

Supplementary Figure 1

- 1) Does your patient have BP > 140/90 and not on medications? YES.
 - If possible, set an alert in your practice software so that a prompt to enter the study appears when untreated hypertensive patients are seen.
- 2) Check UEC, aldosterone, renin, ARR (aldosterone: renin ratio)
 - Please advise patients to do this test 2 hours after getting out of bed, (9 – 10AM; no need to fast)
 - It may be easiest to enter these blood tests and specific instructions into your practice software as a set, eg. “hypertension screening tests”, so that you can order these tests at the click of a button.
- 3) Please CC path result to:
Dr Jun Yang (Endocrinologist), Department of Endocrinology, Level 3, Block E, Monash Medical Centre, Clayton Road, Clayton 3168
 - This can also be pre-entered into your practice software.
- 4) Please ask patients to sign the consent form, allowing their results to be released to Dr Jun Yang, and you can sign as a witness.
 - Please keep the signed consent page.
 - Patients can keep the remaining document to read.
 - Enter patient details and pathology results into an Excel sheet for 40 Category 1 CPD points
- 5) If ARR is abnormal (> 70 pmol/mU) or renin is suppressed, please refer the patient to the bulk-billing Endocrine Hypertension Clinic at Monash Medical Centre in Clayton (fax referral to 9594-3558, attention to Dr Jun Yang).
- 6) If you have other treated hypertensive patients who do not have good BP control, consider screening for PA as well (although they do not qualify for this study). The antihypertensives to use during the testing process, which do not interfere with aldosterone and renin levels, include:
 - verapamil SR 90 – 240 mg daily
 - hydralazine 12.5 – 50 mg bd
 - prazosin 0.5 – 5 mg tds
 - moxonidine 200 mcg d

You can refer patients with an abnormal ARR or suppressed renin to us for further investigations and management, even if they are not part of the study.

Supplementary Figure 2

1. To begin, I'm interested in your thoughts about managing hypertension in general practice.
 - *How has your management changed over the years/ what influenced these changes?*
 - *How confident do you feel managing it?*

2. I wonder if you could think back to a recent patient whom you diagnosed with hypertension, particularly one who you felt needed some active management?
 - *Did you conduct any investigations?*
 - *How did you manage this patient?*

3. One of the things spoken about at the seminar was primary aldosteronism. What do you think about PA?
 - *What do you think about its prevalence?*
 - *Where does it fit into your clinical care of hypertension?*

4. Have you ever seen a patient in whom you thought primary aldosteronism may be present? If so, tell me about that patient

5. Some suggest that it may be sensible to screen all patients with hypertension for PA? What are your thoughts about this?