

Perioperative Management of Hypertension (Adults)

Key Points

- This guideline concerns adults presenting for elective surgery and so excludes paediatrics, obstetrics, and patients presenting for emergency surgery
- Patients who have documented recordings from primary or secondary care of systolic blood pressure (SBP) <160mmHg and diastolic blood pressure (DBP) <100mmHg or an ambulatory or home blood pressure measurement <155/95mmHg, may proceed to surgery
- Hypertension on the day of surgery (BP >180/120mmHg) after three measurements can proceed if documented evidence from secondary care (pre-op assessment clinic or surgical out-patients) of SBP <180mmHg and DBP <120mmHg
- The general practitioner should be informed of SBP>140mmHg or DBP>90mmHg so that the diagnosis of hypertension can be refuted, or confirmed and treated (if the patient is not already known to be hypertensive)
- **Patients taking angiotensin II receptor blockers and ACE inhibitors should continue taking these as normal on the day of surgery**

Version: 3
Date Issued: 12/06/2026
Review Date: 01/06/2029
Key words: Hypertension, blood pressure management, peri-operative anaesthesia, disseminated atheroma, antihypertensive medications.

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Abbreviations

ACE	Angiotensin-Converting Enzyme Inhibitors
AAGBI	Association of Anaesthetists of Great Britain and Ireland
BHS	British Hypertension Society
DBP	Diastolic Blood Pressure
SBP	Systolic Blood Pressure

Summary

This guideline concerns adults presenting for elective surgery and so excludes paediatrics, obstetrics, and patients presenting for emergency surgery.

Patients who have documented recordings from primary care of systolic blood pressure (SBP) <160mmHg and diastolic blood pressure (DBP) <100mmHg may proceed to surgery. Management of blood pressure in primary care should target SBP<140mmHg and DBP<90mmHg, but surgery does not need to be postponed whilst this target is being achieved. If no blood pressure recordings are documented in the referral paperwork, measurements can be requested from the patient's GP practice.

Patients who have SBP <180mmHg and DBP<120mmHg in secondary care (preoperative assessment clinic or surgical outpatients) after three measurements (see appendix 1) can proceed to surgery. However, the general practitioner should be informed of SBP>140mmHg or DBP>90mmHg so that the diagnosis of hypertension can be refuted or confirmed and treated (if the patient is not already known to be hypertensive).

Patients who have SBP>180mmHg or DBP>120mmHg after three measurements in secondary care should be referred back to their general practitioner for management of hypertension prior to proceeding with elective surgery.

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Perioperative Blood Pressure Management

The aim for blood pressure management during anaesthesia is to keep it as close to baseline as possible. Hypertensive patients and those with disseminated atheroma (including carotid, cerebral, cardiac and renal) are dependent on maintenance of near-normal blood pressure for organ perfusion. A patient who has blood pressure recordings that are acceptable for proceeding to surgery may not, therefore, be suitable for hypotensive techniques. Individual cases should be assessed by the anaesthetist caring for them, with involvement of the duty/on call consultant anaesthetist as necessary.

Antihypertensive Medications in the Perioperative Period

All antihypertensive medications should be continued uninterrupted during the perioperative period.

Patients taking angiotensin II receptor blockers and ACE inhibitors for the management of hypertension are no longer advised to withhold their medication on the morning of surgery and should take their dose as normal.

References

1. McCormack, T. et al (2026) 'Measurement and management of adult blood pressure in the peri-operative period: updated guidelines from the Association of Anaesthetists and the British and Irish Hypertension Society', *Anaesthesia*. Available at: doi:10.1111/anae.70082 (accessed: 5 February 2026)
2. Hartle, A. et al. (2016) 'The measurement of adult blood pressure and management of hypertension before elective surgery', *Anaesthesia*, 71(3), pp. 326-337. Available at: <https://doi.org/10.1111/anae.13348> (Accessed: 11 February 2025).
3. Roshanov, P. et al. (2017) 'Withholding versus Continuing Angiotensin-converting Enzyme Inhibitors or Angiotensin II Receptor Blockers before Noncardiac Surgery: An Analysis of the Vascular events', *Anesthesiology*, 126(1), pp. 16-27. Available at: [Anesthesiology](#) (Accessed: 11 February 2025).

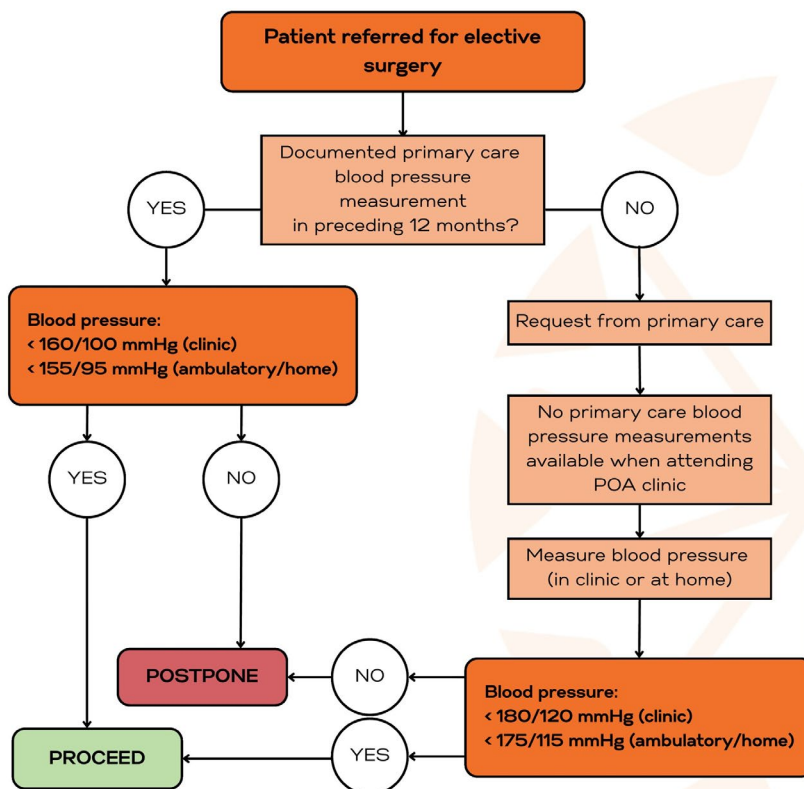
Appendix 1 AAGBI/BHS guidance on accurate measurement of blood pressure

The setting in which blood pressure is measured should be relaxed and temperate in a standardised environment with current calibrated equipment. The seated patient should have their supported arm outstretched for at least one minute before the initial reading. The pulse rate and rhythm should be recorded before the blood pressure is measured by a validated device. Automated sphygmomanometers are inaccurate when the pulse is irregular. In this situation the blood pressure should be measured by auscultation over the brachial artery during manual deflation of an arm cuff. Blood pressure should be measured in both arms in patients scheduled for vascular or renal surgery. If the difference between arms in systolic pressure is greater than 20 mmHg, repeat the measurements: subsequently, measure from the arm with the higher blood pressure.

Appendix 2 Flowchart of the management of hypertension in the perioperative period

Flowchart for the management of adult blood pressure in the peri-operative period

Updated guidelines from the Association of Anaesthetists and the British and Irish Hypertension Society



Full version control record

Version:	3
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Library check completed:	11/02/2026
Ratified at:	Anaesthesia and Theatre Clinical Governance Committee meeting 20 May 2026
Date Issued:	12/06/2026
Review Date:	01/06/2029
Pharmaceutical dosing advice and formulary compliance checked by:	N/A
Key words:	Hypertension, blood pressure, management, peri-operative, anaesthesia, disseminated atheroma, antihypertensive medications.

This guideline has been registered with the Trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health NHS Foundation Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version History

Version	Date	Guideline Lead(s)	Status	Comment
1.0	June 2017	Consultant Anaesthetist	Final	
1.1	April 2022	Clinical Guidelines Administrator	Interim	Transferred to new Clinical Guidelines Template.
2.0	Feb 2025	Consultant Anaesthetist	Final	Scheduled review, no changes, approved at Anaesthetics CG.
3.0	Feb 2026	Dr Elliott Ridgeon, Consultant Anaesthetist (HWPH), Dr Elizabeth Combeer, Consultant Anaesthetist (FPH), Dr Amer Qureshi, Consultant Anaesthetist (HWPH)	Final	Updated guideline to reflect AoA statement Ratified at: Anaesthesia and Theatre Clinical Governance Committee meeting 20 May 2026

Related Documents

None