Denervation"). Therefore, it is reasonable to exclude a white-coat effect using out-of-office BP monitoring for individuals with apparent resistant hypertension.

4. Systematic reviews and meta-analyses have demonstrated that compared with controlled hypertension, white-coat effect is not associated with an increased risk of CVD events.[1,4,13] These studies primarily did not focus on individuals with apparent resistant hypertension, indicating that it is reasonable to conduct out-of-office BP monitoring for the larger group of individuals who are taking antihypertensive medication and who have high office BP (ie, office SBP/DBP ≥130/80 mm Hg). Individuals with office SBP/DBP ≥160/100 mm Hg should have antihypertensive medication intensification as necessary to control BP (Section 5.2, "Medical Management").
5. Systematic reviews and meta-analyses of observational studies have demonstrated that compared with sustained normotension, masked hypertension is associated with an increased risk of CVD events with a risk range similar to that of sustained hypertension.[5,13-15] Studies have examined whether using specific office BP ranges (ie, those approaching the high office BP threshold) or prediction models incorporating demographic and clinical factors for targeting individuals with out-of-office BP monitoring would be a better approach than screening all individuals who do not have high office BP.[28-32] Clinicians may consider using these targeted screening approaches, particularly among those patients with unexplained BP-related target organ damage. However, it remains unclear which diagnostic approach is the best for excluding masked hypertension among individuals without high office BP and what false-positive and -negative rates are acceptable for population screening. Further, these targeted screening approaches should also be examined among populations with a high prevalence of masked hypertension, such as Black populations.[33] Therefore, in the absence of knowing the best approach for targeted screening, the use of out-of-office BP monitoring may be reasonable to exclude masked hypertension among adults with office SBP/DBP <130/80 mm Hg. Recent evidence suggests that compared with placebo, antihypertensive medication may improve target organ damage among adults with masked hypertension.[34] However, the effect on cardiovascular outcomes remains unknown.
6. Systematic reviews and meta-analyses have demonstrated that compared with controlled hypertension, masked uncontrolled hypertension is associated with an increased risk of CVD events and mortality.[13-15] There are some data to suggest that antihypertensive medication targeting out-of-office BP among individuals with masked uncontrolled hypertension reduces hypertension-related target organ damage measures, including urinary albumin-to-creatinine ratio, pulse wave velocity, and left ventricular mass index.[35] Although the effect of antihypertensive medication intensification on the risk of CVD events among individuals with masked uncontrolled hypertension remains unknown, it may be reasonable to exclude masked uncontrolled hypertension using out-of-office BP monitoring for CVD risk stratification.

3.2.3. Secondary Forms of Hypertension

Recommendations for Secondary Forms of Hypertension
References that support recommendations are summarized in the Evidence Table.

COR	LOE	RECOMMENDATIONS
1	C-EO	1. In adults with hypertension, screening for specific forms of secondary hypertension is recommended when clinical suspicion is present (Table 10, Figure 5) to increase rates of detection, diagnosis, and specific targeted therapy.
1	B-NR	2. In adults with resistant hypertension, screening for primary aldosteronism is recommended regardless of whether hypokalemia is present to increase rates of detection, diagnosis, and specific targeted therapy.[1,2]
2a	C-EO	3. In adults who have a positive screening test for a form of secondary hypertension, referral to a clinician who has expertise in that form of hypertension is reasonable for diagnostic confirmation and treatment.

Synopsis

Secondary causes of hypertension can be identified in approximately 5% to 25% of adult patients with hypertension.[1-3] If a cause can be correctly diagnosed and treated, patients with secondary hypertension may experience a marked improvement in BP control with a reduction in CVD risk. Patients with a new diagnosis of hypertension and concomitant conditions should be screened (**Figure 4**) with a history and physical examination and laboratory tests, as recommended in Section 3.1.2 ("Patient Evaluation, Including Laboratory Tests and Other Diagnostic Procedures").