Baptist Health
HEART INSTITUTE

Hypertension Guidelines and Updates

Jay D Geoghagan, MD FACC

Disclosures: None

Hypertension Guidelines

- Where are we?
- How did we get here?
- What do we do now?

HTN: Too Many Recommendations?

- JNC
- ACC/AHA
- ASH/ISH
- ESH/ESC
- AAFP
- ADA

Who Are the Major Players?

- Joint National Committee ... (JNC)
  - JNC 1 - 1977 to JNC 7 – 2003
    - JNC 1-3 focused on DBP only
    - Officially there is no “JNC 8”
  - ACC/AHA/ASH
  - ESC/ESH
  - Others with specific interests

Diagnostic Threshold

- Varies across guidelines
  - Most common 140/90 mmHg
  - Some recommend 130/80 mmHg
- Methodologies differ
- Cardiovascular risk scores and comorbidities incorporated by some
- Mostly important for epidemiology and with “certain”patients

Treatment Targets

Organization	Population	Target BP	Risk Assessment
JNC 7 (2003)	Adults → DM/CKD →	< 140/90 mmHg < 130/80 mmHg	No
"JNC 8" (2014)	< 60 yo → > 60 yo →	< 140/90 mmHg < 150/90 mmHg	No
ACC/AHA (2017)	All adults	< 130/80 mmHg	Yes (Formal Risk score)
ESC/ESH (2018)	All adults initial → If tolerated → > 80 yo →	< 140/90 mmHg < 130/80 mmHg SBP < 160 mmHg ***	Yes (Risk estimation)

Treatment Caveats

- Withdrawing BP meds based on age alone is not recommended.
- Treatment of elderly patients is based on biologic age and not chronologic age
- When first diagnosed, low risk patients with mild HTN can be treated with 6 months of diet/lifestyle modifications
- Non-pharmacologic treatments should always be emphasized

"General" Points of Agreement

- Emphasis on confirming the diagnosis
- Emphasis on lifestyle modifications as active therapy
- Goal BP < 140/90 mmHg for all adults (if tolerated in elderly also)
- Goal BP < 130/80 mmHg for some patients
- Treat high risk patients more aggressively
- Emphasis on confirming the diagnosis

"General" Points of Agreement

- Single pill combination therapy may improve efficacy and compliance
- Beta-blockers are not indicated as first line therapy for uncomplicated HTN
- Causes of resistant hypertension are often obvious
- Treatment of the elderly is beneficial but must be based on patient "fitness" and tolerability

Concerns about Recent Guidelines

- Some groups, including the AAFP, did not endorse the 2017 ACC/AHA guidelines
- Possible conflict of interest in the 2017 guidelines
  - Specifically related to the SPRINT trial
- Concern regarding risk/benefit ratio of lower BP targets
- Method of BP measurement in SPRINT
- Validation of the risk assessment tool

Harmony?!?

Can't we all just get along?

“Harmony” of the Guidelines

- Confirm the diagnosis
- Lifestyle counseling for all and first line treatment for low risk, mild HTN.
- Initial BP target of < 140/90 mmHg for all adults with exception for frail, elderly patients
- Further goal of ≤ 130/80 mmHg based on overall risk and tolerance of therapy
- Assessment of CV risk by some mechanism is important

“Harmony” of the Guidelines

- Early use of combination therapy, preferably in a single pill
- ACEI/ARBs, CCBs, and diuretics are first line drugs in most patients
- Resistant HTN is often caused by obesity, high sodium diet, excessive alcohol, untreated sleep apnea, and NSAIDS

Did You Know?

- The “controversial” 2017 ACC/AHA lower HTN definition did expand the number of people labeled as hypertensive.
- Number recommended treatment was only slightly increased because lifestyle modification was heavily endorsed.

Practical Recommendations

- State target BP in your A/P so that others will know your goal.
- Outline your plan to include non-Rx therapy as well as a timeline.
- If deviating from guidelines, outline the reasons.

Thank You