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HEART INSTITUTE

Update on the ACC/AHA Guidelines for HTN

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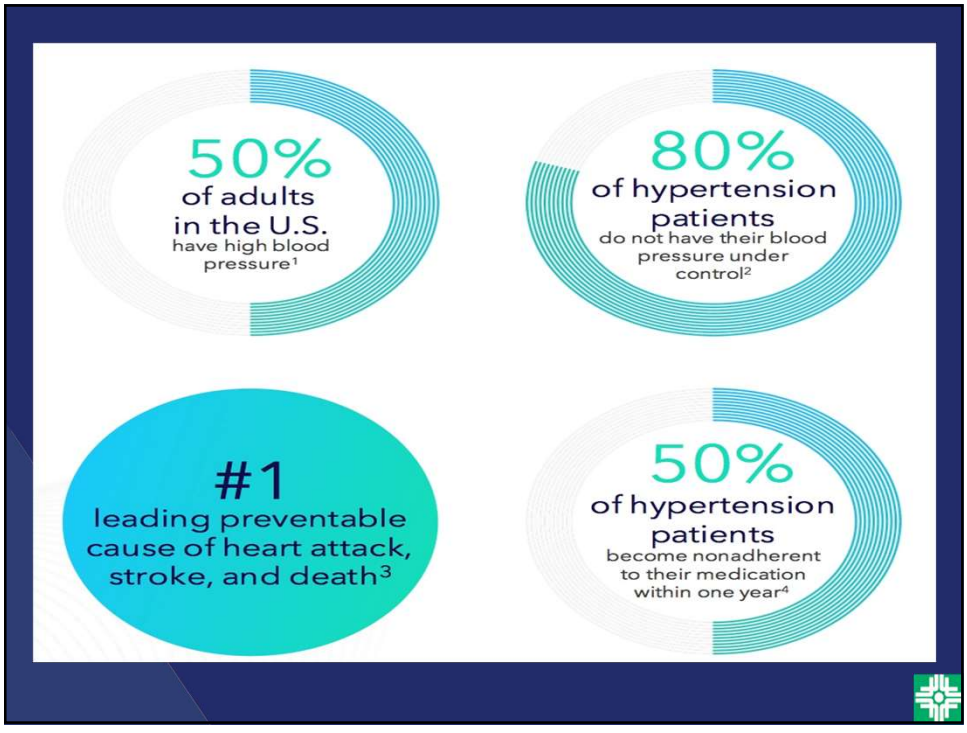
Disclosures: None

2025 HTN Guidelines

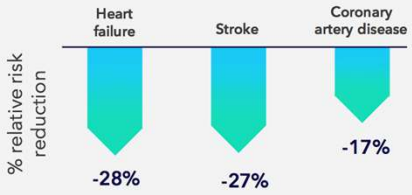
- HTN is the most prevalent and modifiable risk factor for the development of CVDs including CAD, heart failure, afib, stroke, dementia, chronic kidney disease and all-cause mortality.



Reducing office systolic blood pressure (SBP) by 10 mmHg leads to clinically meaningful reductions in cardiovascular events[5]

>20% reduction in relative risk of **major cardiovascular events**

>13% reduction in relative risk of **all-cause mortality**



Overview

- Current Definition
- Treatment
- Management of secondary issues
- Evaluating secondary causes
- Emerging treatment

HTN Definition

- AHA/ACC/AMA – 2025 – unchanged from 2017
- Two or more readings:
  - Normal <120/80
  - Elevated 120-129/<80
  - Stage 1 – 130-139 systolic or 80-90 diastolic
  - Stage 2 - >140 systolic or >90 diastolic

2025 – When to Initiate Therapy

- All adults with average BP >/= 140/90
- Selected adults with
  - >/= 130/80 w CVD, previous stroke, DM, CKD
  - or increased 10-year CV risk of >/= 7.5% defined by PREVENT
- Adults with average >/= 130/80 and lower 10-year CVD risk defined by PREVENT of <7.5%:
  - Initiate if average >/= 130/80 after 3-6 mo trial of lifestyle modifications

PREVENT

- Consider MD calc
- Factors
  - Sex
  - Age
  - Chol/HDL
  - SBP
  - DM
  - Smoking status
  - eGFR
  - Using HTN therapy
  - Using statin
  - BMI

BP Goals

ACC/AHA Class 1 – at increased risk:

- At least <130 SBP
- <120 better to reduce CV events and mortality

ACC/AHA Class 1 – at increased risk:

- DBP <80 to reduce risk of CV events/mortality

ACC/AHA Class 2B – no increased risk:

- <130 SBP
- <120 better to reduce risk of further elevation of BP

ACC/AHA Class 2B – no increased risk:

- Target <80 DBP to reduce risk of CV events

BP Goals

- Class 1 – at increased risk:
  - at least <130 SBP
  - <120 better to reduce CV events and mortality
- 1 – at increased risk:
  - DBP <80 to reduce risk of CV events/mortality
- 2B – no increased risk:
  - <130 SBP
  - <120 better to reduce risk of further elevation of BP
- 2B – no increased risk:
  - target <80 DBP to reduce risk of CV events

Medication Selection

- ACC/AHA Class 1 – initiate
  - Thiazide: hctz, chlorthalidone, indapamide
  - ACE/ARB
  - CCB dihydropyridine

2025 – Initiation with Stage II

- 2 first-line agents of different classes in a single-pill
- Fixed dose combination is preferred to improve adherence and reduce time to achieve HTN control

Drug Therapy Options

- Beta Blockers
  - Selective versus non-selective
- Calcium Channel Blockers
  - Dihydropyridine – Amlodipine
  - Non-dihydropyridine – Verapamil/Diltiazem
- Diuretics
  - Furosemide, Torsemide, Bumetanide, Chlorthalidone, Spironolactone
- ACE/ARB
- Alpha Blockers
- Nitrates
- Miscellaneous
  - Minoxidil – lowers peripheral resistance
  - Hydralazine – relax arteriolar smooth muscle

Guideline Management

- Account for:
  - Heart failure
    - Systolic versus diastolic dysfunction
  - Coronary artery disease
  - Renal dysfunction
  - Reactive airway disease
  - Chronic edema
  - Pulmonary HTN

External Affects

- Caffeine
  - Vasodilation theory/adrenal output
- Na intake
  - Fluid retention
  - Increased venous pressure moves fluid interstitial
  - Afferent/Efferent mechanism at the kidney
- Stress
  - Transient

2025 Strongly Recommended Levels

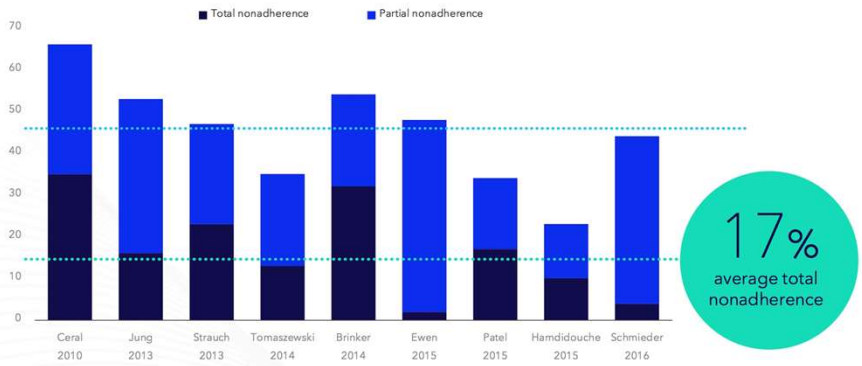
- Lifestyle changes
- Healthy weight – 5% of body weight reduction
- DASH diet
- Reduce Na intake – goal <1500mg/d
  - K substitutes are ok – 2a
  - Careful with CKD and/or meds
- Moderate physical activity program
- Managing stress
  - 2b – meditation, breathing techniques, yoga
- Reducing or eliminating ETOH
  - </= 1 per day women and </= 2 per day men

2025 – Monitoring

- Recommend frequent interactions with team
- Reliance on cuff less devices, including smart watches should be avoided for now

Adherence Issues

Studies show patients struggle to adhere to their treatment strategy[1]



17%
average total nonadherence

[1] Berra E, et al. *Hypertension*. 2015;68:297-306.

Improving Adherence

- Dose consolidation
- SPC – single pill combination
- Pharmacy/health professional coaching
- Electronic home BP monitoring and feedback
- Reminder aids
- Self management interventions

Diabetes

- ACC/AHA Class 1
  - Target <130 and encourage <120 for m/m
  - Target <80 for m/m
  - Appropriate – all first-line classes
  - ACE/ARB if eGFR <60mL/min/1.73m2
  - ACE/ARB if albuminuria >/= 30mg/g

Prevention of Heart Failure

- ACC/AHA Class 1
  - Treating SBP <130 and DBP <80
  - Lowers risk of developing HF

HTN and Chronic Kidney Disease

- ACC/AHA Class 1
  - eGFR <60 or albuminuria >/=30
  - Target BP <130 to reduce mortality
  - ACE/ARB to reduce CVD/renal progression

Obstructive Sleep Apnea

- ACC/AHA Class 2a indication
  - Weight loss intervention combined with CPAP can be affective in reducing SBP
  - With moderate-severe OSA, CPAP can be useful in reducing BP

Obesity and Metabolic Syndrome

- ACC/AHA Class 2b
  - HTN and BMI >27 – GLP-1 may help lower BP
  - HTN and BMI >35 bariatric sx may lower BP

Resistant HTN

- ACC/AHA Class 1 – first line and then add MRA if eGFR >45
- ACC/AHA Class 2a – can't add MRA
  - Amiloride
  - Beta blocker
  - Alpha blocker
  - Central sympatholytic
  - Vasodilators

Secondary HTN Causes Prevalence

- OSA 25-50%
- CKD 14%
- Primary Aldosteronism 5-25%
- Drug or ETOH induces 2-20%
- Renovascular HTN 0.1-5%
- Hypo and Hyperthyroidism <1%
- Pheochromocytoma <0.6%
- Aortic coarctation 0.1%
- Cushing syndrome <0.1%
- Primary hyperparathyroidism - rare
- Congenital adrenal hyperplasia - rare

Primary Aldosteronism

- ACC/AHA Class 1:
  - Screen if
    - Resistant HTN even w/o elevated K
    - Hyperkalemia
    - OSA
    - Adrenal mass
    - Family hx of early onset
    - Stroke <40 yo

Primary Aldosteronism

- Plasma aldosterone
- Renin activity
- Plasma aldosterone:renin ratio
- Continue meds except for MRA
- Refer to HTN specialist or Endocrinologist

Renal Artery Stenosis

- ACC/AHA Class I – medical therapy
- ACC/AHA Class 2a
  - Medical therapy has failed
  - Worsening kidney function and/or CHF
  - Reasonable for revascularization/stent

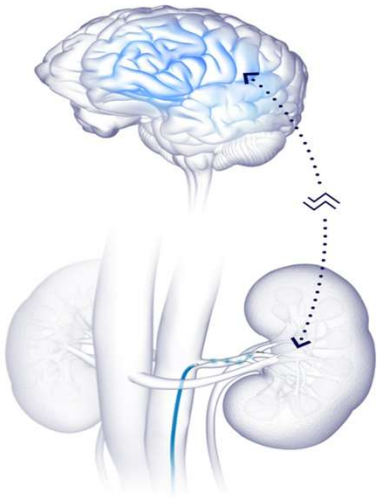
Renal Denervation

- Sympathetic Physiology
- Treatment Intention
  - Interruption of renal sympathetic nerves
  - Progressive stimulation leads to:
    - Increased renin release
    - Reduction in Na excretion
    - Increase in renal vascular resistance
- FDA approved

Resistant HTN and Renal Denervation

- ACC/AHA Class 2b
  - 140-180/90 and eGFR >/= 40ml/min/1.73
  - Despite optimal treatment or
  - Intolerable side effects
  - Renal denervation may be reasonable

Renal Denervation



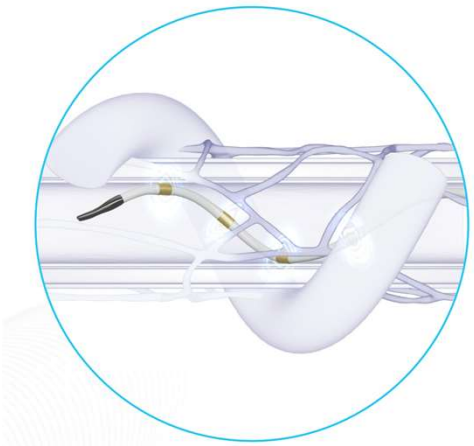
The kidneys modulate the sympathetic tone via the renal nerves to control blood pressure.

Renal denervation disrupts the overactive sympathetic signaling between kidneys and brain to reduce blood pressure.[1]

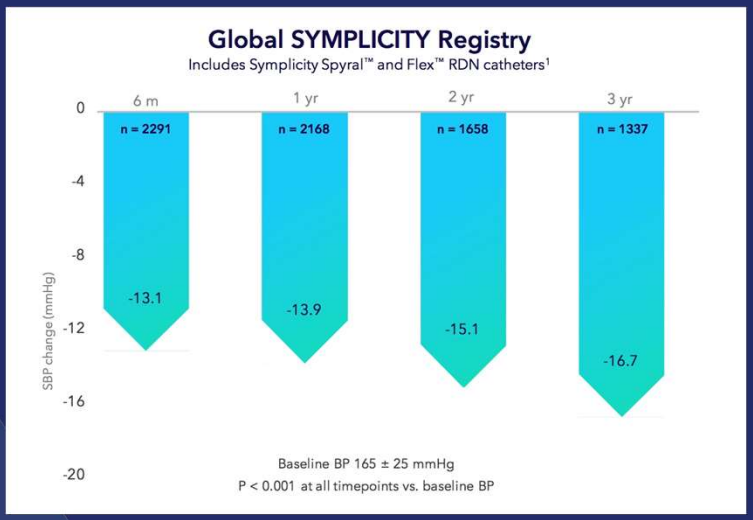
[1] Coates P, et al. *Cardiovasc Revasc Med.* 2022;42:171–177.

Renal Denervation

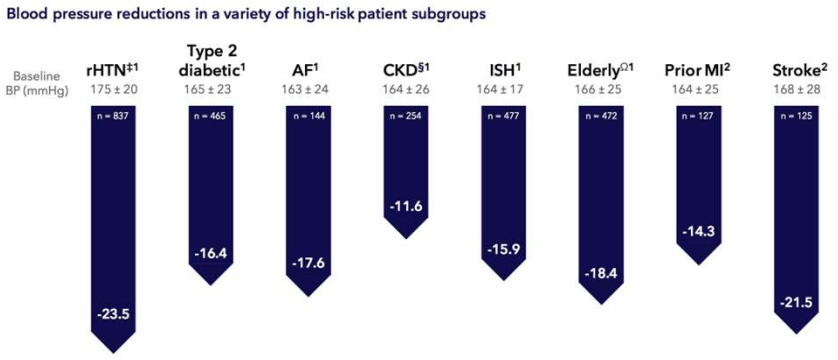
Symplicity Catheter



Symplicity Registry



Subgroup Analysis



2017 versus 2025 Guidelines

- Initiation of therapy
  - 2017 – stage I/<10% risk – repeat 3-6 mo
    - Initiate modifications
  - 2026 - <7.5% risk (PREVENT) – initiate 3-6 mo to prevent target organ damage
    - Initiate modifications

2017 versus 2025 Guidelines

- 2017
  - Initiate BP meds if >/= 140 SBP or >/= 90dbp
  - <10% risk and no hx of CVD
- 2025
  - All adults
  - Initiate BP meds if >/= 140 SBP or >/= 90dbp
  - To reduce CV events and mortality

2017 versus 2025 Guidelines

- 2017
  - Secondary prevention: avg >/= 130/80
  - Primary prevention w 10-y ASCVD risk >10%
- 2025
  - >/= 130/80 secondary prevention to lower CV events and mortality
  - >/= 130/80 w DM or CKD or 10-y CVD risk >/= 7.5% per PREVENT to reduce CVD events and mortality

2017 versus 2025 Guidelines

- Weight loss
  - 2017 recommended
  - 2025 at least 5% of body weight reduction
- Diet
  - 2017 – DASH or similar recommended for HTN
  - 2025 - DASH or similar for prevent or treat HTN
- Na reduction
  - 2017 – reduction rec with HTN
  - 2025 – Na <2300mg/d or ideal <1500mg/d w or w/o HTN
- K supplementation
  - 2017 – supplement with HTN unless contraindicated
  - 2025 – w or w/o HTN – K salt substitutes can be useful to prevent or treat HTN supplement with HTN unless contraindicated

2017 versus 2025 Guidelines

- ETOH
  - 2017 – w HTN No more than 2/day men and 1/day women
  - 2025 – w or w/o HTN – goal abstinence or 2/day men and 1/day women to prevent or treat HTN
- Physical activity
  - 2017 – structured exercise program for HTN
  - 2026 – w or w/o HTN – structured program recommended to prevent or treat HTN
- Meditation
  - 2026 – w or w/o HTN – meditation may be reasonable
- Stress Management
  - 2026 – w or w/o HTN – breathing techniques/yoga may be reasonable

Citations

Jones DW, Ferdinand KC, Taler SJ, et al. 2025 AHA/ ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/ NMA/PCNA/SGIM guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: a report of the American College of Cardiology/American Heart Association Joint Committee on Clinical Practice Guidelines. J Am Coll-*Cardiol. Published online August 14, 2025.* https://doi. org/10.1016/j.jacc.2025.05.007.

Gulati, M, Moore, M, Cibotti-Sun, M. 2025 High Blood Pressure Guideline-at-a-Glance. JACC. *Published online August 15, 2025.* https://doi.org/10.1016/j.jacc.2025.07.010.

Thank You

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