Trust Policy

Worcestershire Acute Hospitals NHS Trust

Postural (Orthostatic) Hypotension Policy & Guideline

This guidance does not override the individual responsibility of health professionals to make appropriate decision according to the circumstances of the individual patient in consultation with the patient and /or carer. Health care professionals must be prepared to justify any deviation from this guidance.

Introduction

This guideline covers the identification and management of orthostatic hypotension in adult inpatients.

This guideline is for use by the following staff groups:

All qualified healthcare professionals involved in the identification and management of orthostatic hypotension.

Lead Clinician(s)

Dr Susan Powell	Consultant Geriatrician
Dr Catherine Jackson	Consultant Geriatrician
Sarah Pittaway	Pharmacist Frailty Practitioner
Sarah Craister	Lead Frailty Physiotherapist

Approved by DMB meeting:	9th December 2024
Approved by Medicines Safety Committee	8th January 2025
Review Date:	8th January 2028

This is the most current document and is to be used until revised version available.

Key Amendments to this Guideline

Date:	Amendment	By:
17th December 2020	Creation of policy. Identification of orthostatic hypotension merged with new management of orthostatic hypotension guideline.	Ruma Dutta, Catherine Jackson, Sarah Pittaway Sarah Craister & Alice Elderton
10th September 2024	This guideline has been updated to include pyridostigmine as a treatment option for neurogenic orthostatic hypotension (dependent on availability). Midodrine is now recommended as a first-line treatment for postural hypotension in patients with Parkinson's Disease. Also includes references to the introduced electronic patient records.	Dr. Susan Powell Dr. Rafiq Ullah

1. Introduction

Postural (orthostatic) hypotension is defined as the inability to maintain blood pressure on assuming an upright position from supine, leading to a drop of at least 20 mmHg in systolic pressure or a reduction in diastolic pressure of at least 10 mmHg.

Postural hypotension (PH) can occur at any age, but its prevalence increases with age. The condition affects approximately 31% of individuals in care home cohorts, 20% of people with hypertension, 21% of diabetics, 25% of patients with Parkinson's Disease (PD), and 29% of patients with dementia (McDonagh et al., 2021). It could be due to a combination of age-related physiological changes including increased baroreceptor sensitivity, side-effects of polypharmacy, especially those with vasoactive potential, and a higher incidence of chronic disease which could impact on blood pressure in general.

Postural hypotension can cause dizziness, nausea, blurred vision, sweating, lethargy, falls and is a frequent cause of syncope. In some cases, it may present with atypical symptoms such as chest pain, neck pain, or difficulty thinking. Additionally, up to one-third of patients may experience "hypotension unawareness," meaning they do not perceive or report any symptoms. It may contribute to morbidity, disability and even death, because of the potential risk of substantial injury, and there is some evidence of a causative link with cardiovascular disease, dementia and even depression. Even asymptomatic postural hypotension can be associated with adverse outcomes.

As per nice guidelines [CG 161], inpatients aged 65 or older, and those aged 50 to 64 with underlying medical conditions, are considered at high risk for falls and should have their lying and standing blood pressure checked upon admission as part of nursing risk assessment by nurses as per trust policy.

The diagnosis of postural hypotension can be made following recording of lying and standing blood pressure measurements. In order to diagnose postural hypotension, it is essential that blood pressure measurement is undertaken accurately using standardised guidelines and equipment (*Vloet et al 2002*).

It is important to remember that postural hypotension can be a long-term condition which can't necessarily be resolved prior to discharge from the acute hospital. If the patient is severely symptomatic, then they should be discussed with a specialist and appropriate risk assessment and management is important.

2. How to record lying and standing blood pressure

The patient must lie supine (flat on back) for at least 5 minutes or until at least two consecutive blood pressure measurements are the same. If the patient is unable to lie flat – lie them as far down as possible but note any change of position from supine. Sitting upright is not appropriate.

On measuring brachial artery blood pressure, ensure that the arm is supported at heart level, the correct sized cuff is used (the cuff must cover 80% of the patient's arm), the cuff is placed over the brachial artery and if measured manually that the result is recorded to nearest 2 mm Hg.

Then measure again in the standing position as per the regime below. If unable to stand, use whatever support, standing aids or equipment is necessary. If still unable to stand, or if intolerant of standing, a sitting BP can be used as a rough surrogate provided legs dangling and body as close to vertical as possible and that this position is documented.

The blood pressure is recorded with the arm supported at heart level:

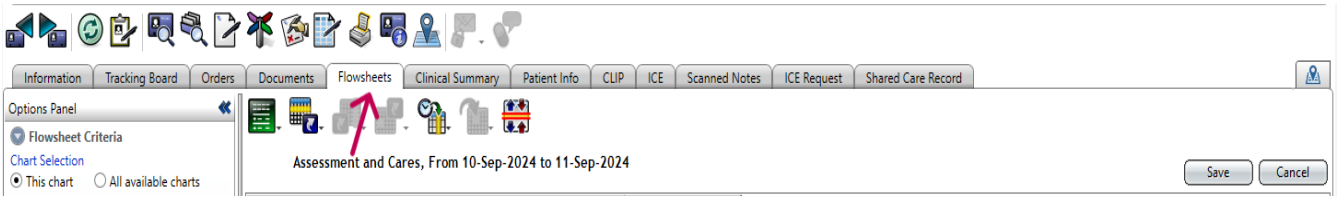
- Within the first minute of standing/upright
- After 3 minutes standing/upright (would continue to record if BP still dropping and patient able)

Document the lowest blood pressure measurement; a clinically significant drop in blood pressure is classified as 20mmHg systolic or 10mmHg diastolic.

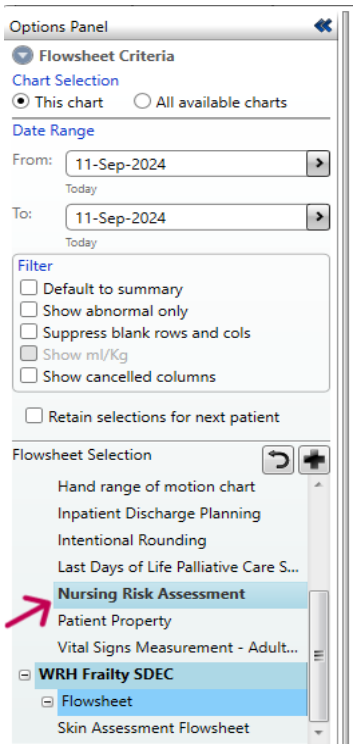
If the patient has severe symptoms, then stop the measurement and lie the patient back down until the symptoms ease.

A step-by-step guide to recording or reviewing Lying and standing Blood Pressure in Sunrise (Electronic Patient Record)

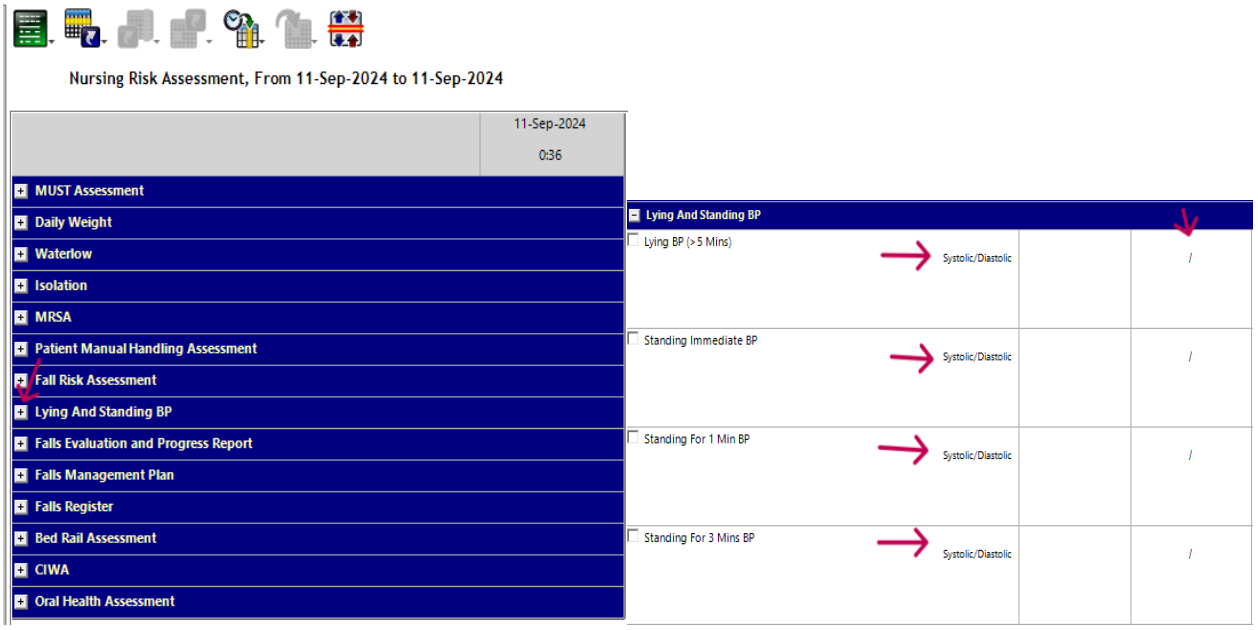
1. Log into the **Sunrise** system.
2. **Search** for the patient whose data you need to enter or review.
3. Once the patient is selected, click on the **"Flowsheets"** tab in the patient menu.



4. From the **sidebar** under the "Flowsheet Selection" panel, locate **"Nursing Risk Assessment"**.



In the “Nursing Risk Assessment” section, click the **"+"** button next to **“Lying and Standing Blood Pressure”**.



You can enter or review the Lying and standing blood pressure readings here.

5. Also, document the blood pressure readings in the **"Documents"** section. Include details about the patient's recent **meals** and **caffeine consumption**. Record any **symptoms** the patient reports, such as Dizziness, Lightheadedness etc. Review all the recorded data and confirm the information is accurate.

3. Equipment

Blood pressure may be recorded using a manual, aneroid sphygmomanometer or by a non – invasive automated device.

As with all medical devices, use should be in accordance with procedures recommended by the manufacturer. All automated medical devices should be properly serviced and maintained and the manual aneroid sphygmomanometer should be checked and calibrated every 6-12 months.

For further information on blood pressure recording please refer to the Royal Marsden Hospital Manual of Clinical Nursing Procedures which can be found in the Clinical Systems section of the intranet.

4. Diagnosis

Undertake the necessary testing to confirm a diagnosis of postural hypotension as above.

Heart rate should be taken at the same time as the blood pressure measurements, as the expected tachycardia in response to hypotension is blunted when there is an underlying neurogenic cause e.g. peripheral neuropathy.

Ambulatory blood pressure monitoring should be ordered in patients with a history suggesting symptomatic postural hypotension, particularly when a drop is not detected during regular autonomic testing.

Tilt-table test may be useful in certain patients when postural hypotension is not detected during the posture test and the patient gives a suggestive history.

5. Causes of postural hypotension

NICE guidelines advise that if postural hypotension is confirmed, the likely causes should be considered, and the condition should be managed appropriately. It is important to include the cause (if known), alongside the diagnosis in the notes.

Postural hypotension may result from neurogenic and non-neurogenic causes.

Neurogenic causes include:

- Primary autonomic failure
  - Parkinson's disease with autonomic failure
  - Lewy Body Dementia
  - Pure autonomic failure (a Lewy body disease in which mostly the peripheral autonomic nerves are involved, without a movement disorder phenotype)
  - Multiple system atrophy (MSA, previously called Shy-Drager syndrome), which can have atypical parkinsonian features (MSA-P) or symptoms of cerebellar ataxia (MSA-C)
- Secondary autonomic failure
  - Diabetes
  - Amyloidosis
  - Uraemia
  - Spinal cord injury

In patients who have postural hypotension caused by impaired autonomic cardiovascular reflexes, the increase in heart rate that accompanies the fall in blood pressure is typically diminished (<10 bpm). However, in some patients, particularly those with multiple system atrophy, the heart rate may increase as much as 20 bpm when the fall in blood pressure is profound. Thus, the ratio of heart rate increase to the blood pressure fall is a more precise measure of baroreflex impairment.

Non-neurogenic causes include:

- Drug induced
  - Alcohol, vasodilators, diuretics, phenothiazines and antidepressants
  - See medication review for further information

- Volume Depletion
  - Haemorrhage, diarrhoea, vomiting, fever or hot temperatures

A normal rise in heart rate accompanying the fall in blood pressure is typical of patients with depletion of intravascular volume (from dehydration or haemorrhage) or impaired vasoconstrictor tone (usually caused by drugs).

- Other
  - Low cardiac output due to cardiac impairment from a myocardial infarction or aortic stenosis, deconditioning due to hospitalisation and bed rest, prolonged standing causing reduced venous return or loss of normal mineralocorticoid secretion.

Consider the possibility of an abdominal aortic aneurysm (AAA) in a patient over 65 years of age with a significant postural drop, a history of fainting or dizziness, tachycardia, pallor, and persistent abdominal or lower back pain. Check for a drop in hemoglobin (Hb) levels and perform an urgent ultrasound scan (USS) of the aorta.

6. Management

The treatment of postural hypotension recommended by European Academy of Neurology guidelines [Formerly: Federation of Neurological Societies (EFNS)] begins with patient education and a trial of non-pharmacological interventions. The emphasis is not treating the BP measurements or modifying the disease course, but to decrease symptoms, improve quality of life and prevent complications such as falls and supine hypertension.

Non-pharmacological management

The aims are to increase intravascular volume, improve venous return and to avoid triggers.

- **General lifestyle advice/physical countermeasures**

- Increase non caffeinated and non-alcoholic fluid intake to 2 litres per day (3.5 pints)
- Eat salty snacks (if no history of heart failure)
- Eat several small meals instead of large meals, ideally high fibre foods
- Avoid excessive alcohol consumption and drink within NHS recommendations of no more than 14 units a week on a regular basis and to spread your drinking over 3 or more days

- Sleep with head raised (if possible 5 inches above horizontal/at 45 degrees)
- Avoid standing still in hot temperatures both indoor and out e.g. long hot showers or baths
- Avoid standing still or sitting for longer than you can tolerate
- Exercise regularly; swimming, walking, etc.
    - Certain exercises can help circulation and reduce symptoms. They can be done lying down or in sitting, and include moving ankles up and down, rotating ankles, clenching & unclenching calf muscles, marching on the spot and crossing/uncrossing legs. You can also do certain exercises in standing; such as marching on the spot and crossing/uncrossing legs

- **Advice on changing posture**

- Bolus drinking: Drink 400-500ml of fluid (water) before getting out of bed 5 minutes prior to mobilizing. The effects of this can last up to 90 minutes.
- When getting up out of bed, sit on the edge of the bed for a few minutes before standing. If you feel dizzy, stay sitting or lie back down. Have a long drink and alternately contract and relax leg and arm muscles as able
- Prescribed compression garments: Evidence suggests the most effective compression is applied from abdomen to ankle
    - Abdominal binders alone can help increase systolic blood pressure more effectively than compression stockings. This should be put on when lying down before rising and removed after resuming the supine position; can be provided by an Orthotist (This referral can be made by a Physiotherapist) Remember that if an abdominal binder is provided, please also give the patient a copy of the trust leaflet.
    - In patients who cannot tolerate abdominal binders, prescribe class 2 above knee compression stockings for wear during the ambulant daytime hours
    - Compression stockings may be contraindicated in patients with evidence of leg ischemia due to peripheral vascular disease, or extensive skin lesions on their lower legs

Please ensure the patient is given the Trust 'Postural Hypotension' leaflet (WAHT-PI-0482).

Medication review

Recognition and discontinuation of drugs that cause postural hypotension is one management step by the treating health professional. The most frequent offending agents are diuretics, antihypertensive agents (primarily sympathetic blockers), antianginal drugs (nitrates), alpha-adrenergic antagonists, antidepressants and dopamine agonists. Lowering the dose or withdrawing the medication where possible may be all that is required to correct postural hypotension. This should be undertaken by a health professional taking into account the patient's condition and wishes as with all medication reviews. If in doubt consult a pharmacist or a geriatrician.

Please do not stop/change Parkinson's medication without discussion with a Geriatrician or the Consultant Neurologist in charge of their care.

Pharmacological management

Should be considered if the non-pharmacological strategies have been unsuccessful and there are recurrent symptoms:

- **Fludrocortisone**

Patients who have an inadequate response to simple non-pharmacological measures may benefit from Fludrocortisone. Fludrocortisone is used off license for the indication of postural hypotension. It is a synthetic mineralocorticoid with negligible glucocorticoid effects. It enhances renal sodium reabsorption and increases plasma volume. After oral administration, fludrocortisone is readily absorbed and peak plasma levels are reached within 45 min. Elimination half - life is around 7 h. To achieve full therapeutic benefit, a high dietary salt intake and adequate fluid intake are required.

Pre-treatment

- Assessment of contraindications and Cautions (see current British National Formulary); isolated bipedal oedema is not a contraindication
- U+Es, glucose, BP, weight, FBC, BMD, Lipids, supine blood pressure

Initially Fludrocortisone 100 micrograms daily titrated to a usual maximum of 300 micrograms daily.

Before each dose titration recheck lying and standing blood pressures and U+Es. Monitor for signs of adverse drug reactions such as volume overload before each dose titration at least once weekly until dose and condition stable. Discontinue if blood pressure in either position increases above 180/100 mm Hg or is considered clinically significant or there is significant volume overload or untreatable hypokalemia.

- **Midodrine (alone or in combination with, for example, fludrocortisone)**

Midodrine is a pro‑drug of desglymidodrine. Desglymidodrine is a sympathomimetic that acts on peripheral alpha-adrenergic receptors, causing vasoconstriction of the venous system and increased peripheral arterial resistance, resulting in an increase in blood pressure. The duration of action of midodrine is approximately 4 hours.

Midodrine is licensed for the treatment of severe postural hypotension due to autonomic dysfunction when corrective factors have been ruled out and other forms of treatment are inadequate (EMC 2017). Midodrine is considered first line for postural hypotension in people with Parkinson's disease, taking into account the contraindications and monitoring requirements (including monitoring for supine hypertension). If midodrine is contraindicated, not tolerated or not effective, consider fludrocortisone (NICE 2017). It is approved by the APC for GP prescribing if initiated by a specialist (Consultant Geriatrician/Cardiologist/Neurologist or other specialist experienced in the management of neurocardiovascular instability)

Pre-Treatment

- U&E's, LFTs
- Assessment of Contra-indications and Cautions (see current British National Formulary)

Ideally Midodrine is given first thing in the morning (before getting out of bed), mid-morning and mid- afternoon.

- For older patients introduce 2.5 milligram once daily and then increase to twice daily after one week; then review

- Usual maintenance dose; 2.5 milligram three times daily (Last dose should be taken at least 4 hours before bedtime)
- Increase as clinically indicated according to response; up to a maximum maintenance dose of 5-10 milligram three times daily (Last dose should be taken at least 4 hours before bedtime)

A careful evaluation of the response to treatment and of the overall balance of the expected benefits and risks should be undertaken with the person before any dose increase or advice to continue therapy for long periods. If supine hypertension occurs, which is not overcome by reducing the dose, consider stopping treatment with Midodrine after discussion with the patient depending on the severity of the symptoms of postural hypotension and consider pyridostigmine.

- **Pyridostigmine**

AS OF DECEMBER 2024, THERE IS A NATIONAL SHORTAGE OF PYRIDOSTIGMINE, AND SO PLEASE DISCUSS WITH PHARMACY BEFORE PRESCRIBING FOR THIS INDICATION, AS SUPPLIES NEED TO BE PRIORITISED FOR MYASTHENIA PATIENTS.

Pyridostigmine can be used alone or in combination to treat postural hypotension especially in patients who develop supine hypertension with standard drug treatment or in those who are refractory to other treatments. Pyridostigmine is used off-licensed to treat neurogenic postural hypotension. Pyridostigmine has been shown to modestly but significantly improve neurogenic postural hypotension without worsening supine hypertension (*Isaacson et al 2021*). It is an acetylcholinesterase inhibitor which enhances cholinergic neurotransmission at sympathetic ganglia, thus increasing cholinergic tone which can result in increased norepinephrine release during orthostatic stress. It is mainly excreted by the kidneys unchanged. The ACC/AHA/HRS recommends (Class IIb) that pyridostigmine may be beneficial in patients with syncope due to neurogenic postural hypotension who are refractory to other treatments (*Shen et al 2021)*.

Recommended dose: Pyridostigmine (30–60 mg two or three times a day)

Pre-treatment assessment:

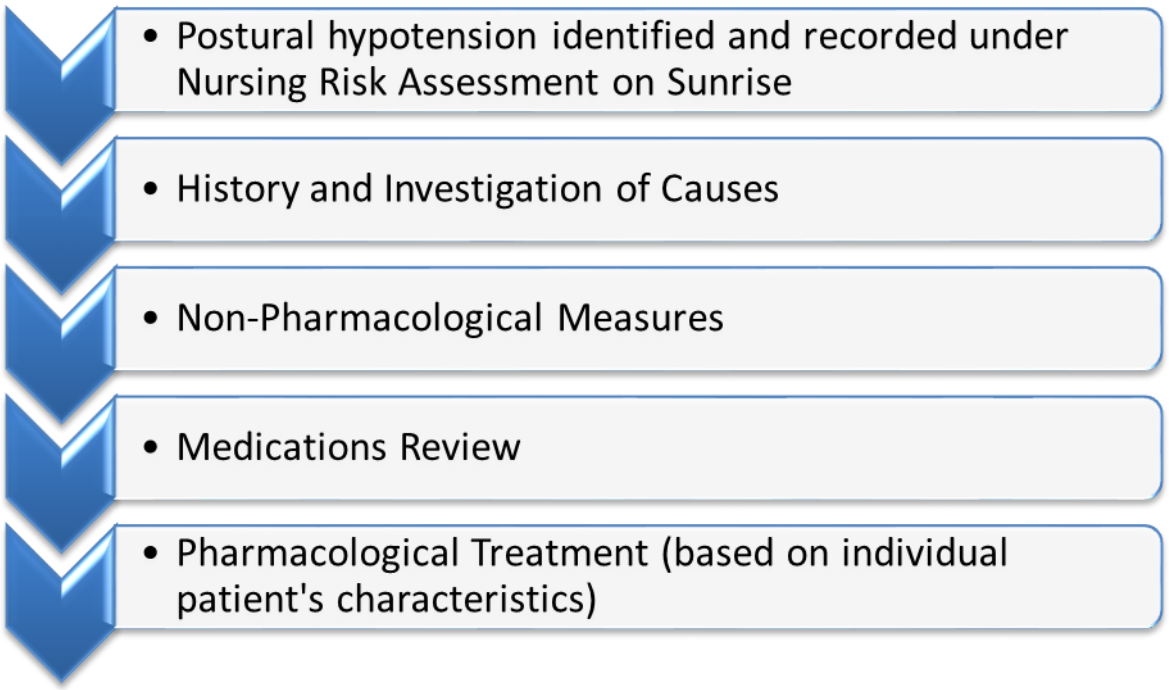
- Perform an ECG to assess for any cardiac rhythm abnormalities.
- Carefully evaluate for contraindications, cautions, and potential side effects (refer to the current British National Formulary).
- Use caution in patients with obstructive lung disease and cardiac rhythm abnormalities, such

as bradycardia and atrioventricular (AV) block.

- Discuss risks and benefits with patient before commencement.

Treatment should be guided by symptom control and supine blood pressure levels not by measured changes in blood pressure only.

Summary



7. Monitoring and compliance

Page/ Section of Key Document	Key control:	Checks to be carried out to confirm compliance with the Policy:	How often the check will be carried out:	Responsible for carrying out the check:	Results of check reported to: *(Responsible for also ensuring actions are developed to address any areas of non-compliance)*	Frequency of reporting:
	WHAT?	**HOW?**	**WHEN?**	**WHO?**	**WHERE?**	**WHEN?**
All	Identification of postural hypotension is as per guideline	Quality/Audit	Weekly	Matron/Ward Manager	Quality Hub/Divisional Governance Meetings	Monthly
All	Management of postural hypotension is as per guideline	Audit	Annually	Doctors/Frailty Practitioners	Falls Steering Group	Annually

8. References

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9. Background

Contribution list

This updated version of this key document has been circulated to the following individuals for consultation;

Name	Designation
Dr. Susan Powell	Consultant Geriatrician
Dr Catherine Jackson	Consultant Geriatrician
Dr. Claire Wilkes	Consultant Geriatrician
Dr. Sarah Packer	Consultant Geriatrician
Hannah Smith	Frailty Nurse Consultant
Fiona Campbell	Frailty Nurse Consultant
Philip Goode	Frailty Nurse Consultant
Donna Kruckow	Lead Nurse Dementia and Older People
Victoria Sturdy	Safer Care Practitioner- Dementia team
Sarah Pittaway	Pharmacist Frailty Practitioner
Sarah Craister	Senior Physiotherapist - Frailty

This key document has been circulated to the following committees/groups for comments:

Committee
Frailty Directorate Meeting
Medicines Safety Committee

Supporting Document 1 - Equality Impact Assessment Tool

To be completed by the key document author and included as an appendix to key document when submitted to the appropriate committee for consideration and approval.

Please complete assessment form on next page;

Herefordshire & Worcestershire STP - Equality Impact Assessment (EIA) Form
Please read EIA guidelines when completing this form

Section 1 - Name of Organisation (please tick)

Herefordshire & Worcestershire STP		Herefordshire Council		Herefordshire CCG	
Worcestershire Acute Hospitals NHS Trust	x	Worcestershire County Council		Worcestershire CCGs	
Worcestershire Health and Care NHS Trust		Wye Valley NHS Trust		Other (please state)	

Name of Lead for Activity	**Dr Susan Powell**

Details of individuals completing this assessment	**Name**	**Job title**	**e-mail contact**
	Dr Susan Powell	**Consultant Geriatrician**	**Susan.powell16@nhs.net**
Date assessment completed	**11/01/25**		

Section 2

Activity being assessed (e.g. policy/procedure, document, service redesign, policy, strategy etc.)	**Title:** **Postural (orthostatic) hypotension policy and guideline**			
What is the aim, purpose and/or intended outcomes of this Activity?	To formalise the procedures for the measurement and recording of postural blood pressures in hospital inpatients at risk of falls. To provide a guideline with regards to the assessment of patients with postural hypotension to identify the underlying cause. To provide advice around both the non-pharmacological and pharmacological management of patients with a postural drop.			
Who will be affected by the	❑x	Service User	❑x	Staff

development & implementation of this activity?	❑x ❑ ❑	Patient Carers Visitors	❑ ❑ ❑	Communities Other __Pharmacy_____
Is this:	❑x Review of an existing activity ❑ New activity ❑ Planning to withdraw or reduce a service, activity or presence?			
What information and evidence have you reviewed to help inform this assessment? (Please name sources, eg demographic information for patients / services / staff groups affected, complaints etc.	NICE guidance and wider literature review as evidenced in the references provided with the guideline. Clinical experience from the contributors.			
Summary of engagement or consultation undertaken (e.g. who and how have you engaged with, or why do you believe this is not required)	Discussed with Dementia and Falls steering group. Also discussed with the multiprofessional frailty team including physiotherapists, nursing and pharmacy colleagues.			
Summary of relevant findings	The measurement of postural blood pressure should be well embedded, but the procedure for recording has changed since the introduction of the new EPR, and this is clarified within the updated guideline. The updated guideline also highlights evidence that even asymptomatic postural hypotension can be associated with adverse outcomes, but at the same time makes it clear that this is a chronic condition and doesn't necessarily have to delay any potential discharge plans. We have also added in the use of pyridostogmine for patients with supine hypertension in particular.			

Section 3

Please consider the potential impact of this activity (during development & implementation) on each of the equality groups outlined below. **Please tick one or more impact box below for each Equality Group and explain your rationale**. Please note it is possible for the potential impact to be both positive and negative within the same equality group and this should be recorded. Remember to consider the impact on e.g. staff, public, patients, carers etc. in these equality groups.

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Age	x			Postural hypotension is seen more commonly in the older population and can increase the risk of falls. Greater awareness and better assessment and treatment will improve outcomes for these patients.
Disability		x		
Gender Reassignment		x		
Marriage & Civil Partnerships		x		

Equality Group	Potential positive impact	Potential neutral impact	Potential negative impact	Please explain your reasons for any potential positive, neutral or negative impact identified
Pregnancy & Maternity		x		
Race including Traveling Communities		x		
Religion & Belief		x		
Sex		x		
Sexual Orientation		x		
Other Vulnerable and Disadvantaged Groups (e.g. carers; care leavers; homeless; Social/Economic deprivation, travelling communities etc.)		x		
Health Inequalities (any preventable, unfair & unjust differences in health status between groups, populations or individuals that arise from the unequal distribution of social, environmental & economic conditions within societies)		x		

Section 4

What actions will you take to mitigate any potential negative impacts?	Risk identified	Actions required to reduce / eliminate negative impact	Who will lead on the action?	Timeframe
	As of Jan 2024, there are limited supplies of pyridostigmine,	This has been added to the guideline with the proviso that its use should be discussed with a clinical pharmacist.	Dr Susan Powell	Included in the guideline
How will you monitor these				

actions?	
When will you review this EIA? (e.g in a service redesign, this EIA should be revisited regularly throughout the design & implementation)	**January 2027**

Section 5 - Please read and agree to the following Equality Statement

1. Equality Statement

1.1. All public bodies have a statutory duty under the Equality Act 2010 to set out arrangements to assess and consult on how their policies and functions impact on the 9 protected characteristics: Age; Disability; Gender Reassignment; Marriage & Civil Partnership; Pregnancy & Maternity; Race; Religion & Belief; Sex; Sexual Orientation

1.2. Our Organisations will challenge discrimination, promote equality, respect human rights, and aims to design and implement services, policies and measures that meet the diverse needs of our service, and population, ensuring that none are placed at a disadvantage over others.

1.3. All staff are expected to deliver services and provide services and care in a manner which respects the individuality of service users, patients, carer's etc, and as such treat them and members of the workforce respectfully, paying due regard to the 9 protected characteristics.

Signature of person completing EIA	Dr Susan Powell
Date signed	11/01//25
Comments:	
Signature of person the Leader Person for this activity	Dr Susan Powell
Date signed	

Supporting Document 2 – Financial Impact Assessment

	Title of document:	Yes/No
1.	**Does the implementation of this document require any additional Capital resources?**	No
2.	**Does the implementation of this document require additional revenue?**	No
3.	**Does the implementation of this document require additional manpower?**	No
4.	**Does the implementation of this document release any manpower costs through a change in practice?**	No
5.	**Are there additional staff training costs associated with implementing this document which cannot be delivered through current training programmes or allocated training times for staff?**	No
	Other comments:	

If the response to any of the above is yes, please complete a business case and which is signed by your Finance Manager and Directorate Manager for consideration by the Accountable Director before progressing to the relevant committee for approval.