults, especially in those with chronic renal disease, are still an area of dispute. A recent meta-analysis [177] has concluded for no significant effect on renal failure, but single studies have yielded discordant results, which may depend on the different nature of renal disease (e.g. diabetic or nondiabetic), presence or absence of proteinuria and the type of BP-lowering agents [renin–angiotensin system (RAS) inhibitors vs other classes]. In children, however, the pediatric ESCAPE Trial (Effect of Strict Blood Pressure Control and ACE Inhibition on Progression of Chronic Renal Failure in Pediatric Patients) demonstrated that superior long-term nephroprotection is achieved by targeting for a low-normal 24-h mean arterial pressure as compared with a high-normal BP target [25]. The partially discrepant findings from experience with adults may be explained by methodological and population differences. Patient age, ethnicity, underlying renal diseases, pharmacological treatment protocols, duration of follow-up and dropout rates varied markedly between the studies. Furthermore, the use of ambulatory BP monitoring in the pediatric ESCAPE trial may have allowed more accurate monitoring of the achieved BP than achieved in the adult trials, where only casual BP readings were obtained.

Nevertheless, in all adult studies, patients with proteinuria seemed to benefit from intensified BP control, whereas there was no significant effect in patients without proteinuria. Furthermore, a recent meta-analysis including almost 80 000 patients from 21 randomized clinical trials

demonstrated that the drug-induced reduction of albuminuria is predictive of subsequent nephroprotection [178].

THERAPEUTIC APPROACH

When to initiate antihypertensive treatment

The decision to initiate antihypertensive treatment should not be taken on BP levels alone, but should consider the total risk for cardiovascular and renal events. The presence or absence of TOD, and other risk factors for cardiovascular morbidity and mortality such as family history of cardiovascular diseases, hyperlipidemia, renal diseases or diabetes establish the global cardiovascular risk. In children with remediable secondary HTN, specific treatment of the underlying disease (renal, endocrine, cardiovascular) must be initiated immediately after detection. However, in those with primary HTN, antihypertensive therapy should first target the risk factors for BP elevation (i.e. overweight/obesity, increased salt intake and low physical activity) in the same way as described in the ‘Lifestyle changes’ section. Lifestyle changes (nonpharmacological therapy) should be initiated in youths with high-normal BP also. It should be continued even after starting pharmacological therapy as it can improve the overall cardiovascular risk profile in hypertensive children.

The decision about when to initiate pharmacological therapy cannot be supported by mortality/morbidity trial evidence, which is lacking because in children eventual outcomes are expected after a long time incompatible with the duration of a controlled trial. Consequently, the suggestions indicated in the decision-making tree of Fig. 2 are formulated in analogy with what has been demonstrated in adults and are largely based on wisdom. Pharmacological therapy should be started in all children with symptomatic HTN, hypertensive TOD, secondary HTN or DM1 or DM2, as well as in those who are unresponsive to nonpharmacological therapy [179], that is those who have persistent HTN despite nonpharmacological therapy for about 1 year. It may be considered individually in children with high-normal BP if hypertensive TOD is already present [180,181].

Goal of treatment

BP control in hypertensive patients has two major treatment objectives: the prevention of cardiovascular events and

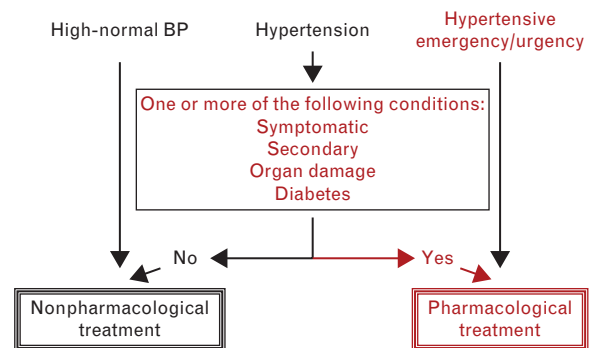


FIGURE 2 When to initiate antihypertensive treatment. One or more of the conditions listed in the box are required for the start of antihypertensive drugs. Persistent hypertension, despite nonpharmacological measures, requires initiation of antihypertensive drug treatment.

TABLE 17. Blood pressure goal in hypertensive children (for office, home and 24-h ambulatory blood pressure measurements)

General hypertensive population ^a	
Blood pressure goal	<95th percentile is recommended <90th percentile should be considered
DM1 and DM2 ^b	
Blood pressure goal	<90th percentile is recommended <75th percentile is recommended in children with nonproteinuric CKD <50th percentile is recommended in children with proteinuric CKD
Children with CKD ^c	
Blood pressure goal	<75th percentile is recommended in children with nonproteinuric CKD <50th percentile is recommended in children with proteinuric CKD

CKD, chronic kidney disease; DM1, diabetes type 1; DM2, diabetes type 2.

^aIn patients aged 16 years or older, the adult cutoff values for office BP are used, 140/90 mmHg.

^bIn patients aged 16 years or older, the adult cutoff values for office BP are used, 130/80 or 125/75 mmHg with proteinuric CKD.

^cIn patients aged 16 years or older, the adult cutoff values for office BP are used, 130/80 or 125/75 mmHg with proteinuric CKD.

renal damage (or deterioration of renal function in patients with already existing CKD). However, the evidence for a specific BP goal in children is scarce, and there is uncertainty as to the relative roles of BP targets and drug-specific effects on cardiovascular and renal outcomes.

Blood pressure target in the general hypertensive pediatric population

In the absence of prospective long-term studies on the impact of different BP levels on intermediate or major cardiovascular and renal end-points in children, the 95th percentile is considered as cutoff for defining HTN in children and adolescents. This provides a rationale for targeting children and adolescents with essential HTN to a BP below the 95th percentiles for age, sex and height, but it is probably wiser and safer to aim at a BP below the 90th percentile, provided this goal can be attained by well tolerated treatment (Table 17).

Home and 24-h ambulatory blood pressure target

Ambulatory BP monitoring is regarded to substantially add to the diagnosis and monitoring of HTN, particularly because it can detect both white-coat and masked hypertensive patients. In children with renal HTN, a substantially less variable BP response to antihypertensive treatment was observed when using ABPM as compared with office BP monitoring only [182], supporting the use of ABPM to monitor attainment and maintenance of BP targets. As ABPM cannot be performed very frequently, office and home BP monitoring should be utilized routinely. It appears appropriate to aim for the same target percentiles for all three modalities of BP assessment [7,56,64,183]. BP goal in hypertensive children (for office, home and ABPMs) are shown in Table 17.

Blood pressure target in diabetic and renal disease

The current European [92] and US guidelines [184] recommend a target BP below 140/90 mmHg in adults with CKD because of insufficient-published evidence for an

additional benefit of an even lower target concerning mortality or cardiovascular or cerebrovascular morbidity. However, the National Institute of Health recently carried out the SBP Intervention Trial (SPRINT), a randomized controlled trial comparing SBP targets of 140 and 120 mmHg, respectively, in 9300 hypertensive adults aged 50 years and older [185]. Results of this trial would not seem generalizable to children and adolescents because the SPRINT was on older adults at high risk for cardiovascular events what seems far removed from a pediatric setting [186].

For children with CKD, the prospective randomized ESCAPE trial has provided evidence that strict BP control aiming for a 24-h BP target below the 50th percentile leads to improved long-term renal survival [25]. On average 1.9 antihypertensive drugs (including the ACE inhibitor ramipril provided at a fixed dose) were required to achieve the lower BP target. A post-hoc analysis indicates similar renal outcomes occurred with any 24-h BP below the 75th percentile, whereas 5-year renal survival increasingly deteriorated when achieved BP remained above this cutoff level [25,187].

Proteinuria is an important modifier of the renoprotective efficacy of intensified BP control. The renal survival benefit of intensified BP control appears limited to children with – even mild – proteinuria [188,189]. Hence, at the current state of knowledge it appears appropriate to target BP to the 75th percentile in children with nonproteinuric CKD and to below the 50th percentile in children with proteinuria of any degree with close monitoring of creatinine.

Although overt diabetic nephropathy is rarely observed in children with diabetes, these patients are considered at increased long-term risk for HTN and renal damage [190,191]. Subtle alterations such as slight increases of SBP and/or a blunted circadian BP variation are commonly found by ABPM early in the course of the disease [191,192] when office BP is still normal. Impaired nocturnal dipping often precedes microalbuminuria, the earliest marker of diabetic nephropathy [191]. Although pediatric evidence regarding the efficacy of preventive antihypertensive and antiproteinuric treatment strategies in juvenile diabetes is still lacking, ample experience with adult diabetes reinforces the recommendation of aiming at a strict BP control in children with diabetes.

TREATMENT STRATEGIES

Lifestyle changes

Considerable advances have been made in recent years in identifying conditions often associated with and considered responsible for high BP in children and adolescents. More limited evidence has been accumulated on the results of corrective interventions. In overweight and obese children, it has been demonstrated that lifestyle interventions incorporating a dietary component along with exercise or behavioral therapy can lead to improvements in both weight and cardiometabolic factors, including BP [193]. In overweight adolescents, weight reduction is associated with a decrease in office BP [194,195] and is the primary therapy for obesity-related HTN [1]. After 1 year of lifestyle intervention,

TABLE 18. Life-style recommendations to reduce high blood pressure values: goals

<i>General recommendations</i>	
Implement the behavioral changes (physical activity and diet) tailored to individual and family characteristics	
Involve the parents/family as partners in the behavioral change process	
Encourage smoke-free environment throughout all stages of life, including discouraging maternal smoking	
Provide educational support and materials	
Establish realistic goals	
Develop a health-promoting reward system	
<i>Goals</i>	
1. BMI	BMI <85th percentile: maintain BMI to prevent overweight BMI 85–95th percentile: weight maintenance (younger children) or gradual weight loss in adolescents to reduce BMI to <85th percentile BMI >95th percentile: gradual weight loss (1–2 kg/month) to achieve value <85th percentile
2. Physical activity	Children and youth aged 5–17 years should accumulate at least 60 min of moderate-to-vigorous-intensity physical activity daily. Amount of physical activity greater than 60 min provides additional health benefits Most of the daily physical activity should be aerobic. Vigorous-intensity activities should be incorporated, including those strengthening muscle and bone, at least three times per week Avoid more than 2 h daily of sedentary activities Competitive sports participation should be limited only in the presence of uncontrolled stage 2 hypertension
3. Diet	Avoid intake of excess sugar, excess soft drinks, saturated fat and salt and recommend fruits, vegetables and grain products Limit salt intake

changes in obesity measures were closely related to changes in 24-h, daytime and night-time BP [196].

Children with insufficient physical activity are about three times more likely to have elevated BP [1], and regular physical activity has cardiovascular benefits. Meta-analysis concluded that short-term physical activity leads to a small but NS decrease in BP [197]. However, regular physical activity results in a significant reduction of BP, not only when measured in the office, but also when monitored for 24-h BP. After 3 months of exercise training, the effects on BP were 7–12 mmHg for SBP and 2–7 mmHg for DBP [198]. Higher levels of physical activity were associated with lower BP and results suggested that the volume of activity might be more important than the intensity [199]. The recommendations for physical activity [200] are included in Table 18. Although children less than 5 years old benefit from being active, more research is needed to determine what dose of physical activity provides the greatest health benefits.

Prospective studies have shown the effects of diet on lifetime BP [201]. Consumption of more than one servings of dairy products/day and more than two servings of fruits and vegetables/day throughout adolescence have shown to lead to about a 35% lower risk of elevated BP [202]. Likewise, saturated fat-reduced diet since infancy decreases BP [203]. Higher sugar sweetened beverage consumption is associated with higher SBP in adolescents [204]. High salt intake in children and adolescents is positively correlated with high SBP and an elevated risk of HTN [205], and a meta-analysis has shown that a 3 g/day reduction of salt intake leads to a decrease in SBP and DBP of 1.2/1.3 mmHg [206]. Starting in newborns, a 15-year follow-up study has suggested a predictive role of the effect of salt intake in

early life on BP [207]. Excessive salt intake seems to be not only linked with BP elevation but also with other cardiovascular risk factors as salt produces a reduction in vascular nitric oxide bioavailability that limits endothelium-dependent dilation [208].

Environmental exposure to tobacco is an important risk factor contributing to the development and severity of cardiovascular disease. The heart and vascular system are highly vulnerable to tobacco smoking. Discouraging maternal smoking and maintaining a strictly smoke-free environment are of great importance because of the accumulating evidence on the importance of fetal and early life factors in determining cardiovascular risk [209]. In adolescents, promotion of smoke-free rules at home may help prevent the uptake of cigarettes. Although in active smokers, cessation of smoking is mandatory to improve cardiovascular risk due to the acute pressor effect that may raise daytime ambulatory BP [92]. In Table 18, the lifestyle recommendations and goals are summarized.

Pharmacological therapy

Therapeutic orphans and regulatory issues

There is a general paucity of high quality efficacy and safety data for the large majority of drugs used to treat HTN in children. As a consequence of this, dosing and assumptions about the therapeutic risk/benefit-ratio of many drugs is based on data derived from studies in hypertensive adults. Attempts have been made to improve this inequity through legislation on both sides of the Atlantic. The 1997 US Food and Drug Administration Modernization Act contained a provision granting a 6-month patent protection to industry if pediatric studies were conducted for new drugs. The subsequent Best Pharmaceuticals for Children Act, Pediatric Research Equity Act and FDA Amendments Act of 2007 have led to further initiatives, including the online public posting of internal FDA pharmacology and efficacy reviews and mechanisms to promote studies of drugs with expired patents. In Europe, the Regulation of Medicinal Products for Pediatric Use (EU Regulation 1901/2006/EC) similarly provided a 6-month extension of market exclusivity for new drugs in which approved pediatric studies were conducted. For drugs no longer under patent protection, the Paediatric Use Marketing Authorization (PUMA; Art. 40, EU Regulation) provides 10 years of market protection as a reward for performing appropriate studies as part of an agreed Paediatric Investigation Plan.

These legislative changes have resulted in a substantial growth in the number of studies of antihypertensive (and other) agents being conducted in children and a commensurate increase in the number achieving a pediatric licence. However, these studies have principally been restricted to newer antihypertensive agents; to date no older drug has received licensing as a result of PUMA (EMA).

Choice of antihypertensive drugs

Monotherapy

When prescribing antihypertensive therapy for adults, decisions regarding the choice of agent can be based upon

evidence from clinical trials in a large number of patients, many of these having compared one class of agent with another [210]. Although an increased emphasis on conducting drug trials in children and adolescents over the past 15 years has yielded important advances, there remains a general lack of high quality long-term outcome data to guide choice of drug therapy for pediatricians managing HTN. It is important to understand that what works for adults does not necessarily work for children and adolescents.

Those trials that have been conducted have mainly investigated the BP-reducing effects of single agents in isolation, with very few comparing drugs of the same or different class to assess relative efficacy or safety. One exception is a study comparing valsartan with enalapril, which showed similar efficacy and adverse event rates for these two agents [211]. Follow-up studies are generally limited in duration, and little is known about the long-term effects of antihypertensive agents on many outcomes, including growth and cognitive development. A recent Cochrane review identified a total of 21 randomized controlled trials of at least 2-week duration comparing antihypertensive agents as either monotherapy or combination therapy with either placebo or another medication, or comparing different doses of the same medication in a total of 3454 children with HTN [212]. Outcomes were limited to BP with no study investigating efficacy of preventing target end organ damage. The most data are available for candesartan, which has demonstrated low-quality evidence of a modest lowering effect on BP. No evidence could be found of a consistent dose response relationship for escalating doses of AT1 blockers (ARBs), calcium channel blockers and ACEi. Few side effects were generally minor, including headaches, dizziness and upper respiratory infections.

Until such time that high-quality clinical trial data are available to compare one class of antihypertensive drug with another, several different agents may potentially be first-line agents. These include the five classes for which evidence of cardiovascular event reduction is available in adults [213], ACE-inhibitors, ARBs, beta-blockers, calcium channel blockers and diuretics. Clinicians who care for children and young adults with HTN need to be familiar with at least one drug from each class of agent. Given the substantial efforts that have been made to perform pediatric-specific studies confirming (at least short term) efficacy and safety in children, it seems sensible to commence therapy with those agents which have a license for use in children.

It is logical to choose an agent which can be administered once-daily because of the benefits that this provides in terms of simplicity of administration, allowing tablet-taking to be incorporated into the patient's daily routine (e.g. bedtime, tooth brushing etc.) and avoiding having to take drugs during school hours. Once-daily administration of medicines is also widely recognized to improve adherence [214].

Drug choice should be targeted to the child's underlying pathophysiology and presence of concurrent disorders. For instance, in a child with HTN associated with diabetes mellitus and microalbuminuria, or with CKD and proteinuria, an ACE inhibitor or ARB is the most appropriate first-

line agent because of their antiproteinuric effect. Similarly, a beta-blocker or calcium channel blocker is the most appropriate agent in the child with HTN and migraine or where HTN has persisted after coarctation repair, and a diuretic most appropriate in the child with corticosteroid-induced HTN. Alternatively, there may be compelling reasons to avoid certain agents, for instance beta-blockers in the hypertensive child with asthma or diabetes, and ACE inhibitors or ARBs in woman teenagers at high risk of pregnancy. Diuretics and beta-blockers should generally be avoided in competitive athletes; these may impair performance through decreased intravascular volume and decreased cardiac output, respectively, and are also listed among doping substances [215].

Primary HTN is a growing problem in the pediatric age group, intrinsically linked to the increased global incidence of obesity. There is some evidence to suggest the use of ACE inhibitors and ARBs as first line agents in the obesity-linked primary HTN population; in adults these agents appear to reduce the incidence of new-onset diabetes and may increase insulin sensitivity [216]. Where these are not tolerated, calcium channel blockers are a reasonable alternative. Given their known effects on glucose metabolism and insulin resistance, it is sensible to avoid the use of beta-blockers without vasodilatory capacity and thiazide diuretics [217]. In children with HTN not related to obesity, there are no substantial data upon which to make a recommendation to support the use of any one agent over another.

Once the appropriate agent has been selected, the child should commence on the lowest recommended dose (Tables 19 and 20) [1,218]. This dose should be up-titrated until the BP falls within the target range or until the maximum recommended dose is reached, at the same time carefully monitoring for the development of side effects. These are drug specific, and some require routine monitoring, for example the assessment of kidney function and potassium balance in children receiving ACE inhibitors and ARBs. Few drug-related side effects may be dose limiting, resulting in the early addition of a second agent or complete replacement of the initial agent.

Monogenic forms of HTN are rare disorders, occurring as a result of single gene mutations and characteristically associated with low renin levels with alterations in acid base and potassium levels. Their recognition is important because patients are readily treated by a specific antihypertensive agent which targets the defective tubular function. Presenting features and appropriate therapies are shown in Table 21 (adapted from [215]).

Combination therapy

Where the use of the maximum recommended or tolerated dose of any single agent does not successfully achieve target BP, then the use of combination therapy is recommended. There is no evidence in the current pediatric literature to support the use of one particular combination over another, though some guidance based on adult data is provided in the ESH/European Society of Cardiology 2013 Guidelines [92] (Fig. 3). It is logical to combine agents from different drug classes and preferably those with complementary modes of action, for example an ACE inhibitor with a diuretic or a vasodilator with a diuretic or a beta-blocker. Following the

TABLE 19. Antihypertensive medications for use in children and young adults

Class of drug	Drug	Recommended starting dose (per day)	Maximal dose (per day)	Dosing interval
Diuretics	Amiloride	0.4–0.6 mg/kg	20 mg	Daily
	Chlortalidone	0.3 mg/kg	2 mg/kg up to 50 mg	Daily
	Furosemide	0.5–2 mg/kg	6 mg/kg	Daily–twice daily
	Hydrochlorothiazide	0.5–1 mg/kg	3 mg/kg/day	Daily
	Spirolactone	1 mg/kg	3.3 mg/kg up to 100 mg	Daily–twice daily
	Eplerenone	25 mg	100 mg	Daily–twice daily
	Triamterene	1–2 mg/kg	3–4 mg/kg up to 300 mg	Twice daily
Beta blockers	Atenolol	0.5–1 mg/kg	2 mg/kg up to 100 mg	Daily–twice daily
	Metoprolol	0.5–1 mg/kg	2 mg/kg	Daily–twice daily
	Propranolol	1 mg/kg	4 mg/kg up to 640 mg	Twice–thrice daily
Calcium channel blockers	Amlodipine	0.06–0.3 mg/kg	5–10 mg	Daily
	Felodipine	2.5 mg	10 mg	Daily
	Nifedipine (extended release form)	0.25–0.5 mg/kg	3 mg/kg up to 120 mg	Daily–twice daily
ACE inhibitors	Benazepril	0.2 mg/kg up to 10 mg	0.6 mg/kg up to 40 mg	Daily
	Captopril	0.3–0.5 mg/kg/dose	6 mg/kg	Twice–thrice daily
	Enalapril	0.08–0.6 mg/kg		Daily
	Fosinopril	0.1–0.6 mg/kg	40 mg	Daily
	Lisinopril	0.08–0.6 mg/kg	0.6 mg/kg up to 40 mg	Daily
	Ramipril	1.5–6 mg/		Daily
ARBs	Candesartan	0.16–0.5 mg/kg		Daily
	Irbesartan	75–150 mg	300 mg	Daily
	Losartan	0.7 mg/kg up to 50 mg	1.4 mg/kg up to 100 mg	Daily–twice daily
	Valsartan	0.4 mg/kg	40–80 mg	Daily
Alpha and beta blocker	Labetolol	1–3 mg/kg	10–12 mg/kg up to 1200 mg	Twice daily
Central alpha-agonist	Clonidine	0.2 mg/kg	2.4 mg	Twice daily
Peripheral alpha-blockers	Doxazosin	1 mg	4 mg	Daily
	Prazosin	0.05–0.1 mg/kg	0.5 mg/kg	Thrice daily
Vasodilators	Hydralazine	0.75 mg/kg	7.5 mg/kg up to 200 mg	Four times daily
	Minoxidil	0.2 mg/kg	50–100 mg/day	Daily–thrice daily

TABLE 20. Clinical conditions for which specific antihypertensive drug classes are recommended or contraindicated

Antihypertensive class	Recommended	Contraindicated
Diuretics potassium-sparing	Hyperaldosteronism	Chronic renal failure ^a Competitive athletes
Thiazide and thiazide-like diuretics	Chronic renal failure Corticosteroid-induced HTN	Competitive athletes Diabetes
Diuretics loop-acting	Congestive heart failure	
Beta-adrenergic blockers	Coarctation of aorta Congestive heart failure Migraine	Bronchial asthma ^a Diabetes Competitive athletes Psoriasis
Calcium channel blockers	Posttransplantation Migraine Coarctation of aorta	Congestive heart failure
ACEi	Chronic kidney disease Diabetes mellitus Microalbuminuria Congestive heart failure Obesity-linked primary HTN	Bilateral renal artery stenosis ^a Renal artery stenosis in solitary kidney ^a Hyperkalemia ^a Pregnancy ^a Females of child-bearing potential should use reliable contraception
ARB	Chronic kidney disease Diabetes mellitus Microalbuminuria Congestive heart failure Obesity-linked primary HTN	Bilateral renal artery stenosis ^a Renal artery stenosis in solitary kidney ^a Hyperkalemia ^a Pregnancy ^a
Intravenous vasodilators	Life-threatening conditions	

ACEi, angiotensin-converting enzyme inhibitor; ARB, AT1 blockers; HTN, hypertension.

^aAbsolute contraindication.

TABLE 21. Presenting features and appropriate therapies for monogenic hypertension

Disorder	Inheritance	Gene	Presentation	Potassium	Renin	Aldosterone	Treatment
Apparent mineralocorticoid excess	AR	<i>HSD11b2</i>	All ages	Low/N	Low	Low	Spironolactone, eplerenone and amiloride
Glucocorticoid remediable aldosteronism	AD	<i>CYP11B2/ CYP11B1</i>	Infant/child	Low/N	Low	Low/N	Amiloride, triamterene and dexamethasone
Congenital adrenal hyperplasia	AR	<i>CYP21A2, CYP11B1</i>	Infant	Low/N	Low	Low	Spironolactone and eplerenone dexamethasone
Liddle syndrome	AD	<i>SCNN1B, SCNN1G</i>	Child/adult	Low/N	Low	Low	Amiloride, triamterene
Gordon syndrome	AD	<i>KLHL3, CUL3, WNK1, WNK4</i>	Adult/child	High/N	Low	High/N	Thiazide

AD, autosomal dominant; AR, autosomal recessive; *CUL3*, *Cullin3* gene; *CYP11B1*, steroid 11 β -hydroxylase deficiency (11 β -OHD) gene; *CYP11B2*, aldosterone synthase gene; *CYP21A2*, steroid 20 β -hydroxylase deficiency (11 β -OHD) gene; *HSD11b2*, 11 β hydroxysteroid dehydrogenase type 2 enzyme (11 β -HSD2) gene; *KLHL3*, Kelch-like 3 gene; *SCNN1G* and *SCNN1B*, subunits of ENaC genes; *WNK1* or 4, with-no-lysine kinase 1 and 4.

review of adult data from the ONTARGET [219], ALTITUDE [220] and VA NEPHRON-D [221] studies, the European Medicines Agency have formally recommended that no two drugs which act separately on the RAS should be used in combination because of risks of hyperkalemia, impaired kidney function and hypotension (www.ema.europa.eu). Dual therapy with ACE inhibitors, ARBs and direct renin inhibitors should therefore be avoided, although it may be cautiously used in patients with heavy proteinuria under strict renal function and potassium levels monitoring. Few data exist on the use of fixed-dose combination agents in children, and these are rarely used, though may have a place in the treatment of adolescents with the aim of improving medication adherence [222].

THERAPEUTIC APPROACHES IN SPECIAL CONDITIONS

Diabetes mellitus

Consensus-based guidelines have recommended, mostly on the basis of expert opinion, that measures to prevent

persistent microalbuminuria, such as optimal blood glucose control, participation in physical activity, a low-protein diet, smoking cessation and BP control, should be promoted [152]. BP treatment includes defining the BP goal, how achievement of this goal will be checked, and which class of antihypertensive drug will be more appropriate.

The BP goal for diabetic patients is a relevant and controversial issue in children as well as in adults. In the latter, no clear evidence is available that the BP should be lower in diabetic than in nondiabetic hypertensive patients [92]. In children, longitudinal studies with cardiovascular or renal events are absent. Because of some evidence that youths with DM1 or DM2 develop early atherosclerotic lesions before the age of 30 [218], the American Heart Association suggests the BP goal be lower than the 90th percentile for age, sex and height [152]. A post-hoc analysis of a trial on DM1 suggests that a lower BP target may be beneficial in reducing UAE and the risk to develop proteinuria [223]. The goals recommended by the present panel are indicated in Table 17: the opinion of the panel is that a goal below the 90th percentile (or below 130/80 mmHg at

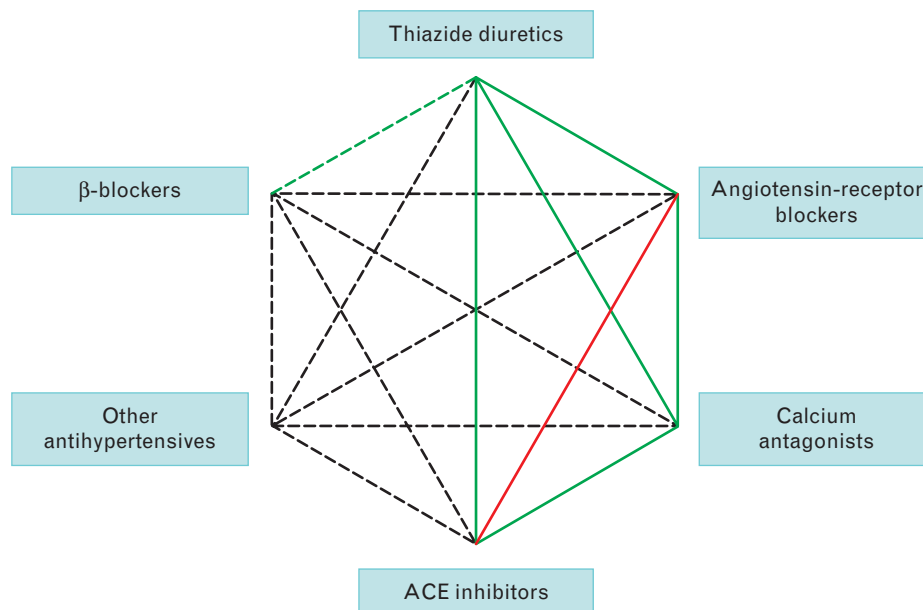


FIGURE 3 Recommendation for combination of antihypertensive drugs (from Ref. [92]). Green/continuous: preferred. Green/dashed: useful (with some limitations). Black/dashed: possible but less well tested. Red/continuous: not recommended. Only dihydropyridines to be combined with β -blockers. Thiazides + β -blockers increase risk of new onset diabetes mellitus. ACE, angiotensin-converting enzyme + angiotensin-receptor blockers combination discouraged.

TABLE 22. Antihypertensive drugs for hypertensive emergencies and urgencies

Drug	Class	Route	Dose	Onset of action	Comment
Sodium nitroprusside	Direct vasodilator	Intravenous infusion	0.5–8 µg/kg per min	Within seconds	May cause thiocyanate toxicity, inactivated by light
Nitroglycerine	Direct vasodilator	Intravenous infusion	0.1–2 µg/kg per min	1–2 min	May cause methemoglobinemia, vasodilating effect primarily on the venous side – efficient in heart failure, limited efficacy in children
Labetalol	Alpha and beta blocker	Intravenous infusion	0.25–3 mg/kg per h	5–10 min	Contraindication in asthma, heart failure and may cause bradycardia
Nicardipine	Calcium channel blocker	Intravenous infusion	1–3 µg/kg per min	Within minutes	Reflex tachycardia
Clonidine	Central alpha-agonist	Intravenous bolus	2–6 µg/kg per dose	10 min	Dry mouth, sedation and rebound hypertension
Esmolol	Beta-blocker	Intravenous infusion	100–500 µg/kg per min	Within seconds	Contraindication in asthma, may cause bradycardia
Enalaprilat	ACEI	Intravenous bolus	0.005–0.01 mg/kg per dose	15 min	Contraindication in suspected bilateral renal artery stenosis
Furosemide	Loop diuretic	Intravenous bolus	0.5–5 mg/kg per dose	Within minutes	Hypokalemia. Useful in volume hypertension
Urapidil	Peripheral alpha blocker and central agonist of 5-HT _{1A} receptors	Intravenous infusion	Initial dose: 0.5–4.0 mg/kg per h maintenance dose: 0.2–2.0 mg/kg per h	1–5 min	May cause sedation, palpitation and nausea
Nifedipine	Calcium channel blocker	Orally	0.25 mg/kg per dose	20–30 min	May cause unpredictable hypotension, reflex tachycardia
Isradipine	Calcium channel blocker (L-type)	Orally	0.05–0.1 mg/kg per dose	1 h	Higher doses may cause blood pressure drop of >25%
Captopril	ACEI	Orally	0.1–0.2 mg/kg per dose	10–20 min	Contraindication in suspected bilateral renal artery stenosis
Minoxidil	Direct vasodilator	Orally	0.1–0.2 mg/kg per dose	5–10 min	Fluid retention

age 16 and above) may be achieved in both children and adolescent, provided treatment is well tolerated.

At the time to select the antihypertensive drugs, two key issues should be considered, the most relevant is to achieve the BP goal over the 24 h and the necessity to reduce salt-intake due to the sodium-dependent component of HTN in diabetes [224]. An additional benefit of starting with drugs blocking the RAS (either ACE inhibitor or ARB) is promised by their ability to reduce UAE and delay the onset of nephropathy, although the advantage in long-term protection has not been established [225].

Heart failure

Unlike in the adult, HTN is not a common cause of heart failure in children and adolescents. However, children and adolescents with end-stage renal failure, diabetes, congenital heart disease or Kawasaki disease are at increased risk of early cardiovascular events and heart failure, and the management of HTN in these patients needs special attention [226]. First-line therapy includes salt restriction and agents that target the renin–angiotensin–aldosterone-system combined with beta-blockers in low doses if necessary to achieve BP control. Addition of diuretics is recommended in patients with volume overload [175,176]. Occasionally, one may see patients with critical CoA presenting with heart failure and upper limb HTN. Surgical or catheter intervention to relieve the obstruction is the first treatment of choice. However, HTN may persist in some patients despite successful repair (the ‘Coarctation of aorta’ section).

Treatment of a hypertensive crisis causing acute heart failure includes the use of intravenous vasodilatory agents (nicardipine), with nitroprusside limited to situations where

other agents fail, or to brief periods of time [227] (the ‘Hypertensive emergencies’ section and Table 22).

Nondiabetic renal disease

In the ‘Goal of treatment’ section, the current evidence is summarized suggesting that HTN in children with CKD, especially if accompanied by proteinuria, requires more intense management to reduce proteinuria and prevent progressive deterioration of renal function. Although nonpharmacological options should be considered, drug treatment remains the mainstay of antihypertensive management in all stages of CKD. The different classes of antihypertensive agents are comparable with respect to their BP-lowering efficacy in children with CKD [228,229], but most of the available clinical evidence has been obtained with drugs blocking the RAS [25,228,230]. They have a powerful, dose-dependent antiproteinuric action in pediatric nephropathies [231]. RAS inhibitors in general have a favorable side-effect profile; however, a few fatalities have been documented in infants with acute intravascular volume depletion while receiving ARBs [231,232]. It is recommended to use RAS blocking agents as first choice with appropriate risk counseling in all proteinuric patients with CKD. In hypertensive infants with nonproteinuric CKD, calcium channel blockers may be considered as first-line therapy for safety considerations.

In three-quarters of hypertensive children with CKD stage 2–4, BP control can be achieved by antihypertensive monotherapy, but at least 50% of children require more than one drug to achieve a sufficiently low-BP target. If multiple drug therapy is required, diuretics and calcium channel blockers are the most suitable addition to a RAS blocker. Whereas the combined administration of ACE

inhibitors, ARBs and the renin inhibitor aliskiren exert additional antiproteinuric effects in adults and children [233,234], it is recommended not to use such combination therapies because of increased rates of serious adverse events such as acute kidney injury and hyperkalemia observed in large randomized trials of high-risk adult patients [219–221].

Metabolic syndrome

Despite the difficulties in defining metabolic syndrome in children and adolescents (the ‘Diabetes mellitus’ section), the construct of clustering of cardiometabolic risk factors are useful in the clinical setting. The key issue is to reduce the highly prevalent overweight and obesity, a complex task to maintain overtime. All effort should be done to educate young people as early as possible to a healthy lifestyle. A combination of physical exercise and dietary intervention is commonly required. Several complementary actions, such as family-based and school-based interventions and benefiting from internet-delivered intervention, are crucial to achieve success [235]. Information about the use of drugs to reduce obesity and/or increase insulin sensitivity is scarce, but the cardiovascular serious few side effects of sibutramine [236] and the gastrointestinal side effect of orlistat do not recommend their use. The use of metformin for abdominal obesity seems to be effective in the short-term but information about the efficacy overtime is lacking [237]. In addition to intervention for obesity, the rest of the cardiometabolic risk factors should be treated, aiming not to increase weight or insulin resistance. For HTN, thiazide diuretics and classic beta-blockers are not recommended, whereas drugs that block the RAS are preferable [92,238]. If beta-blockers are a compelling indication, those with vasodilating capacity should be used. A controversial issue is the role of hyperuricemia in the risk of developing HTN and cardiovascular risk, but today NS evidence exists to give grounded recommendations.

Resistant hypertension

HTN may be termed resistant to treatment, or refractory, when a therapeutic plan that has included attention to lifestyle measures and the prescription of at least three drugs in adequate doses (one diuretic) has failed to lower systolic and DBP sufficiently [92]. This condition implies very high cardiovascular and renal risk and requires prompt intervention. In children and adolescents, once white coat and adherence to treatment has been checked, there is always a secondary cause of HTN. Even though there are no systematic studies reporting secondary causes of resistant HTN, primary glomerulopathies, renal insufficiency, vascular diseases and neurological tumors are the most frequent diseases. In these cases, it is not difficult to diagnose with simple analytical or image technique procedures. If this is not the case, genetic causes of HTN should be ruled out.

Among the genetic causes, the most common are the sodium-dependent ones, although some others should be taken into account such as autosomal-dominant brachydactyly with HTN associated with increased activation of pressure centres in brain stem and increased peripheral vascular resistance.

Hypertensive emergencies

A hypertensive emergency is a life-threatening condition associated with severe HTN. Although there is no absolute level of BP to define severe HTN, some authors suggest to use a cutoff of 20% above the stage 2 HTN limit, which corresponds with an SBP of 178 mmHg in a 17-year-old boy [239]. This should be differentiated from a hypertensive urgency that is defined as severe HTN without acute target organ dysfunction.

Life-threatening conditions include organ dysfunction, mainly neurological, renal or cardiac. The most common symptoms of a hypertensive crisis are headache, dizziness, nausea/vomiting, seizures, confusions, visual symptoms and facial nerve palsy [240]. Acute encephalopathy syndromes can also be produced with no extreme BP elevations when the HTN appears as a sudden onset, since the autoregulation of cerebral flow is not able to control the rapid BP increment.

The cause of HTN causing a hypertensive crisis is mostly secondary (renal, endocrine or cardiac). The evaluation of a child with a hypertensive emergency should include fundoscopic exam (hemorrhages, exudates and papilledema) and neurologic clinical evaluation and CT (to exclude hemorrhage) or MRI (for edema of white matter in the parieto-occipital regions, named PRES) in the case of symptoms of hypertensive encephalopathy.

Children with hypertensive emergencies should be treated in an ICU to ensure monitoring and support of the vital organs including neurologic status. The treatment strategy must be directed toward the immediate reduction of BP to reduce the hypertensive damage to the target organs, but not at a rate that would be likely to cause hypoperfusion of vital organs by an excessively rapid reduction of BP (mainly cerebral hypoperfusion with neurological sequelae or renal hypoperfusion with acute kidney injury).

There is no experimental evidence upon which recommendations on the optimal rate of BP reduction in hypertensive emergencies could be based. From clinical experience, BP should be lowered by no more than 25% of the planned BP reduction over the first 6–8 h, followed by a further gradual reduction over the next 24–48 h [227,241–244]. Faster normalization of severe HTN must be strictly avoided as it can cause more harm than severe HTN itself. Then, careful neurological and cardiovascular assessment should be undertaken throughout the initial treatment.

Children with a hypertensive emergency should always be treated with intravenous drugs. Continuous infusion is safer than bolus in regard to complication (unexpected hypotension with vital organ hypoperfusion and irreversible neurological damage such as visual loss). Sodium nitropruside and labetalol are the most commonly used drugs for hypertensive emergencies in children. However, some drugs are no longer available in some countries. Hypertensive urgencies can be treated by oral drugs. Table 22 indicates drugs and doses used for pediatric hypertensive crises.

Malignant hypertension

Malignant HTN was classically defined by the presence of an acute increase of BP values, with or without previous

HTN, and a funduscopy stages III or IV. Today, it is considered an acute elevation of BP associated with impairment of at least three different target organs or even the presence of microangiopathic hemolytic anemia. The prevalence of malignant HTN has clearly fallen with the advent of antihypertensive medication. Early recognition and management of malignant HTN are fundamental to any improvement in prognosis, although parenteral drug administration is not necessary [245].

TREATMENT OF ASSOCIATED RISK FACTORS

Lipid-lowering agents

The 2011 National Heart, Lung, and Blood Institute Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents [218] recommend to consider statin therapy for children more than 10 years with LDL-C levels of at least 190 mg/dl (<4.9 mmol/l) without other risk factors, or at least 160 mg/dl (<4.1 mmol/l) if additional risk factors are present and in those with LDL-C levels more than 130 mg/dl (>3.4 mmol/l) after 6 months of lifestyle changes. In contrast, the 2013 American College of Cardiology and American Heart Association Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults recommends medication for individuals younger than 40 years only if their LDL-C level is at least 190 mg/dl (4.9 mmol/l) [246]. Children less than 10 years should not be treated with a lipid-lowering medication unless they have a severe primary familial hyperlipidemia or high-risk conditions. Given the conflicting lipid treatment guidelines for youth and current uncertain state of knowledge on long-term safety of statin therapy [247,248], the panel recommend to initially address modifiable risk factors such as diet, exercise, weight and abstinence from tobacco and institute a lipid-lowering therapy only after careful evaluation of potential benefits, harms and patient preferences. In children on statins, monitoring of hepatic enzymes and clinical assessment for muscle toxicity are strongly recommended. Fish oil should be used to reduce triglyceride levels.

Glycemic control

Lifestyle changes should be initiated at the time of diagnosis of DM2 as well as in children with hyperglycemia and elevated risk of DM2. Nutritional advice must focus on eliminating sugar-containing soft drinks, increasing fruit and vegetable intake, reducing processed, prepackaged food and controlling portions. Youths should be encouraged to engage in moderate-to-vigorous exercise for at least 60 min daily. Initial pharmacologic treatment for children with DM2 should include metformin and insulin, alone or in combination, depending on symptoms, severity of hyperglycemia and presence or absence of ketosis/ketoacidosis [225]. The TODAY Study compared the efficacy of three treatment regimens to achieve durable glycemic control in 699 children and adolescents with recent-onset DM2 [249]. Results showed that metformin alone is effective in maintaining durable glycemic control in only half of children, and the addition of rosiglitazone, but not intensive lifestyle

intervention, is superior to metformin alone. These findings suggest that most children require a combination treatment or insulin therapy within a few years after diagnosis and that more effective lifestyle regimens for children must be identified. Several clinical trials of newer oral hypoglycemic agents are underway in DM2 youth, but recruitment is slow and results are not expected for many years.

SCREENING AND TREATMENT OF SECONDARY FORMS OF HYPERTENSION

General strategy to when and how to look for secondary hypertension in children and adolescents

Secondary HTN is generally accepted to be much more common in children and adolescents than in the adult population, with some studies reporting prevalence as high as 75–85% in younger children [250–252]. More recent reports, however, have highlighted the increasing prevalence of primary HTN, which is strongly linked to childhood obesity, particularly in the adolescent population.

Secondary HTN should be suspected in the younger patient in whom there is a very high-BP or secondary complications (hypertensive encephalopathy, cranial nerve palsy, heart failure etc.) or HTN is difficult to treat. A good general rule to follow is that the likelihood of identifying a secondary cause of HTN is inversely related to the age of the child and directly related to the degree of BP elevation [253].

The clinical history should identify potential indicators to a secondary cause for HTN, including previous urine infection, gross hematuria or edema, episodes of acute kidney injury, umbilical artery catheterization, vascular events, snoring and sleep problems suggestive of OSA and any strong family history of HTN at a young age. Examination should seek to identify clinical signs suggestive of systemic disorders associated with HTN (refer to Table 14). In general, young children, children with very high or complicated HTN, and those with the aforementioned clinical symptoms and signs should be investigated more extensively than the older child with seemingly mild HTN.

Renal parenchymal disease

As the most common form of secondary HTN in children and adolescents are diseases of the renal parenchyma, screening to detect an underlying cause of HTN should start with specific tests to detect renal abnormalities. This includes urine analysis (hematuria, proteinuria) and blood tests (creatinine, urea, uric acid and electrolytes) as well as renal function tests [1]. For the diagnosis of chronic glomerular diseases, renal biopsy is often necessary to clarify the form of glomerulonephritis and the degree of glomerular damage, and a special kind of involvement, for example focal segmental glomerulosclerosis. Ultrasonography is able to detect autosomal-dominant and autosomal-recessive forms of polycystic kidney diseases, renal dysplasia or reflux nephropathy. Reflux nephropathy (pyelonephritic scarring) results from vesicoureteric reflux combined with urinary-tract infection in early life and requires a micturition cystourethrography. Additional techniques of

renal imaging (e.g. scintigraphy CT and MRI) are seldom needed. In cases of suspected genetic disease (e.g. Alport syndrome, congenital nephrotic syndrome), genetic testing is required. For treatment approach, see the 'Non-diabetic renal disease' section.

Renovascular hypertension

Diseases of the renal vessels resulting from lesions that cause significant impairment of blood flow to kidneys are far rarer than diseases of the renal parenchyma. The most single cause of renovascular HTN in children is fibromuscular dysplasia [254]. Stenosis of the renal artery is not often associated with neurofibromatosis, but it should be excluded. Also other syndromes, for example Klippel–Trenaunay, Turner and Alagille syndrome have to be considered [255].

Plasma renin activity is often recommended to detect renovascular HTN, but it is not sensitive or specific and has a role to detect low renin HTN, mainly monogenic forms of HTN. Imaging procedures by abdominal ultrasound including color-aided and Doppler sonography of the renal artery shows increased systolic and particularly diastolic flow velocity in the renal arteries. MRI angiography is more sensitive and specific to demonstrate abdominal or renal artery stenosis; this is the diagnostic procedure of choice. However, its sensitivity and specificity is lower than the gold standard procedure, that is renal angiography.

Renal artery revascularization is often able to control HTN in fibromuscular dysplasia [256]. When angioplasty is not effective, surgical procedures should be chosen as the next therapeutic approach [257].

Pheochromocytoma

Pediatric pheochromocytomas and extra-adrenal catecholamine-producing tumors are more frequently familial, bilateral, multifocal and malignant. Half of these tumors are associated with a mutation of one of the 12 known susceptibility genes. These tumors are often identified during presymptomatic screening in children with genetic syndromes such as multiple endocrine neoplasia type 2, von Hippel–Lindau disease, type 1 neurofibromatosis and the paraganglioma syndromes [258,259]. Plasma and/or urine metanephrine measurement and MR imaging are recommended as first-line diagnostic approach. Surgical resection, with appropriate perioperative management of catecholamine-related symptoms, is the treatment of choice. In the case of metastatic disease, surgical removal of metastases and I-131-MIBG radiotherapy can be performed [258,259].

Primary aldosteronism

Primary aldosteronism is characterized by HTN with low plasma renin and elevated aldosterone and often associated with hypokalemia. An early-onset primary aldosteronism suggests inherited causes. Three familial aldosteronisms have been described: familial hyperaldosteronism type 1 (FH-1) (glucocorticoid-remediable aldosteronism caused by mutations affecting aldosterone synthase), FH-2 (with unknown molecular basis) and FH-3 (two distinct syndromes with or without adrenal hyperplasia resulting from different

mutations in genes coding for ion channels) [260]. FH-1 is associated with high morbidity and mortality at an early age and should be treated in children with eplerenone to avoid glucocorticoid effects on growth or antiandrogenic effects of spironolactone. Children with FH-3 and bilateral adrenal hyperplasia present with severe HTN refractory to treatment and need bilateral adrenalectomy. FH-2 is clinically and biochemically indistinguishable from sporadic forms [260].

Cushing's syndrome

In children more than 7 years of age the most frequent cause of endogenous Cushing syndrome is an adrenocorticotrophic hormone secreting pituitary microadenoma (75%), whereas adrenocortical tumors (70% malignant) are more common in younger children. Micronodular adrenal hyperplasia can also occur as part of genetic disorders such as the McCune–Albright syndrome and the primary pigmented bilateral adrenocortical nodular disease [261]. This latter may be associated with Carney complex (multiple endocrine tumors, lentiginos and myxomas). The most common presenting features are weight gain and growth retardation. HTN is present in about half of children with Cushing syndrome. High SBP levels persist 1 year after surgery in 5.5–21% of children [262,263].

Obstructive sleep apnea

Prevalence of sleep-apnea syndrome in children is around 2–3% in the general population [264], although among obese adolescents the prevalence varies between 13 and 66% [265–268]. Dayyat *et al.* [269] described two types of OSA in children. Although type I is characterized by amigdal hypertrophy, mild overweight, hyperactivity and with recurrent infections, type II is present in obese patients with diurnal hypersomnia, HTN and metabolic disturbances. Nocturnal pulsioxymetry can identify children and adolescents at high risk of OSA. During monitoring, three or more desaturations per hour have up to a 97% predictive value in children without any other health problem. However, if the test is normal, this does not exclude the presence of OSA, as the test has a 47% negative predictive value.

Several studies have linked OSA and the alterations in the glucose metabolism with insulin resistance, apart from the BP elevation. The mechanisms that link obesity, OSA and insulin resistance are controversial. Some authors defend the hypothesis that the sleep fragmentation and the nocturnal hypoxia are responsible for insulin resistance [270], increment of cortisol, overdrive of the sympathetic nervous system [271] and the increment in insulin [272]. Others consider that the primary alteration is obesity and insulin resistance, resulting in a respiratory disorder during sleep, facilitating the collapse of the upper airway through inflammatory mediators and a reduction in the neural drive of the dilatory muscle of the airway [273].

HTN treatment in these adolescents should be based on treating obesity. In the most severe forms resistant to losing weight, continuous positive airway pressure should be used.

Coarctation of aorta

CoA accounts for 5–7% of all congenital heart disease with an incidence of approximately three cases per 10 000 births

TABLE 23. Drug-induced hypertension

Drug/substance	Mechanism of action	Treatment
Glicocorticoids	Sodium retention, RAAS activation, sympathetic system activation	Decrease dose if possible, diuretics, ACEi/ARB and DCCB
Cyclosporine	Arteriolar constriction, sodium retention	DCCB, ACEi/ARB; switch to tacrolimus
Tacrolimus	Less potent hypertensive effect than Cyclosporine	DCCB
Liquorice	Mineralocorticoid effect caused by inhibition of 11beta dehydrogenase isoform 2	Avoid; mineralocorticoid receptor antagonists
NSAIDs; cyclooxygenase 2 inhibitors	Sodium retention (indomethacin is most potent)	Sodium restriction, diuretics and DCCB
Antidepressants and antipsychotics (velafaxine, desvenlafaxine, TCAs and clozapine)	Inhibition of serotonin and norepinephrine reuptake	
Monoamine oxidase inhibitors	Sympathomimetic effect	Avoidance of tyramine-rich foods; chlorpromazine
Oral contraceptives containing estrogens and progesterone	Mineralocorticoid effect, increased synthesis of angiotensinogen	Diuretics, ACEi/ARB
Androgens	Mechanism not know. Probable mineralocorticoid effect	Diuretics, ACEi/ARB and DCCB
Phenylephrine hydrochloride (used as upper respiratory tract decongestant and as ophthalmic drops in neonates/infants)	Sympathomimetic effect	Beta and alpha-adrenolytics
Pseudoephedrine hydrochloride	Sympathomimetic effect	Alpha-adrenolytics
Ketamine hydrochloride	Sympathomimetic effect	alpha-adrenolytics, DCCB; propofol attenuates sympathomimetic effect
Methylphenidate, amphetamine	Sympathomimetic effects	Not known – beta and alpha-adrenolytics proposed
Anti-VEGF pathway drugs	Increase of peripheral vascular resistance	DCCB, ACEi/ARB
Erythropoietin/erythropoiesis stimulating agents	Increase of peripheral vascular resistance	DCCB, lower hemoglobin target
Caffeine	Sympathomimetic effects	Beta-adrenolytics
Cocaine, amphetamine and modafenil	Sympathomimetic effect	Benzodiazepines; avoid beta-adrenolytics
Ephedra alkaloids, synephrine and octopamine	Sympathomimetic effect	Avoid

ACEi, angiotensin-converting enzyme inhibitors; ARB, angiotensin II receptor blocker; DCCB, dihydropyridine calcium channel blockers; RAAS, renin–angiotensin–aldosterone system; VEGF, vascular endothelial growth factor.

[274]. Patients with less severe CoA may not be diagnosed until later in childhood when a murmur is heard or HTN noted. In addition, residual or late-onset HTN is a well known complication in successfully repaired CoA. The chronic burden of HTN in CoA patients is likely significantly higher than in other at-risk populations due to the early onset of the illness [275]. This population needs to be treated as at particularly high risk, and HTN should be aggressively sought and treated. Before considering antihypertensive agents, a recoarctation must be ruled out. In children aged 7–16 years, the prevalence of restenosis is suggested to be as high as 21% [276], and masked HTN is common, then ABPM should be performed regularly from the age of seven [80]. Exercise HTN may also be present despite the lack of early or long-term residual or recurrent obstruction. The clinical significance of abnormal BP response to exercise is somewhat controversial [277]. It has been suggested that it is a predictor of chronic HTN [278,279].

Before considering antihypertensive agents, a recoarctation must be ruled out. Beta-blockers, calcium channel blockers and drugs affecting the renin–angiotensin–aldosterone system efficiently lower BP [280,281].

Drug-induced hypertension

Drug-induced HTN (DIH) is defined as HTN caused by the unintended effect of a drug, or from a drug's antagonizing effects on antihypertensive treatment [282]. The two major mechanisms of DIH are sodium retention and sympathomimetic effect (Table 23). Treatment of DIH is by withdrawal of the drug causing DIH and sometimes short-term antihypertensive treatment may be needed. When therapy with a therapeutic agent causing DIH cannot be stopped,

chronic antihypertensive treatment should be started. DIH may present as resistant HTN or exacerbation of HTN in a child already treated with antihypertensive drugs, or *de novo* in a previously normotensive child [282,283]. The distinct cause of DIH is the use of illicit psychostimulants which exert sympathoexcitatory effect. Oral-contraceptive drugs should be considered in adolescent girls and should be removed when HTN is detected; BP can be increased even after 2 months of withdrawal. The recent introduction in cancer treatment of antiangiogenic drugs has become a relevant cause of DIH. Inhibitors of angiogenesis produce reduced activity of vascular endothelial growth factor pathway via tyrosin kinase.

Treatment of DIH is based on expert opinions and case series. The most frequent DIH, mechanism and recommended treatment are in Table 23.

Monogenic causes of hypertension

Monogenic diseases should be suspected in children with low renin HTN and a family history of early-onset severe HTN, death from cerebral vascular accidents and heart failure or refractory HTN. A trend to hypokalemia is a common feature of the majority of the low renin hypertensive states, with the exception of Gordon's syndrome.

Most forms of monogenic HTN are sodium-dependent secondary to mineralocorticoid effect caused by mineralocorticoids, cortisol, mineralocorticoid-independent sodium reabsorption by epithelial sodium channel (ENaC), activated mineralocorticoid receptor or deoxycorticosterone [282,283]. Figure 4 outlines a rational approach to each of the most frequent monogenic causes. Following the clinical suspicion, a specific test should be performed.

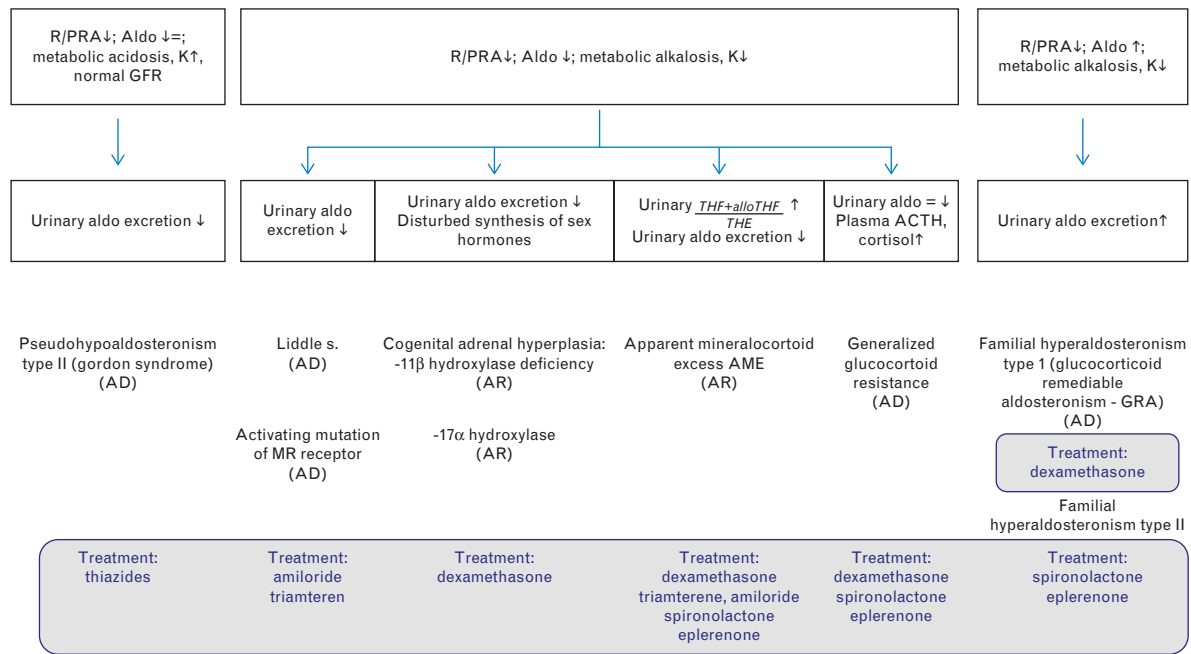


FIGURE 4 Mendelian causes of hypertension. Metabolite profile and recommended treatment. Diagnostic algorithm in low plasma renin activity hypertension and genetic testing. Ratio of urinary THF + alloTHF/THE, normal less than 1.3, apparent mineralocorticoid excess 5–10-fold higher. Shaded area corresponds to the recommended treatment. ACTH, adrenocorticotropic hormone; AD, autosomal dominant; Aldo, aldosterone; alloTHF, allotetrahydrocortisol; AR, autosomal recessive; GFR, glomerular filtration rate; GRA, glucocorticoid remediable aldosteronism; PRA, plasma renin activity; R, rennin; THE, tetrahydrocortisone; THF, tetrahydrocortisol.

Treatment of monogenic HTN is directed against main pathophysiological disturbances and confirmed by results of case series. Treatment of sodium-dependent, low-renin monogenic HTN is based on low-sodium diet and blockade of pathological mechanisms of sodium reabsorption. Treatment of pseudohypoaldosteronism type II is based on thiazides. Treatment of Liddle syndrome and of activating mutation of MR treatment is directed against ENaC and based on amiloride or triamterene. In apparent mineralocorticoid excess (defective metabolism of cortisol to cortison) treatment is based on dexamethasone, blockers of ENaC and MR. Congenital adrenal hyperplasia associated with HTN, that is deficiency of 11β or of 17α hydroxylase, is treated with dexamethasone and blockers of MR. Treatment of choice in FH-1 is dexamethasone and in FH-2 are blockers of MR. In autosomal-dominant brachydactyly with HTN multidrug regimen based on beta-blockers devoided of sympathomimetic action, alpha-blockers and calcium channel blockers are suggested [284] (Fig. 4). Diagnosis of secondary causes of hypertension is shown in Table 24.

FOLLOW-UP

Depending on the underlying cause of HTN, periodic, probably life-long follow-up is advisable in the majority of children. Regular home BP monitoring can greatly facilitate the management of HTN for better assessing of BP control. In children with CKD or diabetes, regular ABPMs at 6–12-month intervals are recommended to rule out selective nocturnal HTN.

In patients with LVH or inadequately controlled BP, cardiac assessment should be repeated at least every 6 months. Fundoscopy should be performed at least annually in patients with HTNR. Patients with well controlled

TABLE 24. Diagnosis of secondary causes of hypertension

Chronic kidney disease	Protein, erythrocytes and erythrocyte casts in urine Serum creatinine concentration and potassium
	Abdominal ultrasound
Renovascular hypertension	[^{99m} Tc ^m]dimercaptosuccinic acid static scanning
	PRA
	Abdominal ultrasound
	Renal artery Doppler ultrasound
	MRI angiography
	Angiography
Pheochromocytoma and paraganglioma	24-h urine and plasma catecholamines or metanephrines
	MRI
	i123 metaiodobenzylguanidine
Primary aldosteronism	PRA
	Plasma aldosterone
Cushing's syndrome	Plasma cortisol, ACTH
	24-h urinary free cortisol
CoA	Rx chest
	Echocardiography
	MRI angiography
	Aortography
Mendelian	PRA, adrenal steroid metabolites
	DNA testing
Drug-induced	Liquorice, oral contraceptives, glucocorticoids and nonsteroidal
	Anti-inflammatory drugs, sympathomimetics, erythropoietin, cyclosporine, tacrolimus, cocaine and metabolic steroids
Hyperthyroidism	TSH, FT3 and FT4
Congenital adrenal hyperplasia	Plasma deoxycorticosterone and corticosterone, 18-hydroxycorticosterone, 18-hydroxy deoxycorticosterone and 11 deoxycortisol

ACTH, adrenocorticotropic hormone; CoA, coarctation of aorta; FT3, free triiodothyronine; FT4, free thyroxine; PRA, plasma renin activity; TSH, thyroid stimulating hormone.

HTN and no target organ disorder should be monitored at larger intervals, for example every 12–24 months, to rule out de novo TOD.

In some patients, in whom treatment is accompanied by an effective BP control for an extended period, it may be possible to reduce the number and dose of drugs. This may be particularly the case if BP control is accompanied by healthy lifestyle changes, such as weight loss, exercise habits and a low-fat and low-salt diet, which remove environmental pressor influences. Reduction of medications should be made gradually and the patient should frequently be checked because of the risk of reappearance of HTN.

IMPLEMENTATION OF GUIDELINES AND WHERE TO INTERVENE: COMMUNITY SETTINGS AND STAKEHOLDERS

Synergistic actions at various levels (learned societies and international expert committees, general practitioners, pediatricians, nurses and other healthcare providers, schools, parents and policy makers) should be successfully implemented to limit, and even reduce, the burden of HTN in children and adolescents. The role of learned societies, particularly the ESH, is crucial not only for spreading the guidelines all over European Countries, but also for obtaining the acceptance by national HTN societies and leagues.

In parallel, a concerted public action is needed to both improve identification and treatment of high BP among children and adolescents, and to encourage lifestyle factors, namely healthy nutrition, low salt intake, non-smoking, alcohol avoidance and exercise activity, as preventive and curative measures. Only an aggressive public policy initiative will lead healthcare providers, insurers and other payers to increase the reimbursement of costs associated with the investigation and long-term treatment of high BP in children and adolescents. Indeed, a comprehensive preventive program in each European country involving all the above actors, as well as families and school teachers, is a prerequisite to promoting management implementation in practice and improving child and adolescent health.

TABLE 25. Future research

Develop accurate devices for oscillometric BP measurement
Obtain robust reference values for office, home and ambulatory BP-based on a European pediatric population
Increase knowledge in the use of out-of-office BP measurements, 24-h and home
Refine the clinical significance of white-coat, masked HTN and isolated nocturnal hypertension
Obtain further insights about Central BP and PWV as markers of function of the vascular system
Unravel the significance of ISH and their management
Develop biomarkers for risk of developing hypertension and organ damage as tools to stratify risk by using precision medicine
Conduct large, long term randomized therapeutic trials using onset of organ damage as intermediate objectives (such as onset of microalbuminuria and/or left ventricular hypertrophy) to obtain information about when to initiate antihypertensive drug treatment and the BP goals
Conduct controlled studies with antihypertensive drugs to improve knowledge about specific benefits and disadvantages of BP-lowering agents and establish adequate doses

BP, blood pressure; ISH, isolated systolic hypertension; HTN, hypertension; PWV, pulse wave velocity.

A converging action is the only means to closing the gap between experts' recommendations and undiagnosed HTN in children and adolescents, undetected TOD and poor BP control.

The writing committee is well aware of the fact that issuing these guidelines does not imply implementation. These guidelines represent a consensus among specialists involved in the detection and control of high BP in children and adolescents. Scientific evidence derived from trials is not available in children, and therefore these guidelines are likely to be modified in forthcoming years depending on new evidence to be acquired. The recommendations of the present document synthesize a considerable amount of scientific data and clinical experience, and represent the best clinical wisdom upon which physicians, nurses and families should base their decisions. In addition, because they call attention to the burden of HTN in children and adolescents, and its contribution to the current epidemic of cardiovascular disease, these guidelines should encourage public policy makers to develop a global effort to improve identification and treatment of high BP among children and adolescents.

FUTURE RESEARCH

Several times, these guidelines have acknowledged and lamented the lack of solid, trial-based evidence for recommendations on diagnosis and management of pediatric HTN. Areas requiring urgent increase in knowledge have been listed in Table 25. A commitment to finding answers to the outlined issues should guide concerted actions over the next several years in Europe.

ACKNOWLEDGEMENTS

Conflicts of interest

There are no conflicts of interest.

REFERENCES

- Lurbe E, Cifkova R, Cruickshank JK, Dillon MJ, Ferreira I, Invitti C, *et al.*, European Society of Hypertension. Management of high blood pressure in children and adolescents: recommendations of the European Society of Hypertension. *J Hypertens* 2009; 27:1719–1742.
- Moyer VA, U.S. Preventive Services Task Force. Screening for primary hypertension in children and adolescents: U.S. Preventive Services Task Force recommendation statement. *Ann Intern Med* 2013; 159:613–619.
- Brady TM, Redwine KM, Flynn JT, American Society of Pediatric Nephrology. Screening blood pressure measurement in children: are we saving lives? *Pediatr Nephrol* 2014; 29:947–950.
- Chiolero A, Bovet P, Paradis G. Controversy about hypertension screening in children: a public health perspective. *J Hypertens* 2015; 33:1352–1355.
- Bianchetti MG, Bucher BS, Simonetti GD. Controversy about hypertension screening in children: a clinical perspective. *J Hypertens* 2015; 33:1356–1358.
- Lurbe E, Ingelfinger JR. Blood pressure in children and adolescents: current insights. *J Hypertens* 2016; 34:176–183.
- National High Blood Pressure Education Program Working Group on High Blood Pressure in Children and Adolescents. The fourth report on the diagnosis, evaluation, and treatment of high blood pressure in children and adolescents. *Pediatrics* 2004; 114:555–576.
- Lurbe E, Torro MI, Alvarez-Pitti J, Redon P, Redon J. Central blood pressure and pulse wave amplification across the spectrum of peripheral blood pressure in overweight and obese youth. *J Hypertens* 2016; 34:1389–1395.

9. Chen X, Wang Y. Tracking of blood pressure from childhood to adulthood: a systematic review and meta-regression analysis. *Circulation* 2008; 117:3171–3180.
10. Toschke AM, Kohl L, Mansmann U, von Kries R. Meta-analysis of blood pressure tracking from childhood to adulthood and implications for the design of intervention trials. *Acta Paediatr* 2010; 99:24–29.
11. Tirosh A, Afek A, Rudich A, Percik R, Gordon B, Ayalon N, et al. Progression of normotensive adolescents to hypertensive adults: a study of 26,980 teenagers. *Hypertension* 2010; 56:203–209.
12. Vik KL, Romundstad P, Nilsen TI. Tracking of cardiovascular risk factors across generations: family linkage within the population-based HUNT study, Norway. *J Epidemiol Community Health* 2013; 67:564–570.
13. Carrico RJ, Sun SS, Sima AP, Rosner B. The predictive value of childhood blood pressure values for adult elevated blood pressure. *Open J Pediatr* 2013; 3:116–126.
14. Campana EM, Brandão AA, Pozzan R, França MdeF, Fonseca FL, Pizzi OL, et al. Blood pressure in young individuals as a cardiovascular risk marker. The Rio de Janeiro study. *Arq Bras Cardiol* 2009; 93:608–615.
15. Erlingsdottir A, Indridason OS, Thorvaldsson O, Edvardsson VO. Blood pressure in children and target-organ damage later in life. *Pediatr Nephrol* 2010; 25:323–328.
16. Sundin PO, Udumyan R, Sjöström P, Montgomery S. Predictors in adolescence of ESRD in middle-aged men. *Am J Kidney Dis* 2014; 64:723–729.
17. Daniels SR, Loggie JM, Khoury P, Kimball TR. Left ventricular geometry and severe left ventricular hypertrophy in children and adolescents with essential hypertension. *Circulation* 1998; 97:1907–1911.
18. Sorof JM, Cardwell G, Franco K, Portman RJ. Ambulatory blood pressure and left ventricular mass in hypertensive children. *Hypertension* 2002; 39:903–908.
19. Litwin M, Niemirska A, Śladowska J, Antoniewicz J, Daszkowska J, Wierzbicka A, et al. Left ventricular hypertrophy and arterial wall thickening in children with essential hypertension. *Pediatr Nephrol* 2006; 21:811–819.
20. Assadi F. Relation of left ventricular hypertrophy to microalbuminuria and C-reactive protein in children and adolescents with essential hypertension. *Pediatr Cardiol* 2008; 29:580–584.
21. Tomczak J, Wasilewska A, Milewski R. Urine NGAL and KIM-1 in children and adolescents with hyperuricemia. *Pediatr Nephrol* 2013; 28:1863–1869.
22. Litwin M, Niemirska A, Śladowska-Kozłowska J, Wierzbicka A, Janas R, Wawer ZT, et al. Regression of target organ damage in children and adolescents with primary hypertension. *Pediatr Nephrol* 2010; 25:2489–2499.
23. Seeman T, Gilik J, Vondrak K, Simkova E, Flogelova H, Hladikova M, et al. Regression of left-ventricular hypertrophy in children and adolescents with hypertension during ramipril monotherapy. *Am J Hypertens* 2007; 20:990–996.
24. Assadi F. Effect of microalbuminuria lowering on regression of left ventricular hypertrophy in children and adolescents with essential hypertension. *Pediatr Cardiol* 2007; 28:27–33.
25. Wühl E, Trivelli A, Picca S, Litwin M, Peco-Antic A, Zurowska A, et al., ESCAPE Trial Group. Strict blood-pressure control and progression of renal failure in children. *N Engl J Med* 2009; 361:1639–1650.
26. Aatola H, Magnussen CG, Juonala M, Koivisto T, Hutri-Kähönen N, Juonala M, et al. Simplified definitions of elevated pediatric blood pressure and high adult arterial stiffness. *Pediatrics* 2013; 132:e70–e76.
27. Juonala M, Magnussen CG, Venn A, Dwyer T, Burns TL, Davis PH, et al. Influence of age on associations between childhood risk factors and carotid intima-media thickness in adulthood: the Cardiovascular Risk in Young Finns Study, the Childhood Determinants of Adult Health Study, the Bogalusa Heart Study, and the Muscatine Study for the International Childhood Cardiovascular Cohort (i3C) Consortium. *Circulation* 2010; 122:2514–2520.
28. Juhola J, Magnussen CG, Berenson GS, Venn A, Burns TL, Sabin MA, et al. Combined effects of child and adult elevated blood pressure on subclinical atherosclerosis: the International Childhood Cardiovascular Cohort Consortium. *Circulation* 2013; 128:217–224.
29. Kishi S, Teixeira-Tura G, Ning H, Venkatesh BS, Wu C, Almeida A, et al. Cumulative blood pressure in early adulthood and cardiac dysfunction in middle age the CARDIA study. *J Am Coll Cardiol* 2015; 65:2679–2687.
30. Ferreira I, van de Laar RJ, Prins MH, Twisk JW, Stehouwer CD. Carotid stiffness in young adults: a life-course analysis of its early determinants The Amsterdam Growth and Health Longitudinal Study. *Hypertension* 2012; 59:54–61.
31. Chiolero A, Cachat F, Burnier M, Paccaud F, Bovet P. Prevalence of hypertension in schoolchildren based on repeated measurements and association with overweight. *J Hypertens* 2007; 25:2209–2217.
32. Katona É, Zrínyi M, Lengyel S, Komonyi É, Paragh G, Zatik J, et al. The prevalence of adolescent hypertension in Hungary – the Debrecen hypertension study. *Blood Press* 2011; 20:134–139.
33. Ostrowska-Nawarycz L, Nawarycz T. Prevalence of excessive body weight and high blood pressure in children and adolescents in the city of Łódź. *Kardiologia Pol* 2007; 65:1079–1087.
34. Akgun C, Dogan M, Akbayram S, Tuncer O, Peker E, Taskin G, et al. The incidence of asymptomatic hypertension in school children. *J Nippon Med Sch* 2010; 77:160–165.
35. Papandreou D, Stamou M, Malindretos P, Rouso I, Mavromichalis I. Prevalence of hypertension and association of dietary mineral intake with blood pressure in healthy schoolchildren from northern Greece aged 7–15 years. *Ann Nutr Metab* 2007; 51:471–476.
36. Maldonado J, Pereira T, Fernandes R, Santos R, Carvalho M. An approach of hypertension prevalence in a sample of 5381 Portuguese children and adolescents. The AVELEIRA registry. “Hypertension in children”. *Blood Press* 2011; 20:153–157.
37. Gupta-Malhotra M, Banker A, Shete S, Hashmi SS, Tyson JE, Barratt MS, et al. Essential hypertension vs. secondary hypertension among children. *Am J Hypertens* 2015; 28:73–80.
38. Rosner B, Cook NR, Daniels S, Falkner B. Childhood blood pressure trends and risk factors for high blood pressure: the NHANES experience 1988–2008. *Hypertension* 2013; 62:247–254.
39. Genovesi S, Antolini L, Giussani M, Pieruzzi F, Galbiati S, Valsecchi MG, et al. Usefulness of waist circumference for the identification of childhood hypertension. *J Hypertens* 2008; 26:1563–1570.
40. Sorof JM, Lai D, Turner J, Poffenbarger T, Portman RJ. Overweight, ethnicity, and the prevalence of hypertension in school-aged children. *Pediatrics* 2004; 113:475–482.
41. Flechtner-Mors M, Neuhauser H, Reinehr T, Roost HP, Wiegand S, Siegfried W, et al., APV initiative and the BMBF Competence Network Obesity. Blood pressure in 57,915 pediatric patients who are overweight or obese based on five reference systems. *Am J Cardiol* 2015; 115:1587–1594.
42. Redwine KM, Acosta AA, Poffenbarger T, Portman RJ, Samuels J. Development of hypertension in adolescents with Ppe-hypertension. *J Pediatr* 2012; 160:98–103.
43. Lurbe E, Thijs L, Torro MI, Alvarez J, Staessen JA, Redon J. Sexual dimorphism in the transition from masked to sustained hypertension in healthy youths. *Hypertension* 2013; 62:410–414.
44. TODAY Study Group. Rapid rise in hypertension and nephropathy in youth with type 2 diabetes. *Diabetes Care* 2013; 36:1735–1741.
45. Parker ED, Sinaiko AR, Kharbanda EO, Margolis KL, Daley MF, Trower NK, et al. Change in weight status and development of hypertension. *Pediatrics* 2016; 137:1–9.
46. Bocelli A, Favilli S, Pollini I, Bini RM, Ballo P, Chiappa E, Zuppirol A. Prevalence and long-term predictors of left ventricular hypertrophy, late hypertension, and hypertensive response to exercise after successful aortic coarctation repair. *Pediatr Cardiol* 2013; 34:620–629.
47. Havlik RJ, Garrison RJ, Feinleib M, Kannel WB, Castelli WP, McNamara PM. Blood pressure aggregation in families. *AM J Epidemiol* 1979; 110:304–312.
48. Bochud M, Bovet P, Elston RC, Paccaud F, Falconnet C, Maillard M, et al. High heritability of ambulatory blood pressure in families of East African descent. *Hypertension* 2005; 45:445–450.
49. Bonati MT, Graziano F, Monti MC, Crocamo C, Terradura-Vagnarelli O, Cirillo M, et al. Heritability of blood pressure through latent curve trajectories in families from the Gubbio population study. *J Hypertens* 2014; 32:2179–2187.
50. Lifton RP, Gharavi AG, Geller DS. Molecular mechanisms of human hypertension. *Cell* 2001; 104:545–556.
51. Padmanabhan S, Caulfield M, Dominiczak AF. Blood pressure genomics. *Circ Res* 2015; 116:937–959.
52. Harding S, Whitrow M, Lenguerrand E, Maynard M, Teyhan A, Cruickshank JK, et al. Emergence of ethnic differences in blood

- pressure in adolescence: the determinants of adolescent social well being and health study. *Hypertension* 2010; 55:1063–1069.
53. O'Brien E, O'Malley K. Evaluation of blood pressure measuring devices with special reference to ambulatory systems. *J Hypertens Suppl* 1990; 8:S133–S139.
 54. Association for the Advancement of Medical Instrumentation. American National Standard. *Electronic or automated sphygmomanometers ANSI/AAMI SP10-1992*. Arlington, VA, USA: AAMI; 1993.
 55. O'Brien E, Pickering T, Asmar R, Myers M, Parati G, Staessen J, *et al.*, On behalf of the Working Group on Blood Pressure Monitoring of the European Society of Hypertension. International protocol for validation of blood pressure measuring devices in adults. *Blood Press Monit* 2002; 7:3–17.
 56. Neuhauser HK, Thamm M, Ellert U, Hense HW, Rosario AS. Blood pressure percentiles by age and height from nonoverweight children and adolescents in Germany. *Pediatrics* 2011; 127:e978–988.
 57. Kułaga Z, Litwin M, Grajda A, Kułaga K, Gurzkowska B, Gózdź M, *et al.*, OLAF Study Group. Oscillometric blood pressure percentiles for Polish normal-weight school-aged children and adolescents. *J Hypertens* 2012; 30:1942–1954.
 58. Barba G, Buck C, Bammann K, Hadjigeorgiou C, Hebestreit A, Mårild S, *et al.*, IDEFICS Consortium. Blood pressure reference values for European nonoverweight school children: the IDEFICS study. *Int J Obes* 2014; 38:S48–S56.
 59. O'Brien E, Parati G, Stergiou G, Asmar R, Beilin L, Bilo G, *et al.*, European Society of Hypertension Working Group on Blood Pressure Monitoring. European Society of Hypertension position paper on ambulatory blood pressure monitoring. *J Hypertens* 2013; 31:1731–1768.
 60. Parati G, Stergiou G, O'Brien E, Asmar R, Beilin L, Bilo G, *et al.*, European Society of Hypertension Working Group on Blood Pressure Monitoring and Cardiovascular Variability. European Society of Hypertension practice guidelines for ambulatory blood pressure monitoring. *J Hypertens* 2014; 32:1359–1366.
 61. Salice P, Ardissino G, Barbier P, Bacà L, Vecchi DL, Ghiglia S, *et al.* Differences between office and ambulatory blood pressures in children and adolescents attending a hospital hypertension clinic. *J Hypertens* 2013; 31:2165–2175.
 62. Sega R, Facchetti R, Bombelli M, Cesana G, Corrao G, Grassi G, *et al.* Prognostic value of ambulatory and home blood pressures compared with office blood pressure in the general population: follow-up results from the Pressioni Arteriose Monitorate e Loro Associazioni (PAMELA) study. *Circulation* 2005; 111:1777–1783.
 63. Lurbe E. Ambulatory blood pressure in children: confidence and wisdom. *J Hypertens* 2013; 31:2125–2127.
 64. Stergiou GS, Yiannes NG, Rarra VC, Panagiotakos DB. Home blood pressure normalcy in children and adolescents: the Arsakeion School study. *J Hypertens* 2007; 25:1375–1379.
 65. Salgado CM, Jardim PC, Viana JK, Jardim TdeS, Velasquez PP. Home blood pressure in children and adolescents: a comparison with office and ambulatory blood pressure measurements. *Acta Paediatr* 2011; 100:163–168.
 66. Asayama K, Staessen JA, Hayashi K, Hosaka M, Tatsuta N, Kurokawa N, *et al.* Mother-offspring aggregation in home versus conventional blood pressure in the Tohoku Study of Child Development (TSCD). *Acta Cardiol* 2012; 67:449–456.
 67. Stergiou GS, Nasothimiou EG, Giovas PP, Rarra VC. Long-term reproducibility of home vs. office blood pressure in children and adolescents: the Arsakeion school study. *Hypertens Res* 2009; 32:311–315.
 68. Wühl E, Hadtstein C, Mehls O, Schaefer F, Escape Trial Group. Home, clinic, and ambulatory blood pressure monitoring in children with chronic renal failure. *Pediatr Res* 2004; 55:492–497.
 69. Furusawa EA, Filho UD, Junior DM, Koch VH. Home and ambulatory blood pressure to identify white coat and masked hypertension in the pediatric patient. *Am J Hypertens* 2011; 24:893–897.
 70. Stergiou GS, Ntineri A, Kollias A, Destounis A, Nasothimiou E, Roussias L. Changing relationship among clinic, home, and ambulatory blood pressure with increasing age. *J Am Soc Hypertens* 2015; 9:544–552.
 71. Kollias A, Dafni M, Poulidakis E, Ntineri A, Stergiou GS. Out-of-office blood pressure and target organ damage in children and adolescents: a systematic review and meta-analysis. *J Hypertens* 2014; 32:2315–2331.
 72. Karatzi K, Protogerou A, Rarra V, Stergiou GS. Home and office blood pressure in children and adolescents: the role of obesity. The Arsakeion School Study. *J Hum Hypertens* 2009; 23:512–520.
 73. Stergiou GS, Giovas PP, Kollias A, Rarra VC, Papagiannis J, Georgakopoulos D, *et al.* Relationship of home blood pressure with target-organ damage in children and adolescents. *Hypertens Res* 2011; 35:640–644.
 74. Stergiou G, Nasothimiou E, Giovas P, Kapoyiannis A, Vazeou A. Diagnosis of hypertension in children and adolescents based on home versus ambulatory blood pressure monitoring. *J Hypertens* 2008; 26:1556–1562.
 75. Stergiou GS, Christodoulakis G, Giovas P, Lourida P, Alamara C, Roussias LG. Home blood pressure monitoring in children: how many measurements are needed? *Am J Hypertens* 2008; 21:633–638.
 76. Lurbe E, Torro MI, Alvarez J. Ambulatory blood pressure monitoring in children and adolescents: coming of age? *Curr Hypertens Rep* 2013; 15:143–149.
 77. Matsuoka S, Awazu M. Masked hypertension in children and young adults. *Pediatr Nephrol* 2004; 19:651–654.
 78. Stabouli S, Kotsis V, Toumanidis S, Papamichael C, Constantopoulos A, Zakopoulos N. White-coat and masked hypertension in children: association with target organ damage. *Pediatr Nephrol* 2005; 20:1151–1155.
 79. Lurbe E, Torro I, Alvarez V, Nawrot T, Paya R, Redon J, *et al.* Prevalence, persistence, and clinical significance of masked hypertension in youth. *Hypertension* 2005; 45:493–498.
 80. Di Salvo G, Castaldi B, Baldini L, Gala S, del Gaizo F, D'Andrea A, *et al.* Masked hypertension in young patients after successful aortic coarctation repair: impact on left ventricular geometry and function. *J Hum Hypertens* 2011; 25:739–745.
 81. Pauca AL, Wallenhaupt SL, Kon ND, Tucker WY. Does radial artery pressure accurately reflect aortic pressure? *Chest* 1992; 102:1193–1198.
 82. Milne L, Keehn L, Guilcher A, Reidy JF, Karunanithy N, Rosenthal E, *et al.* Central aortic blood pressure from ultrasound wall-tracking of the carotid artery in children: comparison with invasive measurements and radial tonometry. *Hypertension* 2015; 65:1141–1146.
 83. Roman MJ, Devereux RB. Association of central and peripheral blood pressures with intermediate cardiovascular phenotypes. *Hypertension* 2014; 63:1148–1153.
 84. Elmenhorst J, Hulpke-Wette M, Barta C, Dalla Pozza R, Springer S, Oberhoffer R. Percentiles for central blood pressure and pulse wave velocity in children and adolescents recorded with an oscillometric device. *Atherosclerosis* 2015; 238:9–16.
 85. Mahoney LT, Schieken RM, Clarke WR, Lauer RM. Left ventricular mass and exercise responses predict future blood pressure. The Muscatine Study. *Hypertension* 1988; 12:206–213.
 86. Grøntved A, Brage S, Møller NC, Kristensen PL, Wedderkopp N, Froberg K, *et al.* Hemodynamic variables during exercise in childhood and resting systolic blood pressure levels 6 years later in adolescence: the European Youth Heart Study. *J Hum Hypertens* 2011; 25:608–614.
 87. Kavey RE, Kveselis DA, Atallah N, Smith FC. White coat hypertension in childhood: evidence for end-organ effect. *J Pediatr* 2007; 150:491–497.
 88. Kavey RE, Kveselis DA, Gaum WE. Exaggerated blood pressure response to exercise in children with increased low-density lipoprotein cholesterol. *Am Heart J* 1997; 133:162–168.
 89. Møller NC, Grøntved A, Wedderkopp N, Ried-Larsen M, Kristensen PL, Andersen LB, *et al.* Cardiovascular disease risk factors and blood pressure response during exercise in healthy children and adolescents: the European Youth Heart Study. *J Appl Physiol* 2010; 109:1125–1132.
 90. Garg R, Malhotra V, Dhar U, Tripathi Y. The isometric handgrip exercise as a test for unmasking hypertension in the offsprings of hypertensive parents. *J Clin Diagn Res* 2013; 7:996–999.
 91. Hacke C, Weisser B. Reference values for exercise systolic blood pressure in 12- to 17-year-old adolescents. *Am J Hypertens* 2016; 29:747–753.
 92. Mancia G, Fagard R, Narkiewicz K, Redón J, Zanchetti A, Böhm M, *et al.*, Task Force Members. 2013 ESH/ESC Guidelines for the management of arterial hypertension: the Task Force for the management of arterial hypertension of the European Society of Hypertension (ESH) and of the European Society of Cardiology (ESC). *J Hypertens* 2013; 31:1281–1357.

93. Alpay H, Ozdemir N, Wühl E, Topuzoğlu A. Ambulatory blood pressure monitoring in healthy children with parental hypertension. *Pediatr Nephrol* 2009; 24:155–161.
94. Gopinath B, Baur LA, Hardy LL, Wang JJ, Teber E, Wong TY, et al. Parental history of hypertension is associated with narrower retinal arteriolar caliber in young girls. *Hypertension* 2011; 58:425–430.
95. Othman AS, Othman NI, Rosman A, Nudin SS, Rahman AR. Central and peripheral blood pressure profile of young offspring with hypertensive and normotensive parents. *J Hypertens* 2012; 30:1552–1555.
96. Eriksson JG, Forsén T, Tuomilehto J, Winter PD, Osmond C, Barker DJ. Catch-up growth in childhood and death from coronary heart disease: longitudinal study. *BMJ* 1999; 318:427–431.
97. Barker DJ, Osmond C, Forsén TJ, Kajantie E, Eriksson JG. Trajectories of growth among children who have coronary events as adults. *N Engl J Med* 2005; 353:1802–1809.
98. Gluckman PD, Hanson MA, Cooper C, Thornburg KL. Effect of in utero and early-life conditions on adult health and disease. *N Engl J Med* 2008; 359:61–73.
99. Fabricius-Bjerre S, Jensen RB, Færch K, Larsen T, Mølgaard C, Michaelsen KF, et al. Impact of birth weight and early infant weight gain on insulin resistance and associated cardiovascular risk factors in adolescence. *PLoS One* 2011; 6:e20595.
100. Skilton MR, Marks GB, Ayer JG, Garden FL, Garnett SP, Harner JA, et al. Weight gain in infancy and vascular risk factors in later childhood. *Pediatrics* 2013; 131:e1821–e1828.
101. Lurbe E, Garcia-Vicent C, Torro MI, Aguilar F, Redon J. Associations of birth weight and postnatal weight gain with cardiometabolic risk parameters at 5 years of age. *Hypertension* 2014; 63:1326–1332.
102. Falkner B, Ingelfinger J. Understanding the power of perinatal events and metabolic status in childhood. *Hypertension* 2014; 63:1166–1167.
103. Meng L, Hou D, Zhao X, Hu Y, Liang Y, Liu J, et al. Cardiovascular target organ damage could have been detected in sustained pediatric hypertension. *Blood Press* 2015; 24:284–292.
104. Lang RM, Bierig M, Devereux RB, Flachskampf FA, Foster E, Pellikka PA, et al. Recommendations for chamber quantification. *Eur J Echocardiogr* 2006; 7:79–108.
105. Devereux RB, Alonso DR, Lutas EM, Gottlieb GJ, Campo E, Sachs I, et al. Echocardiographic assessment of left ventricular hypertrophy: comparison to necropsy findings. *Am J Cardiol* 1986; 57:450–458.
106. de Simone G, Devereux RB, Daniels SR, Koren MJ, Meyer RA, Laragh JH. Effect of growth on variability of left ventricular mass: assessment of allometric signals in adults and children and their capacity to predict cardiovascular risk. *J Am Coll Cardiol* 1995; 25:1056–1062.
107. de Simone G, Daniels SR, Kimball TR, Roman MJ, Romano C, Chinali M, et al. Evaluation of concentric left ventricular geometry in humans: evidence for age-related systematic underestimation. *Hypertension* 2005; 45:64–68.
108. Khoury PR, Mitsnefes M, Daniels SR, Kimball TR. Age-specific reference intervals for indexed left ventricular mass in children. *J Am Soc Echocardiogr* 2009; 22:709–714.
109. Chinali M, Emma F, Esposito C, Rinelli G, Franceschini A, Doyon A, et al. Left ventricular mass indexing in infants, children, and adolescents: a simplified approach for the identification of left ventricular hypertrophy in clinical practice. *J Pediatr* 2016; 170:193–198.
110. Sharp AS, Tapp RJ, Thom SA, Francis DP, Hughes AD, Stanton AV, et al. Tissue Doppler E/E' ratio is a powerful predictor of primary cardiac events in a hypertensive population: an ASCOT substudy. *Eur Heart J* 2010; 31:747–752.
111. Killian L, Simpson JM, Savis A, Rawlins D, Sinha MD. Electrocardiography is a poor screening test to detect left ventricular hypertrophy in children. *Arch Dis Child* 2010; 95:832–836.
112. Bratincsak A, Williams M, Kimata C, Perry JC. The electrocardiogram is a poor diagnostic tool to detect left ventricular hypertrophy in children: a comparison with echocardiographic assessment of left ventricular mass. *Congenit Heart Dis* 2015; 10:E164–E171.
113. Doyon A, Kracht D, Bayazit AK, Deveci M, Duzova A, Krmar RT, et al., For the 4C Study Consortium. Carotid artery intima-media thickness and distensibility in children and adolescents: reference values and role of body dimensions. *Hypertension* 2013; 62:550–556.
114. Calabro MP, Carerj S, Russo MS, De Luca FL, Onofrio MTN, Antonini-Canterin F, et al. Carotid artery intima-media thickness and stiffness index β changes in normal children: role of age, height and sex. *J Cardiovasc Med* 2015; Epub ahead of print.
115. Järvisalo MJ, Jartti L, Näntö-Salonen K, Irjala K, Rönnemaa T, Hartiala JJ, et al. Increased aortic intima-media thickness: a marker of pre-clinical atherosclerosis in high-risk children. *Circulation* 2001; 104:2943–2947.
116. Wiegman A, de Groot E, Hutten BA, Rodenburg J, Gort J, Bakker HD, et al. Arterial intima-media thickness in children heterozygous for familial hypercholesterolaemia. *Lancet* 2004; 363:369–370.
117. Zhu W, Huang X, He J, Li M, Neubauer H. Arterial intima-media thickening and endothelial dysfunction in obese Chinese children. *Eur J Pediatr* 2005; 164:337–344.
118. Meyer AA, Kundt G, Steiner M, Schuff-Werner P, Kienast W. Impaired flow-mediated vasodilation, carotid artery intima-media thickening, and elevated endothelial plasma markers in obese children: the impact of cardiovascular risk factors. *Pediatrics* 2006; 117:1560–1567.
119. Sorof JM, Alexandrov AV, Cardwell G, Portman RJ. Carotid artery intimal-medial thickness and left ventricular hypertrophy in children with elevated blood pressure. *Pediatrics* 2003; 111:61–66.
120. Lande MB, Carson NL, Roy J, Meagher CC. Effects of childhood primary hypertension on carotid intima media thickness: a matched controlled study. *Hypertension* 2006; 48:40–44.
121. Järvisalo MJ, Raitakari M, Toikka JO, Putto-Laurila A, Rontu R, Laine S, et al. Endothelial dysfunction and increased arterial intima-media thickness in children with type 1 diabetes. *Circulation* 2004; 109:1750–1755.
122. Ben-Shlomo Y, Spears M, Boustred C, May M, Anderson SG, Benjamin EJ, et al. Aortic pulse wave velocity improves cardiovascular event prediction: an individual participant meta-analysis of prospective data from 17,635 subjects. *J Am Coll Cardiol* 2014; 63:636–646.
123. Reusz GS, Cseppek O, Temmar M, Kis E, Cherif AB, Thaleb A, et al. Reference values of pulse wave velocity in healthy children and teenagers. *Hypertension* 2010; 56:217–224.
124. Thurn D, Doyon A, Sözeri B, Bayazit AK, Canpolat N, Duzova A, et al., 4C Study Consortium. Aortic pulse wave velocity in healthy children and adolescents: reference values for the Vicorder device and modifying factors. *Am J Hypertens* 2015; 28:1480–1488.
125. Aggoun Y, Bonnet D, Sidi D, Girardet JP, Brucker E, Polak M, et al. Arterial mechanical changes in children with familial hypercholesterolemia. *Arterioscler Thromb Vasc Biol* 2000; 20:2070–2075.
126. Oren A, Vos LE, Uiterwaal CSPM, Gorissen WHM, Grobbee DE, Bots ML. Adolescent blood pressure does not predict aortic stiffness in healthy young adults. The Atherosclerosis Risk in Young Adults (ARYA) study. *J Hypertens* 2003; 21:321–326.
127. Juonala M, Järvisalo MJ, Mäki-Torkko N, Kähönen M, Viikari JSA, Raitakari OT. Risk factors identified in childhood and decreased carotid artery elasticity in adulthood: the Cardiovascular Risk in Young Finns Study. *Circulation* 2005; 112:1486–1493.
128. Riggio S, Mandraffino G, Sardo MA, Iudicello R, Camarda N, Imbalzano E, et al. Pulse wave velocity and augmentation index, but not intima-media thickness, are early indicators of vascular damage in hypercholesterolemic children. *Eur J Clin Invest* 2010; 40:250–257.
129. Sinha MD, Keehn L, Milne L, Sofocleous P, Chowienczyk PJ. Decreased arterial elasticity in children with nondialysis chronic kidney disease is related to blood pressure and not to glomerular filtration rate. *Hypertension* 2015; 66:809–815.
130. Lubrano R, Travasso E, Raggi C, Guido G, Masciangelo R, Elli M. Blood pressure load, proteinuria and renal function in prehypertensive children. *Pediatr Nephrol* 2009; 24:823–831.
131. Tullus K, Roebuck DJ, McLaren CA, Marks SD. Imaging in the evaluation of renovascular disease. *Pediatr Nephrol* 2010; 25:1049–1056.
132. Mitchell P, Cheung N, de Haseth K, Taylor B, Rochtchina E, Islam FM, et al. Blood pressure and retinal arteriolar narrowing in children. *Hypertension* 2007; 49:1156–1162.
133. Daniels SR, Lipman MJ, Burke MJ, Loggie JM. The prevalence of retinal vascular abnormalities in children and adolescents with essential hypertension. *Am J Ophthalmol* 1991; 111:205–258.
134. Foster BJ, Ali H, Mamber S, Polomeno RC, Mackie AS. Prevalence and severity of hypertensive retinopathy in children. *Clin Pediatr* 2009; 48:926–930.
135. Williams KM, Shah AN, Morrison D, Sinha MD. Hypertensive retinopathy in severely hypertensive children: demographic, clinical, and ophthalmoscopic findings from a 30-year British cohort. *J Pediatr Ophthalmol Strabismus* 2013; 50:222–228.

136. Sharma M, Kupferman JC, Brosgol Y, Paterno K, Goodman S, Prohovnik I, *et al.* The effects of hypertension on the paediatric brain: a justifiable concern. *Lancet Neurol* 2010; 9:933–940.
137. Agarwal A, Kapur G, Altinok D. Childhood posterior reversible encephalopathy syndrome: magnetic resonance imaging findings with emphasis on increased leptomeningeal FLAIR signal. *Neuroradiol J* 2015; 28:638–643.
138. Vlachopoulos C, Xaplanteris P, Aboyans V, Brodmann M, Cifkova R, Cosentino F, *et al.* The role of vascular biomarkers for primary and secondary prevention. *Atherosclerosis* 2015; 241:507–532.
139. Hlatky MA, Greenland P, Arnett DK, Ballantyne CM, Criqui MH, Elkind MS, *et al.*, American Heart Association Expert Panel on Subclinical Atherosclerotic Diseases and Emerging Risk Factors and the Stroke Council. Criteria for evaluation of novel markers of cardiovascular risk: a scientific statement from the American Heart Association. *Circulation* 2009; 119:2408–2416.
140. Jameson JL, Longo DL. Precision medicine—personalized, problematic and promising. *New Eng J Med* 2015; 372:2229–2234.
141. Nguyen S, McCulloch C, Brakeman P, Portale A, Hsu CY. Being overweight modifies the association between cardiovascular risk factors and microalbuminuria in adolescents. *Pediatrics* 2008; 121:37–45.
142. Reilly JJ, Kelly J. Long-term impact of overweight and obesity in childhood and adolescence on morbidity and premature mortality in adulthood: systematic review. *Int J Obes* 2011; 35:891–898.
143. Park MH, Falconer C, Viner RM, Kinra S. The impact of childhood obesity on morbidity and mortality in adulthood: a systematic review. *Obes Rev* 2012; 13:985–1000.
144. World Health Organization. Obesity and overweight 2015. Available at: <http://www.who.int/mediacentre/factsheets/fs311/en/> [last accessed 13 April 2016].
145. Wright CM, Parker L, Lamont D, Craft AW. Implications of childhood obesity for adult health: findings from thousand families cohort study. *BMJ* 2001; 323:1280–1284.
146. Juonala M, Magnussen CG, Berenson GS, Venn A, Burns TL, Sabin MA, *et al.* Childhood adiposity, adult adiposity, and cardiovascular risk factors. *N Engl J Med* 2011; 365:1876–1885.
147. Steinberger J, Daniels SR, Eckel RH, Hayman L, Lustig RH, McCrindle B, *et al.*, American Heart Association Atherosclerosis, Hypertension, and Obesity in the Young Committee of the Council on Cardiovascular Disease in the Young; Council on Cardiovascular Nursing; and Council on Nutrition, Physical Activity, and Metabolism. Progress and challenges in metabolic syndrome in children and adolescents: a scientific statement from the American Heart Association Atherosclerosis, Hypertension, and Obesity in the Young Committee of the Council on Cardiovascular Disease in the Young; Council on Cardiovascular Nursing; and Council on Nutrition, Physical Activity, and Metabolism. *Circulation* 2009; 119:628–647.
148. Cameron FJ, Wherrett DK. Care of diabetes in children and adolescents: controversies, changes, and consensus. *Lancet* 2015; 385:2096–2106.
149. Zeitler P, Fu J, Tandon N, Nadeau K, Urakami T, Bartlett T, *et al.* ISPAD Clinical Practice Consensus Guidelines 2014 Compendium Type 2 diabetes in the child and adolescent. *Pediatr Diabetes* 2014; 15:26–46.
150. Rodriguez BL, Dabelea D, Liese AD, Fujimoto W, Waitzfelder B, Liu L, *et al.*, SEARCH Study Group. Prevalence and correlates of elevated blood pressure in youth with diabetes mellitus: the search for diabetes in youth study. *J Pediatr* 2010; 157:245–251.
151. American Diabetes Association. Children and adolescents. Sec. 11. In standards of medical care in diabetes 2015. *Diabetes Care* 2015; 38:S70–S76.
152. Maahs DM, Daniels SR, de Ferranti SD, Dichek HL, Flynn J, Goldstein BI, *et al.*, American Heart Association Atherosclerosis, Hypertension and Obesity in Youth Committee of the Council on Cardiovascular Disease in the Young, Council on Clinical Cardiology, Council on Cardiovascular and Stroke Nursing, Council for High Blood Pressure Research, and Council on Lifestyle and Cardiometabolic Health. Cardiovascular disease risk factors in youth with diabetes mellitus: a scientific statement from the American Heart Association. *Circulation* 2014; 130:1532–1558.
153. Nambam B, DuBose SN, Nathan BM, Beck RW, Maahs DM, Wadwa RP, *et al.*, T1D Exchange Clinic Network. Therapeutic inertia: underdiagnosed and undertreated hypertension in children participating in the T1D Exchange Clinic Registry. *Pediatr Diabetes* 2016; 17:15–20.
154. Lingens N, Dobos E, Witte K, Busch C, Lemmer B, Klaus G, *et al.* Twenty-four-hour ambulatory blood pressure profiles in pediatric patients after renal transplantation. *Pediatr Nephrol* 1997; 11:23–26.
155. Mitsnefes M, Stablein D. Hypertension in pediatric patients on long-term dialysis: a report of the North American Pediatric Renal Transplant Cooperative Study (NAPRTCS). *Am J Kidney Dis* 2005; 45:309–315.
156. Seeman T, Simkova E, Kreisinger J, Vondrák K, Dusek J, Gilík J, *et al.* Control of hypertension in children after renal transplantation. *Pediatr Transplant* 2006; 10:316–322.
157. Flynn JT, Mitsnefes M, Pierce C, Cole SR, Parekh RS, Furth SL, *et al.*, Chronic Kidney Disease in Children Study Group. Blood pressure in children with chronic kidney disease: a report from the Chronic Kidney Disease in Children Study. *Hypertension* 2008; 52:631–637.
158. Schaefer F, Mehls O. Hypertension in chronic kidney disease. In: Portman RJ, Sorof JM, Ingelfinger JR, editors. *Pediatric hypertension*. Totowa, NJ: Humana Press; 2004. pp. 371–387.
159. Klag MJ, Whelton PK, Randall BL, Neaton JD, Brancati FL, Ford CE, *et al.* Blood pressure and end-stage renal disease in men. *N Engl J Med* 1996; 334:13–18.
160. Locatelli F, Marcelli D, Comelli M, Alberti D, Graziani G, Buccianti G, *et al.* Proteinuria and blood pressure as causal components of progression to end-stage renal failure. Northern Italian Cooperative Study Group. *Nephrol Dial Transplant* 1996; 11:461–467.
161. Iseki K, Ikemiya Y, Iseki C, Takishita S. Proteinuria and the risk of developing end-stage renal disease. *Kidney Int* 2003; 63:1468–1474.
162. Wingen AM, Fabian-Bach C, Schaefer F, Mehls O. Randomised multicentre study of a low-protein diet on the progression of chronic renal failure in children. European Study Group of Nutritional Treatment of Chronic Renal Failure in Childhood. *Lancet* 1997; 349:1117–1123.
163. Ohkubo T, Hozawa A, Yamaguchi J, Kikuya M, Ohmori K, Michimata M, *et al.* Prognostic significance of the nocturnal decline in blood pressure in individuals with and without high 24-h blood pressure: the Ohasama study. *J Hypertens* 2002; 20:2183–2189.
164. Jacob P, Hartung R, Bohlender J, Stein G. Utility of 24-h ambulatory blood pressure measurement in a routine clinical setting of patients with chronic renal disease. *J Hum Hypertens* 2004; 18:745–751.
165. Timio M, Venanzi S. “Nondipper” hypertensive patients and progressive renal insufficiency: a 3-year longitudinal study. *Clin Nephrol* 1995; 43:382–387.
166. Cifkova R, Skodova Z, Bruthans J, Holub J, Adamkova V, Jozifova M, *et al.* Longitudinal trends in cardiovascular mortality and blood pressure levels, prevalence, awareness, treatment, and control of hypertension in the Czech population from 1985 to 2007/2008. *J Hypertens* 2010; 28:2196–2203.
167. Banach M, Bromfield S, Howard G, Howard VJ, Zanchetti A, Aronow WS, *et al.* Association of systolic blood pressure levels with cardiovascular events and all-cause mortality among older adults taking antihypertensive medication. *Int J Cardiol* 2014; 176:219–226.
168. Thomopoulos C, Parati G, Zanchetti A. Effects of blood pressure lowering on outcome incidence in hypertension. 1. Overview, meta-analyses, and meta-regression analyses of randomized trials. *J Hypertens* 2014; 32:2285–2295.
169. Emdin CA, Rahimi K, Neal B, Callender T, Perkovic V, Patel A. Blood pressure lowering in type 2 diabetes: a systematic review and meta-analysis. *JAMA* 2015; 313:603–615.
170. Thomopoulos C, Parati G, Zanchetti A. Effects of blood pressure lowering on outcome incidence in hypertension: 7. Effects of more vs. less intensive blood pressure lowering and different achieved blood pressure levels – updated overview and meta-analyses of randomized trials. *J Hypertens* 2016; 34:613–622.
171. Devereux RB, Wachtell K, Gerds E, Boman K, Nieminen MS, Papademetriou V, *et al.* Prognostic significance of left ventricular mass change during treatment of hypertension. *JAMA* 2004; 292:2350–2356.
172. Devereux RB, Dahlöf B, Gerds E, Boman K, Nieminen MS, Papademetriou V, *et al.* Regression of hypertensive left ventricular hypertrophy by losartan compared with atenolol: the Losartan Intervention for Endpoint Reduction in Hypertension (LIFE) trial. *Circulation* 2004; 110:1456–1462.
173. Fagard RH, Celis H, Thijs L, Wouters S. Regression of left ventricular mass by antihypertensive treatment: a meta-analysis of randomized comparative studies. *Hypertension* 2009; 54:1084–1091.

174. Seeman T, Dostalek L, Gilik J. Control of hypertension in treated children and its association with target organ damage. *Am J Hypertens* 2012; 25:389–395.
175. Matteucci MC, Chinali M, Rinelli G, Wühl E, Zurowska A, Charbit M, et al., ESCAPE Trial Group. Change in cardiac geometry and function in CKD children during strict BP control: a randomized study. *Clin J Am Soc Nephrol* 2013; 8:203–210.
176. Kupferman JC, Aronson Friedman L, Cox C, Flynn J, Furth S, Warady B, et al., CKiD Study Group. BP control and left ventricular hypertrophy regression in children with CKD. *J Am Soc Nephrol* 2014; 25:167–174.
177. Ettehad D, Emdin CA, Kiran A, Anderson SG, Callender T, Emberson J, et al. Blood pressure lowering for prevention of cardiovascular disease and death: a systematic review and meta-analysis. *Lancet* 2016; 387:957–967.
178. Heerspink HJ, Kröpelin TF, Hoekman J, de Zeeuw D, Reducing Albuminuria as Surrogate Endpoint (REASSURE) Consortium. Drug-induced reduction in albuminuria is associated with subsequent renoprotection: a meta-analysis. *J Am Soc Nephrol* 2015; 26:2055–2064.
179. Ferguson MA, Flynn JT. Pharmacologic treatment of childhood hypertension. In: Flynn JT, Ingelfinger JR, Portman RJ, editors. *Pediatric hypertension*. New York: Humana Press; 2013. pp. 539–555.
180. Stabouli S, Kotsis V, Rizos Z. Left ventricular mass in normotensive prehypertensive and hypertensive children and adolescents. *Pediatr Nephrol* 2009; 24:1545–1551.
181. Urbina EM, Khoury PR, McCoy C, Daniels SR, Kimball TR, Dolan LM. Cardiac and vascular consequences of prehypertension in youth. *J Clin Hypertens* 2011; 13:332–342.
182. Gimpel C, Wühl E, Arbeiter K, Drozd D, Trivelli A, Charbit M, et al., ESCAPE Trial Group. Superior consistency of ambulatory blood pressure monitoring in children: implications for clinical trials. *J Hypertens* 2009; 27:1568–1574.
183. Wühl E, Witte K, Soergel M, Mehls O, Schaefer F, German Working Group on Pediatric Hypertension. Distribution of 24-h ambulatory blood pressure in children: normalized reference values and role of body dimensions. *J Hypertens* 2002; 20:1995–2007.
184. James PA, Oparil S, Carter BL, Cushman WC, Dennison-Himmelfarb C, Handler J, et al. 2014 evidence-based guideline for the management of high blood pressure in adults: report from the panel members appointed to the Eighth Joint National Committee (JNC 8). *JAMA* 2014; 311:507–520.
185. Wright JT Jr, Williamson JD, Whelton PK, Snyder JK, Sink KM, Rocco MV, et al., SPRINT Research Group. A randomized trial of intensive versus standard blood-pressure control. *N Engl J Med* 2015; 373:2103–2116.
186. Falkner B, Gidding SS. Is the SPRINT blood pressure treatment target of 120/80 mmHg relevant for children? *Hypertension* 2016; 67:826–828.
187. Furth S, Flynn J, Pierce C, Mitsnefes M, Wong C, Saland J, et al. Lower systolic BP associated with slower CKD progression in the CKiD study. *J Am Soc Nephrol* 2010;551A.
188. Arguedas JA, Perez MI, Wright JM. Treatment blood pressure targets for hypertension. *Cochrane Database Syst Rev* 2009;CD004349.
189. Upadhyay A, Earley A, Haynes SM, Uhlig K. Systematic review: blood pressure target in chronic kidney disease and proteinuria as an effect modifier. *Ann Intern Med* 2011; 154:541–548.
190. Raile K, Galler A, Hofer S, Herbst A, Dunstheimer D, Busch P, et al. Diabetic nephropathy in 27,805 children, adolescents and adults with type 1 diabetes. Effect of diabetes duration, A1C, hypertension, dyslipidemia, diabetes onset, and sex. *Diabetes Care* 2007; 30:2523–2528.
191. Lurbe E, Redon J, Kesani A, Pascual JM, Tacons J, Alvarez V, et al. Increase in nocturnal blood pressure and progression to microalbuminuria in type 1 diabetes. *N Engl J Med* 2002; 347:797–805.
192. Ettinger LM, Freeman K, DiMartino-Nardi JR, Flynn JT. Microalbuminuria and abnormal ambulatory blood pressure in adolescents with type 2 diabetes mellitus. *J Pediatr* 2005; 147:67–73.
193. Ho M, Garnett SP, Baur L, Burrows T, Stewart L, Neve M, Collins C. Effectiveness of lifestyle interventions in child obesity: systematic review with meta-analysis. *Pediatrics* 2012; 130:e1647–e1671.
194. Rocchini AP, Katch V, Anderson J, Hinderliter J, Becque D, Martin M, et al. Blood pressure in obese adolescents: effect of weight loss. *Pediatrics* 1988; 82:16–23.
195. Holm JC, Gamborg M, Neland M, Ward L, Gammeltoft S, Heitmann BL, et al. Longitudinal changes in blood pressure during weight loss and regain of weight in obese boys and girls. *J Hypertens* 2012; 30:368–374.
196. Hvidt KN, Olsen MH, Ibsen H, Holm JC. Effect of changes in BMI and waist circumference on ambulatory blood pressure in obese children and adolescents. *J Hypertens* 2014; 32:1470–1477.
197. Kelley GA, Kelley KS, Tran ZV. The effects of exercise on resting blood pressure in children and adolescents: a meta-analysis of randomized controlled trials. *Prev Cardiol* 2003; 6:8–16.
198. Farpour-Lambert NJ, Aggoun Y, Marchand LM, Martin XE, Herrmann FR, Beghetti M. Physical activity reduces systemic blood pressure and improves early markers of atherosclerosis in prepubertal obese children. *J Am Coll Cardiol* 2009; 54:2396–2406.
199. Leary SD, Ness AR, Smith GD, Mattocks C, Deere K, Blair SN, et al. Physical activity and blood pressure in childhood: findings from a population-based study. *Hypertension* 2008; 51:92–98.
200. World Health Organization. Physical activity and young people. Recommended levels of physical activity for children aged 5–17 years. 2010. Available at: http://www.who.int/dietphysicalactivity/factsheet_young_people/en/ [last accessed 13th April 2016].
201. Shi L, Krupp D, Remer T. Salt, fruit and vegetable consumption and blood pressure development: a longitudinal investigation in healthy children. *Br J Nutr* 2014; 111:662–671.
202. Moore LL, Bradlee ML, Singer MR, Qureshi MM, Buendia JR, Daniels SR. Dietary Approaches to Stop Hypertension (DASH) eating pattern and risk of elevated blood pressure in adolescent girls. *Br J Nutr* 2012; 108:1678–1685.
203. Niinikoski H, Jula A, Viikari J, Rönnemaa T, Heino P, Lagström H, et al. Blood pressure is lower in children and adolescents with a low-saturated-fat diet since infancy: the special Turku coronary risk factor intervention project. *Hypertension* 2009; 53:918–924.
204. Nguyen S, Choi HK, Lustig RH, Hsu CY. Sugar-sweetened beverages, serum uric acid, and blood pressure in adolescents. *J Pediatr* 2009; 154:807–813.
205. Yang Q, Zhang Z, Kuklina EV, Fang J, Ayala C, Hong Y, et al. Sodium intake and blood pressure among US children and adolescents. *Pediatrics* 2012; 130:611–619.
206. He FJ, MacGregor GA. Importance of salt in determining blood pressure in children: meta-analysis of controlled trials. *Hypertension* 2006; 48:861–869.
207. Geleijnse JM, Hofman A, Witteman JC, Hazebroek AA, Valkenburg HA, Grobbee DE. Long-term effects of neonatal sodium restriction on blood pressure. *Hypertension* 1997; 29:913–917.
208. Boegehold MA. The effect of high salt intake on endothelial function: reduced vascular nitric oxide in the absence of hypertension. *J Vasc Res* 2013; 50:458–467.
209. Simonetti GD, Schwertz R, Klett M, Hoffmann GF, Schaefer F, Wühl E. Determinants of blood pressure in preschool children: the role of parental smoking. *Circulation* 2011; 123:292–298.
210. Thomopoulos C, Parati G, Zanchetti A. Effects of blood pressure-lowering on outcome incidence in hypertension: 5. Head-to-head comparisons of various classes of antihypertensive drugs – overview and meta-analyses. *J Hypertens* 2015; 33:1321–1341.
211. Schaefer F, Litwin M, Zachwieja J, Zurowska A, Turi S, Grosso A, et al. Efficacy and safety of valsartan when compared to enalapril in hypertensive children: a 12 week, randomised, double-blind, parallel-group study. *J Hypertens* 2011; 29:2484–2490.
212. Chaturvedi S, Lipszyc DH, Licht C, Craig JC, Parekh R. Pharmacological interventions for hypertension in children. *Cochrane Database Syst Rev* 2014; 2:CD008117.
213. Thomopoulos C, Parati G, Zanchetti A. Effects of blood pressure lowering on outcome incidence in hypertension: 4. Effects of various classes of antihypertensive drugs-overview and meta-analyses. *J Hypertens* 2015; 33:195–211.
214. Claxton AJ, Cramer J, Pierce C. A systematic review of the associations between dose regimens and medication compliance. *Clin Ther* 2001; 23:1296–1310.
215. Ferguson MA, Flynn JT. Rational use of antihypertensive medications in children. *Pediatr Nephrol* 2013; 29:979–988.
216. Elliott WJ, Meyer PM. Incident diabetes in clinical trials of antihypertensive drugs: a network meta-analysis. *Lancet* 2007; 369:201–207.
217. Mancia G, Grassi G, Zanchetti A. New-onset diabetes and antihypertensive drugs. *J Hypertens* 2006; 24:3–10.

218. Expert Panel on Integrated Guidelines for Cardiovascular Health and Risk Reduction in Children and Adolescents. National Heart, Lung, and Blood Institute. Expert panel on integrated guidelines for cardiovascular health and risk reduction in children and adolescents: summary report. *Pediatrics* 2011; 128:S213–S256.
219. Yusuf S, Teo KK, Pogue J, Dyal L, Copland I, Schumacher H, *et al.*, ONTARGET Investigators. Telmisartan, ramipril, or both in patients at high risk for vascular events. *N Engl J Med* 2008; 358:1547–1559.
220. Parving HH, Brenner BM, McMurray JJ, de Zeeuw D, Haffner SM, Solomon SD, *et al.*, ALTITUDE Investigators. Cardiorenal end points in a trial of aliskiren for type 2 diabetes. *N Engl J Med* 2012; 367:2204–2213.
221. Fried LF, Emanuele N, Zhang JH, Brophy M, Conner TA, Duckworth W, *et al.*, VA NEPHRON-D Investigators. Combined angiotensin inhibition for the treatment of diabetic nephropathy. *N Engl J Med* 2013; 369:1892–1903.
222. Sorof JM, Cargo P, Graepel J, Humphrey D, King E, Rolf C, *et al.* Beta-blocker/thiazide combination for treatment of hypertensive children: a randomised double-blind, placebo-controlled trial. *Pediatr Nephrol* 2002; 17:345–350.
223. de Boer IH, Rue TC, Cleary PA, Lachin JM, Molitch ME, Steffes MW, *et al.*, Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications Study Research Group. Long-term renal outcomes of patients with type 1 diabetes mellitus and microalbuminuria: an analysis of the Diabetes Control and Complications Trial/Epidemiology of Diabetes Interventions and Complications cohort. *Arch Intern Med* 2011; 171:412–420.
224. Giunti S, Barit D, Cooper ME. Diabetic nephropathy: from mechanisms to rational therapies. *Minerva Med* 2006; 97:241–262.
225. American Diabetes Association. Cardiovascular disease and risk management. Sec. 8. In standards of medical care in diabetes 2016. *Diabetes Care* 2016; 39:60–71.
226. Rad EM, Assadi F. Management of hypertension in children with cardiovascular disease and heart failure. *Int J Prev Med* 2014; 5:10–16.
227. Flynn JT, Tullus K. Severe hypertension in children and adolescents: pathophysiology and treatment. *Pediatr Nephrol* 2009; 24:1101–1112.
228. Simonetti GD, Rizzi M, Donadini R, Bianchetti MG. Effects of anti-hypertensive drugs on blood pressure and proteinuria in childhood. *J Hypertens* 2007; 25:2370–2376.
229. Von Vigier RO, Franscini LMD, Bianda ND, Pfister R, Casaulta-Aebischer C, Bianchetti MG. Antihypertensive efficacy of amlodipine in children with chronic kidney diseases. *J Hum Hypertens* 2001; 15:387–391.
230. Ellis D, Vats A, Moritz ML, Reitz S, Grosso MJ, Janosky JE. Long-term antiproteinuric and renoprotective efficacy and safety of losartan in children with proteinuria. *J Pediatr* 2003; 143:89–97.
231. Schaefer F, van de Walle J, Zurawska A, Gimpel C, van Hoeck K, Drozd D, *et al.*, Candesartan in Children with Hypertension Investigators. Efficacy, safety and pharmacokinetics of candesartan cilexetil in hypertensive children from 1 to less than 6 years of age. *J Hypertens* 2010; 28:1083–1090.
232. Flynn JT, Meyers KE, Neto JP, de Paula Meneses R, Zurawska A, Bagga A, *et al.* Efficacy and safety of the angiotensin receptor blocker valsartan in children with hypertension aged 1 to 5 years. *Hypertension* 2008; 52:222–228.
233. MacKinnon M, Shurraw S, Akbari A, Knoll GA, Jaffey J, Clark HD. Combination therapy with an angiotensin receptor blocker and an ACE inhibitor in proteinuric renal disease: a systematic review of the efficacy and safety data. *Am J Kidney Dis* 2006; 48:8–20.
234. Lubrano R, Soscia F, Elli M, Ventriglia F, Raggi C, Travasso E, *et al.* Renal and cardiovascular effects of angiotensin-converting enzyme inhibitor plus angiotensin II receptor antagonist therapy in children with proteinuria. *Pediatrics* 2006; 118:e833–e838.
235. Pulgaron ER, Delamater AM. Obesity and type 2 diabetes in children: epidemiology and treatment. *Curr Diab Rep* 2014; 14:508.
236. Viner RM, Hsia Y, Tomsic T, Wong IC. Efficacy and safety of anti-obesity drugs in children and adolescents: systematic review and meta-analysis. *Obes Rev* 2010; 11:593–602.
237. Matson KL, Fallon RM. Treatment of obesity in children and adolescents. *J Pediatr Pharmacol Ther* 2012; 17:45–57.
238. Redon J, Cifkova R, Laurent S, Nilsson P, Narkiewicz K, Erdine S, *et al.*, Scientific Council of the European Society of Hypertension. The metabolic syndrome in hypertension: European society of hypertension position statement. *J Hypertens* 2008; 26:1891–1900.
239. Wu HP, Yang WC, Wu YK, Zhao LL, Chan CY, Fu YC. Clinical significance of blood pressure ratios in hypertensive crisis in children. *Arch Dis Child* 2012; 97:200–205.
240. Deal JE, Barrat TM, Dillon MJ. Management of hypertensive emergencies. *Arch Dis Child* 1992; 67:1089–1092.
241. Adelman RD, Coppo R, Dillon MJ. The emergency management of severe hypertension. *Pediatr Nephrol* 2000; 14:422–427.
242. Patel HP, Mitsnefes M. Advances in the pathogenesis and management of hypertensive crisis. *Curr Opin Pediatr* 2005; 17:210–214.
243. Chandar J, Zilleruelo G. Hypertensive crisis in children. *Pediatr Nephrol* 2012; 27:741–751.
244. Yang WC, Zhao LL, Chen CY, Wu YK, Chang YJ, Wu HP. First-attack pediatric hypertensive crisis presenting to the pediatric emergency department. *BMC Pediatrics* 2012; 12:200.
245. Cremer A, Amraoui F, Lip GY, Morales E, Rubin S, Segura J, *et al.* From malignant hypertension to hypertension-MOD: a modern definition for an old but still dangerous emergency. *J Hum Hypertens* 2015; doi: 10.1038/jhh.2015.112.
246. Stone NJ, Robinson JG, Lichtenstein AH, Bairey Metz CN, Eckel RH, Blum CB, *et al.*, American College of Cardiology/American Heart Association Task Force on Practice Guidelines. 2013 ACC/AHA guideline on the treatment of blood cholesterol to reduce atherosclerotic cardiovascular risk in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines. *Circulation* 2014; 129 (Suppl 2):1–45.
247. Vuorio A, Kuoppala J, Kovanen PT, Humphries SE, Tonstad S, Wiegman A, *et al.* Statins for children with familial hypercholesterolemia. *Cochrane Database Syst Rev* 2014; 7:CD006401.
248. Gooding HC, Rodday AE, Wong JB, Gillman MW, Lloyd-Jones DM, Leslie LK, *et al.* Application of pediatric and adult guidelines for treatment of lipid levels among US adolescents transitioning to young adulthood. *JAMA Pediatr* 2015; 169:569–574.
249. Hirst K, Pyle L, Linder B, Copeland K, Arslanian S, Cuttler L, *et al.* A clinical trial to maintain glycemic control in youth with type 2 diabetes. *N Engl J Med* 2012; 366:2247–2256.
250. Amar MY, Hogg RJ, Arant BS. Etiology of sustained hypertension in children in the southwestern United States. *Pediatr Nephrol* 1994; 8:186–189.
251. Gomes RS, Quirino IG, Pereira RM. Primary versus secondary hypertension in children followed up at an outpatient tertiary unit. *Pediatr Nephrol* 2011; 26:441–447.
252. Flynn J, Zhang Y, Solar-Yohay S, Shi V. Clinical and demographic characteristics of children with hypertension. *Hypertension* 2012; 60:1047–1054.
253. Vogt BA. Hypertension in children and adolescents: definition, pathophysiology, risk-factors and long-term sequelae. *Curr Ther Res* 2001; 62:283–297.
254. Olin JW, Gornik HL, Bacharach JM, Biller J, Fine LJ, Gray BH, *et al.*, American Heart Association Council on Peripheral Vascular Disease. American Heart Association Council on Clinical Cardiology. American Heart Association Council on Cardiopulmonary, Critical Care, Perioperative and Resuscitation. American Heart Association Council on Cardiovascular Disease in the Young. American Heart Association Council on Cardiovascular Radiology and Intervention. American Heart Association Council on Epidemiology and Prevention. American Heart Association Council on Functional Genomics and Translational Biology. American Heart Association Council for High Blood Pressure Research. American Heart Association Council on the Kidney in Cardiovascular Disease. American Heart Association Stroke Council. Fibromuscular dysplasia: state of the science and critical unanswered questions: a scientific statement from the American Heart Association. *Circulation* 2014; 129:1048–1078.
255. Tullus K, Brennan E, Hamilton G, Lord R, McLaren CA, Marks SD, *et al.* Renovascular hypertension in children. *Lancet* 2008; 371:1453–1463.
256. Kari JA, Roebuck DJ, McLaren CA, Davis M, Dillon MJ, Hamilton G, *et al.* Angioplasty for renovascular hypertension in 78 children. *Arch Dis Child* 2015; 100:474–478.
257. Eliason JL, Coleman DM, Criado E, Kershaw DB, Blatt NB, Williams DM, *et al.* Operations for failed endovascular therapy of 32 renal artery stenoses in 24 children. *Pediatr Nephrol* 2016; 31:809–817.
258. Waguespack SG, Rich T, Grubbs E, Ying AK, Perrier ND, Ayala-Ramirez M, *et al.* A current review of the etiology, diagnosis, and treatment of pediatric pheochromocytoma and paraganglioma. *J Clin Endocrinol Metab* 2010; 95:2023–2037.

259. Garnier S, Réguerre Y, Orbach D, Brugières L, Kalfa N. Pediatric pheochromocytoma and paraganglioma: an update. *Bull Cancer* 2014; 101:966–975.
260. Zennaro MC, Boulkroun S, Fernandes-Rosa F. An update on novel mechanisms of primary aldosteronism. *J Endocrinol* 2015; 224:R63–R77.
261. Stratakis CA. Cushing syndrome in paediatrics. *Endocrinol Metab Clin North Am* 2012; 41:793–803.
262. Magiakou MA, Mastorakos G, Zachman K, Chrousos GP. Blood pressure in children and adolescents with Cushing's syndrome before and after surgical care. *J Clin Endocrinol Metab* 1997; 82:1734–1738.
263. Sinaii N, Patronas N, Batista DL, Keil M, Samuel J, Moran J, et al. Blood pressure in pediatric patients with Cushing syndrome. *J Clin Endocrinol Metab* 2009; 94:2002–2082.
264. Su MS, Zhang HL, Cai XH, Lin Y, Liu PN, Zhang Y, et al. Obesity in children with different risk factors for obstructive sleep apnea: a community based study. *Eur J Pediatr* 2016; 175:211–220.
265. Silvestre JM, Jesé-Mayer DE, Bass MT. Polisomnography in obese children with a history of sleep-associated breathing disorders. *Pediatr Pulmonol* 1993; 16:124–129.
266. Marcus CL, Curtis S, Koerner CB. Evaluation of pulmonary function and polisomnography in obese children and adolescents. *Pediatr Pulmonol* 1996; 21:176–183.
267. Chay OM, Goh A, Abisheganaden J. Obstructive sleep apnea syndrome in obese Singapore children. *Pediatr Pulmonol* 2000; 29:284–290.
268. Wing YK, Hui SH, Pak WM. A controlled study of sleep related disordered breathing in obese children. *Arch Dis Child* 2003; 88:1043–1047.
269. Dayyat ED, Kheirandish-Gozal L, Gozal D. Childhood obstructive sleep apnea: one or two distinct disease entities? *Sleep Med Clin* 2007; 2:433–444.
270. Levy P, Bonsignore MR, Eckel J. Sleep, sleep-disordered breathing and metabolic consequences. *Eur Respir J* 2009; 34:243–260.
271. Fletcher S, Miller J, Schaaf JW, Fletcher JG. Urinary catecholamines before and after tracheostomy in patients with obstructive sleep apnea and hypertension. *Sleep* 1987; 10:35–44.
272. Strohl KP, Novak RD, Singer W, Cahan C, Boehm KD, Denko CW, Hoffstem VS. Insulin levels, blood pressure, and sleep apnea. *Sleep* 1994; 17:614–618.
273. Vgontzas AN. Does obesity plays a major role in the pathogenesis of sleep apnea and its associated manifestations via inflammation, visceral adiposity and insulin resistance? *Arch Physiol Biochem* 2008; 114:211–223.
274. Torok RD, Campbell MJ, Fleming GA, Hill KD. Coarctation of the aorta: management from infancy to adulthood. *World J Cardiol* 2015; 7:765–775.
275. Morgan GJ, Lee KJ, Chaturvedi R, Bradley TJ, Mertens L, Benson L. Systemic blood pressure after stent management for arch coarctation implications for clinical care. *JACC Cardiovasc Interv* 2013; 6:192–201.
276. O'Sullivan JJ, Derrick G, Darnell R. Prevalence of hypertension in children after early repair of coarctation of the aorta: a cohort study using casual and 24 h blood pressure measurement. *Heart* 2002; 88:163–166.
277. Hager A, Kanz S, Kaemmerer H, Schreiber C, Hess J. Coarctation Long-term Assessment (COALA): significance of arterial hypertension in a cohort of 404 patients up to 27 years after surgical repair of isolated coarctation of the aorta, even in the absence of restenosis and prosthetic material. *J Thorac Cardiovasc Surg* 2007; 134:738–745.
278. Grontved A, Brage S, Moller NC, Kristensen PL, Wedderkopp N, Froberg K, et al. Hemodynamic variables during exercise in childhood and resting systolic blood pressure levels 6 years later in adolescence: the European Youth Heart Study. *J Hum Hypertens* 2011; 25:608–614.
279. Luijendijk P, Bouma BJ, Vriend JW, Vliegen HW, Groenink M, Mulder BJ. Usefulness of exercise-induced hypertension as predictor of chronic hypertension in adults after operative therapy for aortic isthmus coarctation in childhood. *Am J Cardiol* 2011; 108:435–439.
280. Giordano U, Cifra B, Giannico S, Turchetta A, Calzolari A. Mid-term results, and therapeutic management, for patients suffering hypertension after surgical repair of aortic coarctation. *Cardiol Young* 2009; 19:451–455.
281. Moltzer E, Mattace Raso FU, Karamermer Y, Boersma E, Webb GD, Simoons ML, et al. Comparison of candesartan versus metoprolol for treatment of systemic hypertension after repaired aortic coarctation. *Am J Cardiol* 2010; 105:217–222.
282. Grossman A, Messerli FH, Grossman E. Drug-induced hypertension – an unappreciated cause of secondary hypertension. *Eur J Pharmacol* 2015; 763:15–22.
283. Kassel LE, Odum LE. Our own worst enemy: pharmacologic mechanisms of hypertension. *Adv Cbr Kid Dis* 2015; 22:245–252.
284. Maass PG, Aydin A, Luft FC, Schächterle C, Weise A, Stricker S, et al. PDE3A mutations cause autosomal dominant hypertension with brachydactyly. *Nat Genet* 2015; 47:647–653.