Table 5. Managing Interfering Medications and Interpretation

Management Strategy	Medication to withdraw	Timeline of withdrawal	Replacement Antihypertensive agents	Interpretation of Negative Screen	Interpretation of Positive Screen
No medication withdrawal	None	---	---	Possible false negative if moderate to high pretest probability Screen on different day with minimal- or full-medication withdrawal strategy	Possible false positive if individual taking β-blocker or centrally acting α_2-agonists Repeat screen after withdrawing these medications
Minimal medication withdrawal	Stop MRAs and ENaC inhibitors	4 weeks before testing	Hydralazine* α-Blockers Non-dihydropyridine CCBs Moxonidine	Possible false negative if moderate to high pretest probability Screen on different day with full withdrawal strategy If pretest probability is not moderate to high, then likely true negative	Likely true positive Proceed to algorithm (Figure 2)
	Stop β-blockers and centrally acting α_2-agonists	2 weeks before testing			

Management Strategy	Medication to withdraw	Timeline of withdrawal	Replacement Antihypertensive agents	Interpretation of Negative Screen	Interpretation of Positive Screen
Ideal full medication withdrawal	Stop MRAs, ENaC inhibitors and other diuretics	4 weeks before testing	Hydralazine* α-Blockers Non-dihydropyridine CCBs Moxonidine	Possible false negative if moderate to high pretest probability Repeat screen on different day. If pretest probability is not moderate to high, then likely true negative	Likely true positive Proceed to algorithm
	β-Blockers ACE inhibitors ARBs Dihydro-pyridine CCBs Centrally acting α_2-agonists SGLT2 inhibitors	2 weeks before testing			

*Ideally individuals receiving hydralazine should also be administered a negative chronotropic agent such as verapamil slow release to avoid reflex tachycardia.

ACE, angiotensin-converting enzyme; ARB, angiotensin II–receptor blocker; CCB, calcium-channel blocker; MRA, mineralocorticoid antagonist; SGLT2, sodium-glucose cotransporter 2.