

Hypertension

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**2017 ACC/AHA/AAPA/ABC/ACPM/AGS/
APhA/ASH/ASPC/NMA/PCNA
Guideline for the Prevention, Detection,
Evaluation, and Management of High Blood
Pressure in Adults**

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BP Measurement Definitions

BP Measurement	Definition
SBP	First Korotkoff sound*
DBP	Fifth Korotkoff sound*
Pulse pressure	SBP minus DBP
Mean arterial pressure	DBP plus one third pulse pressure†
Mid-BP	Sum of SBP and DBP, divided by 2

*See Section 4 for a description of Korotkoff sounds.

†Calculation assumes normal heart rate .

BP indicates blood pressure; DBP, diastolic blood pressure; and SBP, systolic blood pressure.

CVD Risk Factors Common in Patients With Hypertension

Modifiable Risk Factors*	Relatively Fixed Risk Factors†
<ul style="list-style-type: none"> • Current cigarette smoking, secondhand smoking • Diabetes mellitus • Dyslipidemia/hypercholesterolemia • Overweight/obesity • Physical inactivity/low fitness • Unhealthy diet 	<ul style="list-style-type: none"> • CKD • Family history • Increased age • Low socioeconomic/educational status • Male sex • Obstructive sleep apnea • Psychosocial stress

*Factors that can be changed and, if changed, may reduce CVD risk.

†Factors that are difficult to change (CKD, low socioeconomic/educational status, obstructive sleep apnea, cannot be changed (family history, increased age, male sex), or, if changed through the use of current intervention techniques, may not reduce CVD risk (psychosocial stress).

CKD indicates chronic kidney disease; and CVD, cardiovascular disease.

Definition of High BP

COR	LOE	Recommendation for Definition of High BP
I	B-NR	BP should be categorized as normal, elevated, or stage 1 or 2 hypertension to prevent and treat high BP.

Categories of BP in Adults*

BP Category	SBP		DBP
Normal	<120 mm Hg	and	<80 mm Hg
Elevated	120–129 mm Hg	and	<80 mm Hg
Hypertension			
Stage 1	130–139 mm Hg	or	80–89 mm Hg
Stage 2	≥140 mm Hg	or	≥90 mm Hg

*Individuals with SBP and DBP in 2 categories should be designated to the higher BP category.

BP indicates blood pressure (based on an average of ≥2 careful readings obtained on ≥2 occasions, as detailed in DBP, diastolic blood pressure; and SBP systolic blood pressure.

Prevalence of Hypertension Based on 2 SBP/DBP Thresholds*†

	SBP/DBP \geq 130/80 mm Hg or Self-Reported Antihypertensive Medication†		SBP/DBP \geq 140/90 mm Hg or Self-Reported Antihypertensive Medication‡	
Overall, crude	46%		32%	
	Men (n=4717)	Women (n=4906)	Men (n=4717)	Women (n=4906)
Overall, age-sex adjusted	48%	43%	31%	32%
Age group, y				
20–44	30%	19%	11%	10%
45–54	50%	44%	33%	27%
55–64	70%	63%	53%	52%
65–74	77%	75%	64%	63%
75+	79%	85%	71%	78%
Race-ethnicity §				
Non-Hispanic White	47%	41%	31%	30%
Non-Hispanic Black	59%	56%	42%	46%
Non-Hispanic Asian	45%	36%	29%	27%
Hispanic	44%	42%	27%	32%

The prevalence estimates have been rounded to the nearest full percentage.

*130/80 and 140/90 mm Hg in 9623 participants (\geq 20 years of age) in NHANES 2011–2014.

†BP cutpoints for definition of hypertension in the present guideline.

‡BP cutpoints for definition of hypertension in JNC 7.

§ Adjusted to the 2010 age-sex distribution of the U.S. adult population.

BP indicates blood pressure; DBP, diastolic blood pressure; NHANES, National Health and Nutrition Examination Survey; and SBP, systolic blood pressure.

Accurate Measurement of BP in the Office

COR	LOE	Recommendation for Accurate Measurement of BP in the Office
I	C-EO	For diagnosis and management of high BP, proper methods are recommended for accurate measurement and documentation of BP.

Checklist for Accurate Measurement of BP

Key Steps for Proper BP Measurements

Step 1: Properly prepare the patient.

Step 2: Use proper technique for BP measurements.

Step 3: Take the proper measurements needed for diagnosis and treatment of elevated BP/hypertension.

Step 4: Properly document accurate BP readings.

Step 5: Average the readings.

Step 6: Provide BP readings to patient.

Selection Criteria for BP Cuff Size for Measurement of BP in Adults

Arm Circumference	Usual Cuff Size
22–26 cm	Small adult
27–34 cm	Adult
35–44 cm	Large adult
45–52 cm	Adult thigh

Out-of-Office and Self-Monitoring of BP

COR	LOE	Recommendation for Out-of-Office and Self-Monitoring of BP
I	A ^{SR}	Out-of-office BP measurements are recommended to confirm the diagnosis of hypertension and for titration of BP-lowering medication, in conjunction with telehealth counseling or clinical interventions.

SR indicates systematic review.

Corresponding Values of SBP/DBP for Clinic, HBPM, Daytime, Nighttime, and 24-Hour ABPM Measurements

Clinic	HBPM	Daytime ABPM	Nighttime ABPM	24-Hour ABPM
120/80	120/80	120/80	100/65	115/75
130/80	130/80	130/80	110/65	125/75
140/90	135/85	135/85	120/70	130/80
160/100	145/90	145/90	140/85	145/90

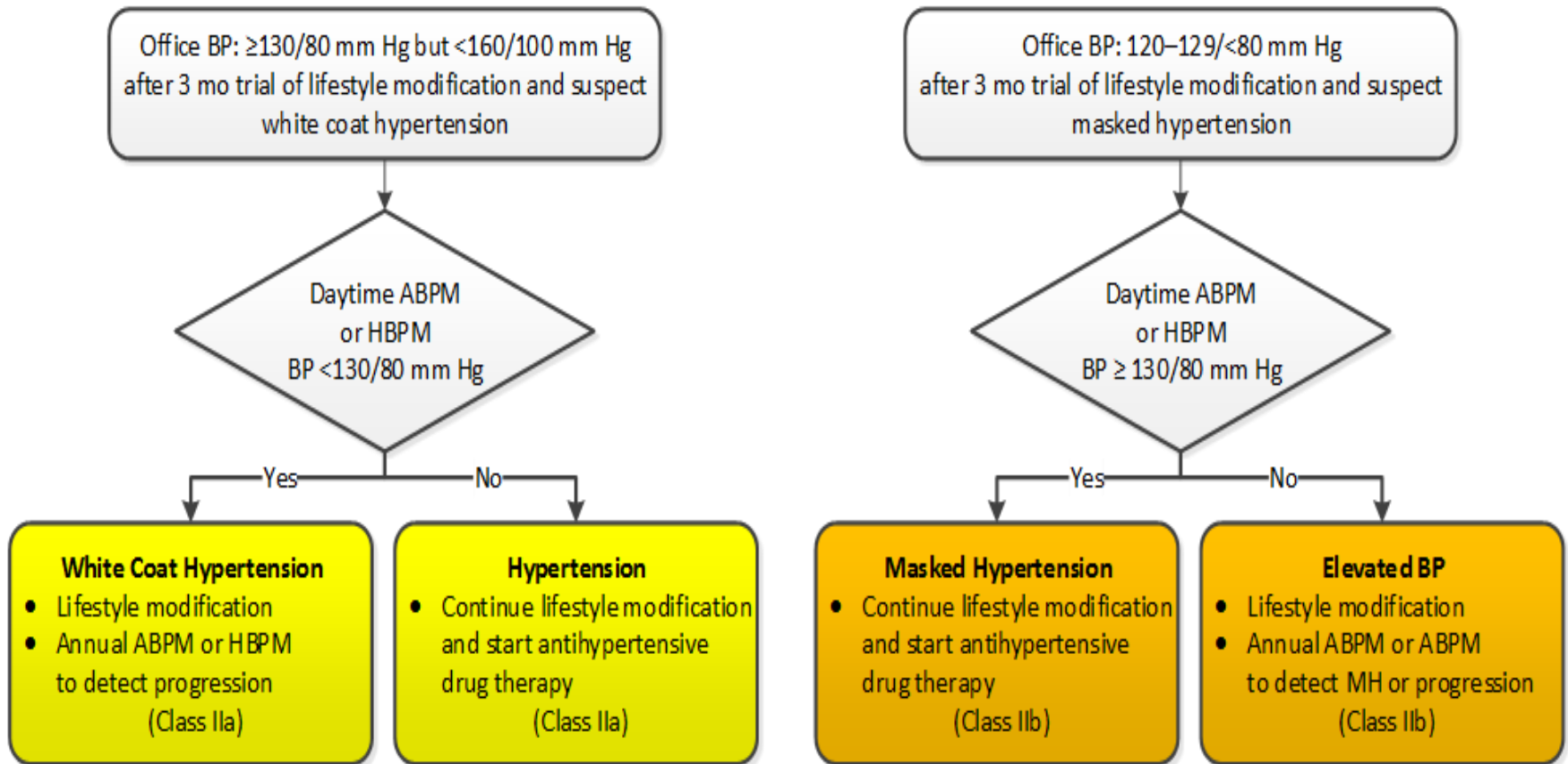
ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; DBP diastolic blood pressure; HBPM, home blood pressure monitoring; and SBP, systolic blood pressure.

BP Patterns Based on Office and Out-of-Office Measurements

	Office/Clinic/Healthcare Setting	Home/Nonhealthcare/ABPM Setting
Normotensive	No hypertension	No hypertension
Sustained hypertension	Hypertension	Hypertension
Masked hypertension	No hypertension	Hypertension
White coat hypertension	Hypertension	No hypertension

ABPM indicates ambulatory blood pressure monitoring; and BP, blood pressure.

Detection of White Coat Hypertension or Masked Hypertension in Patients Not on Drug Therapy



Colors correspond to Class of Recommendation in Table 1.

ABPM indicates ambulatory blood pressure monitoring; BP, blood pressure; and HBPM, home blood pressure monitoring.

Secondary Forms of Hypertension

COR	LOE	Recommendations for Secondary Forms of Hypertension
I	C-EO	Screening for specific form(s) of secondary hypertension is recommended when the clinical indications and physical examination findings are present or in adults with resistant hypertension.
IIb	C-EO	If an adult with sustained hypertension screens positive for a form of secondary hypertension, referral to a physician with expertise in that form of hypertension may be reasonable for diagnostic confirmation and treatment.

Screening for Secondary Hypertension

New-onset or uncontrolled hypertension in adults

Conditions

- Drug-resistant/induced hypertension
- Abrupt onset of hypertension
- Onset of hypertension at <30 y
- Exacerbation of previously controlled hypertension
- Disproportionate TOD for degree of hypertension
- Accelerated/malignant hypertension
- Onset of diastolic hypertension in older adults (age ≥ 65 y)
- Unprovoked or excessive hypokalemia

Yes

No

Screen for secondary hypertension (Class I) (see Table 13)

Screening not indicated (No Benefit)

Positive screening test

Yes

No

Refer to clinician with specific expertise (Class IIb)

Referral not necessary (No Benefit)

Causes of Secondary Hypertension With Clinical Indications

Common causes
Renal parenchymal disease
Renovascular disease
Primary aldosteronism
Obstructive sleep apnea
Drug or alcohol induced
Uncommon causes
Pheochromocytoma/paraganglioma
Cushing's syndrome
Hypothyroidism
Hyperthyroidism
Aortic coarctation (undiagnosed or repaired)
Primary hyperparathyroidism
Congenital adrenal hyperplasia
Mineralocorticoid excess syndromes other than primary aldosteronism
Acromegaly

Primary Aldosteronism

COR	LOE	Recommendations for Primary Aldosteronism
I	C-EO	In adults with hypertension, screening for primary aldosteronism is recommended in the presence of any of the following concurrent conditions: resistant hypertension, hypokalemia (spontaneous or substantial, if diuretic induced), incidentally discovered adrenal mass, family history of early-onset hypertension, or stroke at a young age (<40 years).
I	C-LD	Use of the plasma aldosterone: renin activity ratio is recommended when adults are screened for primary aldosteronism.
I	C-EO	In adults with hypertension and a positive screening test for primary aldosteronism, referral to a hypertension specialist or endocrinologist is recommended for further evaluation and treatment.

Renal Artery Stenosis

COR	LOE	Recommendations for Renal Artery Stenosis
I	A	Medical therapy is recommended for adults with atherosclerotic renal artery stenosis.
IIb	C-EO	In adults with renal artery stenosis for whom medical management has failed (refractory hypertension, worsening renal function, and/or intractable HF) and those with nonatherosclerotic disease, including fibromuscular dysplasia, it may be reasonable to refer the patient for consideration of revascularization (percutaneous renal artery angioplasty and/or stent placement).

Obstructive Sleep Apnea

COR	LOE	Recommendation for Obstructive Sleep Apnea
IIb	B-R	In adults with hypertension and obstructive sleep apnea, the effectiveness of continuous positive airway pressure (CPAP) to reduce BP is not well established.

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Nonpharmacological Interventions

Nonpharmacological Interventions

COR	LOE	Recommendations for Nonpharmacological Interventions
I	A	Weight loss is recommended to reduce BP in adults with elevated BP or hypertension who are overweight or obese.
I	A	A heart-healthy diet, such as the DASH (Dietary Approaches to Stop Hypertension) diet, that facilitates achieving a desirable weight is recommended for adults with elevated BP or hypertension.
I	A	Sodium reduction is recommended for adults with elevated BP or hypertension.
I	A	Potassium supplementation, preferably in dietary modification, is recommended for adults with elevated BP or hypertension, unless contraindicated by the presence of CKD or use of drugs that reduce potassium excretion.

Nonpharmacological Interventions (cont.)

COR	LOE	Recommendations for Nonpharmacological Interventions
I	A	Increased physical activity with a structured exercise program is recommended for adults with elevated BP or hypertension.
I	A	Adult men and women with elevated BP or hypertension who currently consume alcohol should be advised to drink no more than 2 and 1 standard drinks* per day, respectively.

*In the United States, 1 “standard” drink contains roughly 14 g of pure alcohol, which is typically found in 12 oz of regular beer (usually about 5% alcohol), 5 oz of wine (usually about 12% alcohol), and 1.5 oz of distilled spirits (usually about 40% alcohol).

Best Proven Nonpharmacological Interventions for Prevention and Treatment of Hypertension*

	Nonpharmacological Intervention	Dose	Approximate Impact on SBP	
			Hypertension	Normotension
Weight loss	Weight/body fat	Best goal is ideal body weight, but aim for at least a 1-kg reduction in body weight for most adults who are overweight. Expect about 1 mm Hg for every 1-kg reduction in body weight.	-5 mm Hg	-2/3 mm Hg
Healthy diet	DASH dietary pattern	Consume a diet rich in fruits, vegetables, whole grains, and low-fat dairy products, with reduced content of saturated and total fat.	-11 mm Hg	-3 mm Hg
Reduced intake of dietary sodium	Dietary sodium	Optimal goal is <1500 mg/d, but aim for at least a 1000-mg/d reduction in most adults.	-5/6 mm Hg	-2/3 mm Hg
Enhanced intake of dietary potassium	Dietary potassium	Aim for 3500–5000 mg/d, preferably by consumption of a diet rich in potassium.	-4/5 mm Hg	-2 mm Hg

*Type, dose, and expected impact on BP in adults with a normal BP and with hypertension.

DASH indicates Dietary Approaches to Stop Hypertension; and SBP, systolic blood pressure.

Resources: Your Guide to Lowering Your Blood Pressure With DASH—How Do I Make the DASH?

Available at: <https://www.nhlbi.nih.gov/health/resources/heart/hbp-dash-how-to>.

Top 10 Dash Diet Tips. Available at: http://dashdiet.org/dash_diet_tips.asp



Best Proven Nonpharmacological Interventions for Prevention and Treatment of Hypertension* (cont.)

	Nonpharmacological Intervention	Dose	Approximate Impact on SBP	
			Hypertension	Normotension
Physical activity	Aerobic	<ul style="list-style-type: none"> ● 90–150 min/wk ● 65%–75% heart rate reserve 	-5/8 mm Hg	-2/4 mm Hg
	Dynamic resistance	<ul style="list-style-type: none"> ● 90–150 min/wk ● 50%–80% 1 rep maximum ● 6 exercises, 3 sets/exercise, 10 repetitions/set 	-4 mm Hg	-2 mm Hg
	Isometric resistance	<ul style="list-style-type: none"> ● 4 × 2 min (hand grip), 1 min rest between exercises, 30%–40% maximum voluntary contraction, 3 sessions/wk ● 8–10 wk 	-5 mm Hg	-4 mm Hg
Moderation in alcohol intake	Alcohol consumption	<p>In individuals who drink alcohol, reduce alcohol[†] to:</p> <ul style="list-style-type: none"> ● Men: ≤2 drinks daily ● Women: ≤1 drink daily 	-4 mm Hg	-3 mm

*Type, dose, and expected impact on BP in adults with a normal BP and with hypertension.

†In the United States, one “standard” drink contains roughly 14 g of pure alcohol, which is typically found in 12 oz of regular beer (usually about 5% alcohol), 5 oz of wine (usually about 12% alcohol), and 1.5 oz of distilled spirits (usually about 40% alcohol).

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Patient Evaluation

Basic and Optional Laboratory Tests for Primary Hypertension

Basic testing	Fasting blood glucose*
	Complete blood count
	Lipid profile
	Serum creatinine with eGFR*
	Serum sodium, potassium, calcium*
	Thyroid-stimulating hormone
	Urinalysis
	Electrocardiogram
Optional testing	Echocardiogram
	Uric acid
	Urinary albumin to creatinine ratio

*May be included in a comprehensive metabolic panel.
eGFR indicates estimated glomerular filtration rate.

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Treatment of High BP

Follow-Up After Initial BP Evaluation

COR	LOE	Recommendations for Follow-Up After Initial BP Elevation
I	B-R	Adults with an elevated BP or stage 1 hypertension who have an estimated 10-year ASCVD risk less than 10% should be managed with nonpharmacological therapy and have a repeat BP evaluation within 3 to 6 months.
I	B-R	Adults with stage 1 hypertension who have an estimated 10-year ASCVD risk of 10% or higher should be managed initially with a combination of nonpharmacological and antihypertensive drug therapy and have a repeat BP evaluation in 1 month.
I	B-R	Adults with stage 2 hypertension should be evaluated by or referred to a primary care provider within 1 month of the initial diagnosis, have a combination of nonpharmacological and antihypertensive drug therapy (with 2 agents of different classes) initiated, and have a repeat BP evaluation in 1 month.

Follow-Up After Initial BP Evaluation (cont.)

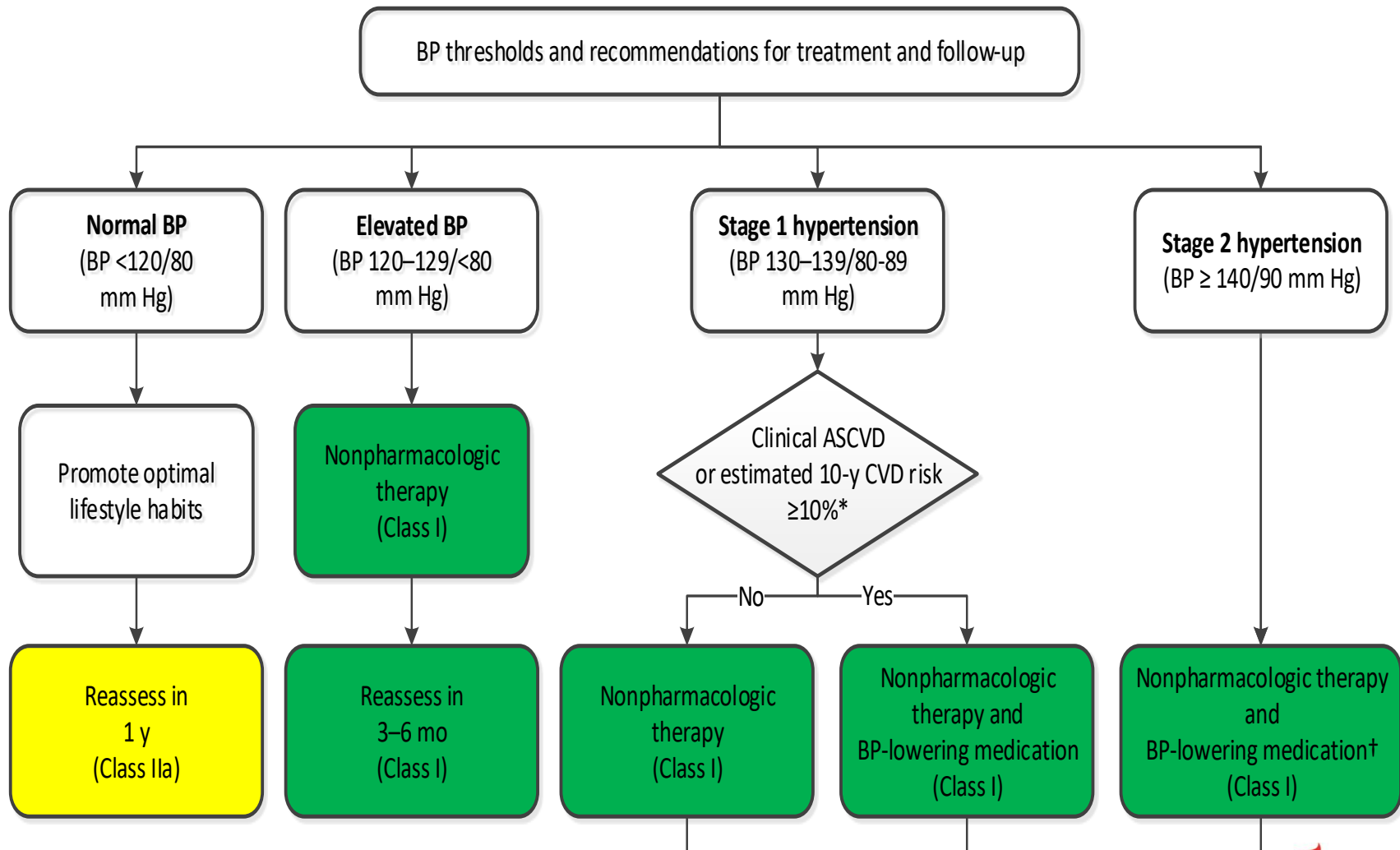
COR	LOE	Recommendations for Follow-Up After Initial BP Elevation
I	B-R	For adults with a very high average BP (e.g., SBP \geq 180 mm Hg or DBP \geq 110 mm Hg), evaluation followed by prompt antihypertensive drug treatment is recommended.
IIa	C-EO	For adults with a normal BP, repeat evaluation every year is reasonable.

BP Goal for Patients With Hypertension

COR	LOE	Recommendations for BP Goal for Patients With Hypertension
I	SBP: B-R ^{SR}	For adults with confirmed hypertension and known CVD or 10-year ASCVD event risk of 10% or higher a BP target of less than 130/80 mm Hg is recommended.
	DBP: C-EO	
IIb	SBP: B-NR	For adults with confirmed hypertension, without additional markers of increased CVD risk, a BP target of less than 130/80 mm Hg may be reasonable.
	DBP: C-EO	

SR indicates systematic review.

Blood Pressure (BP) Thresholds and Recommendations for Treatment and Follow-Up



General Principles of Drug Therapy

COR	LOE	Recommendation for General Principle of Drug Therapy
III: Harm	A	Simultaneous use of an ACE inhibitor, ARB, and/or renin inhibitor is potentially harmful and is not recommended to treat adults with hypertension.

Choice of Initial Medication

COR	LOE	Recommendation for Choice of Initial Medication
I	A ^{SR}	For initiation of antihypertensive drug therapy, first-line agents include thiazide diuretics, CCBs, and ACE inhibitors or ARBs.

SR indicates systematic review.

Choice of Initial Monotherapy Versus Initial Combination Drug Therapy

COR	LOE	Recommendations for Choice of Initial Monotherapy Versus Initial Combination Drug Therapy*
I	C-EO	Initiation of antihypertensive drug therapy with 2 first-line agents of different classes, either as separate agents or in a fixed-dose combination, is recommended in adults with stage 2 hypertension and an average BP more than 20/10 mm Hg above their BP target.
IIa	C-EO	Initiation of antihypertensive drug therapy with a single antihypertensive drug is reasonable in adults with stage 1 hypertension and BP goal <130/80 mm Hg with dosage titration and sequential addition of other agents to achieve the BP target.

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Hypertension in Patients With Comorbidities

Stable Ischemic Heart Disease

COR	LOE	Recommendations for Treatment of Hypertension in Patients With Stable Ischemic Heart Disease (SIHD)
I	SBP: B-R	In adults with SIHD and hypertension, a BP target of less than 130/80 mm Hg is recommended.
	DBP: C-EO	
I	SBP: B-R	Adults with SIHD and hypertension (BP \geq 130/80 mm Hg) should be treated with medications (e.g., GDMT beta blockers, ACE inhibitors, or ARBs) for compelling indications (e.g., previous MI, stable angina) as first-line therapy, with the addition of other drugs (e.g., dihydropyridine CCBs, thiazide diuretics, and/or mineralocorticoid receptor antagonists) as needed to further control hypertension.
	DBP: C-EO	

Heart Failure

COR	LOE	Recommendation for Prevention of HF in Adults With Hypertension
I	SBP: B-R	In adults at increased risk of HF, the optimal BP in those with hypertension should be less than 130/80 mm Hg.
	DBP: C-EO	

Heart Failure With Reduced Ejection Fraction

COR	LOE	Recommendations for Treatment of Hypertension in Patients With HFrEF
I	C-EO	Adults with HFrEF and hypertension should be prescribed GDMT titrated to attain a BP of less than 130/80 mm Hg.
III: No Benefit	B-R	Nondihydropyridine CCBs are not recommended in the treatment of hypertension in adults with HFrEF.

Heart Failure With Preserved Ejection Fraction

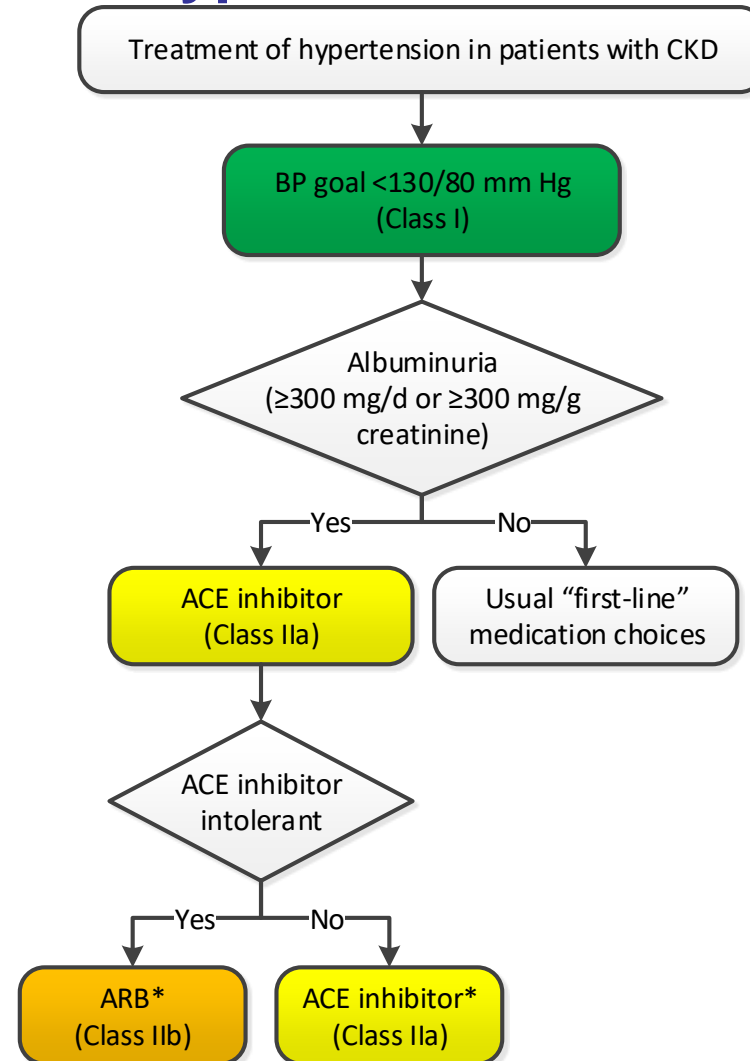
COR	LOE	Recommendations for Treatment of Hypertension in Patients With HF_pEF
I	C-EO	In adults with HF _p EF who present with symptoms of volume overload, diuretics should be prescribed to control hypertension.
I	C-LD	Adults with HF _p EF and persistent hypertension after management of volume overload should be prescribed ACE inhibitors or ARBs and beta blockers titrated to attain SBP of less than 130 mm Hg.

Chronic Kidney Disease

COR	LOE	Recommendations for Treatment of Hypertension in Patients With CKD
I	SBP: B-R ^{SR}	Adults with hypertension and CKD should be treated to a BP goal of less than 130/80 mm Hg.
	DBP: C-EO	
IIa	B-R	In adults with hypertension and CKD (stage 3 or higher or stage 1 or 2 with albuminuria [≥ 300 mg/d, or ≥ 300 mg/g albumin-to-creatinine ratio or the equivalent in the first morning void]), treatment with an ACE inhibitor is reasonable to slow kidney disease progression.
IIb	C-EO	In adults with hypertension and CKD (stage 3 or higher or stage 1 or 2 with albuminuria [≥ 300 mg/d, or ≥ 300 mg/g albumin-to-creatinine ratio in the first morning void]), treatment with an ARB may be reasonable if an ACE inhibitor is not tolerated.

SR indicates systematic review.

Management of Hypertension in Patients With CKD



•Colors correspond to Class of Recommendation in Table 1.

•*CKD stage 3 or higher or stage 1 or 2 with albuminuria ≥ 300 mg/d or ≥ 300 mg/g creatinine.

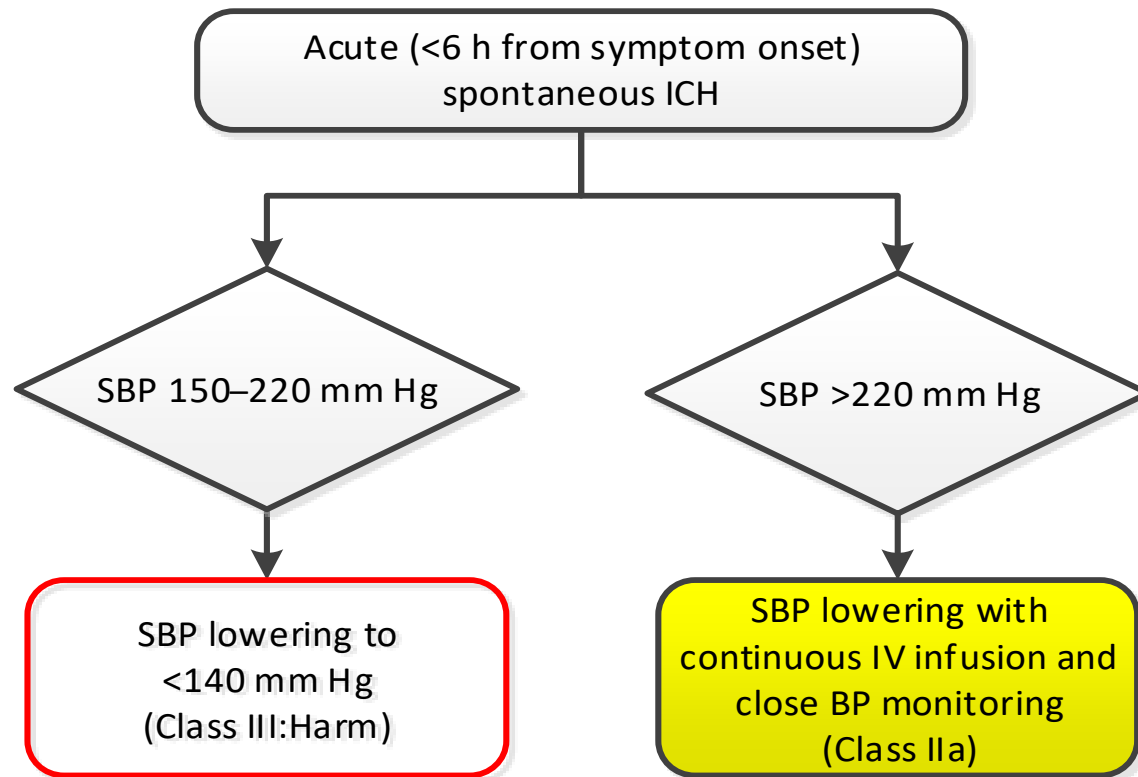
Hypertension After Renal Transplantation

COR	LOE	Recommendations for Treatment of Hypertension After Renal Transplantation
IIa	SBP: B-NR	After kidney transplantation, it is reasonable to treat patients with hypertension to a BP goal of less than 130/80 mm Hg.
	DBP: C-EO	
IIa	B-R	After kidney transplantation, it is reasonable to treat patients with hypertension with a calcium antagonist on the basis of improved GFR and kidney survival.

Emergency Hypertension

- Hypertension with end organ damage

Management of Hypertension in Patients With Acute ICH



Colors correspond to Class of Recommendation in Table 1. BP indicates blood pressure; ICH, intracerebral hemorrhage; IV, intravenous; and SBP, systolic blood pressure.

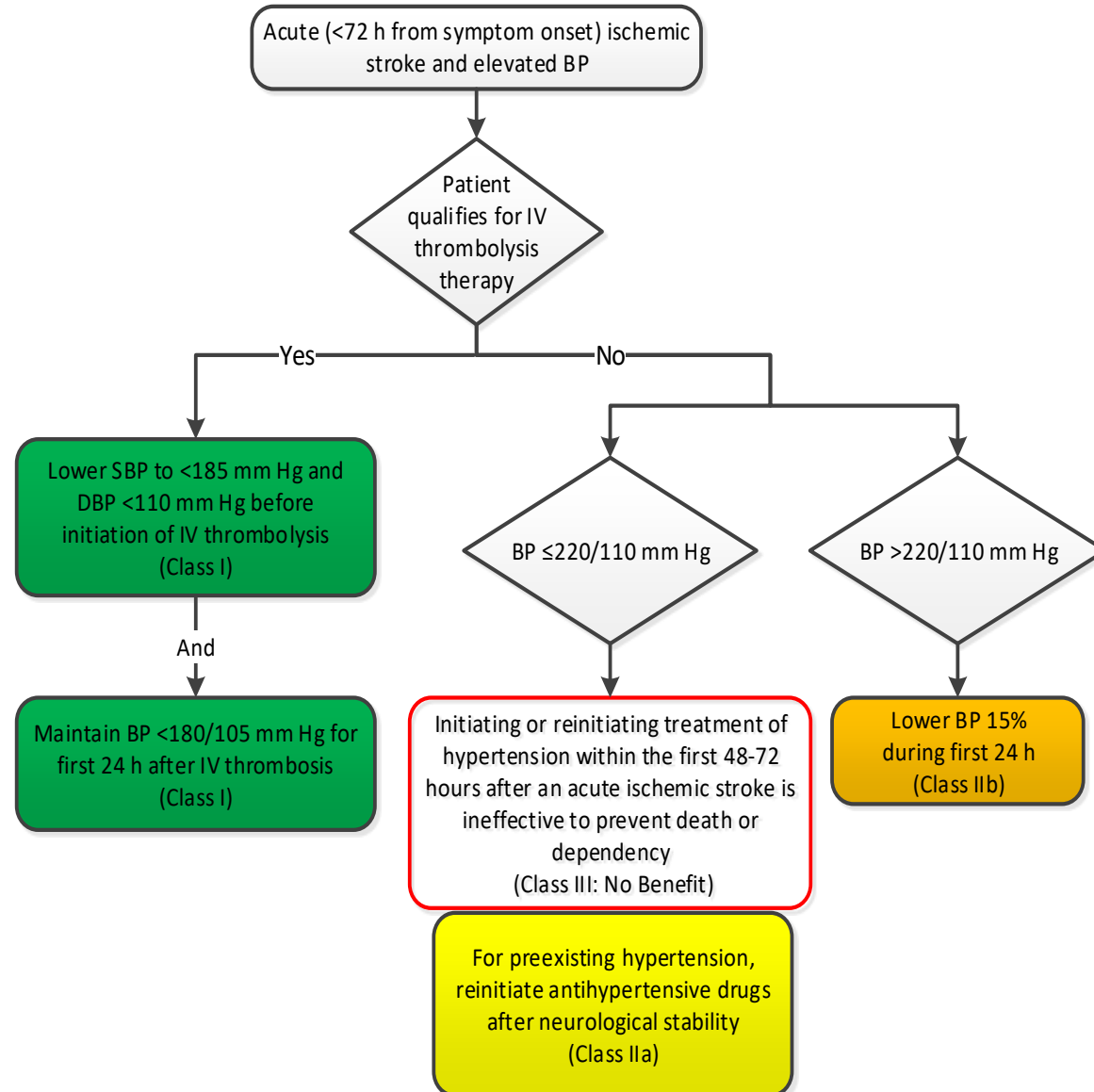
Acute Ischemic Stroke

COR	LOE	Recommendations for Management of Hypertension in Patients With Acute Ischemic Stroke
I	B-NR	Adults with acute ischemic stroke and elevated BP who are eligible for treatment with intravenous tissue plasminogen activator should have their BP slowly lowered to less than 185/110 mm Hg before thrombolytic therapy is initiated.
I	B-NR	In adults with an acute ischemic stroke, BP should be less than 185/110 mm Hg before administration of intravenous tissue plasminogen activator and should be maintained below 180/105 mm Hg for at least the first 24 hours after initiating drug therapy.
IIa	B-NR	Starting or restarting antihypertensive therapy during hospitalization in patients with BP greater than 140/90 mm Hg who are neurologically stable is safe and reasonable to improve long-term BP control, unless contraindicated.

Acute Ischemic Stroke (cont.)

COR	LOE	Recommendations for Management of Hypertension in Patients With Acute Ischemic Stroke
IIb	C-EO	In patients with BP of 220/120 mm Hg or higher who did not receive intravenous alteplase or endovascular treatment and have no comorbid conditions requiring acute antihypertensive treatment, the benefit of initiating or reinitiating treatment of hypertension within the first 48 to 72 hours is uncertain. It might be reasonable to lower BP by 15% during the first 24 hours after onset of stroke.
III: No Benefit	A	In patients with BP less than 220/120 mm Hg who did not receive intravenous thrombolysis or endovascular treatment and do not have a comorbid condition requiring acute antihypertensive treatment, initiating or reinitiating treatment of hypertension within the first 48 to 72 hours after an acute ischemic stroke is not effective to prevent death or dependency.

Management of Hypertension in Patients With Acute Ischemic Stroke



Colors correspond to Class of Recommendation in Table 1.

BP indicates blood pressure; DBP, diastolic blood pressure; IV, intravenous; and SBP, systolic blood pressure.

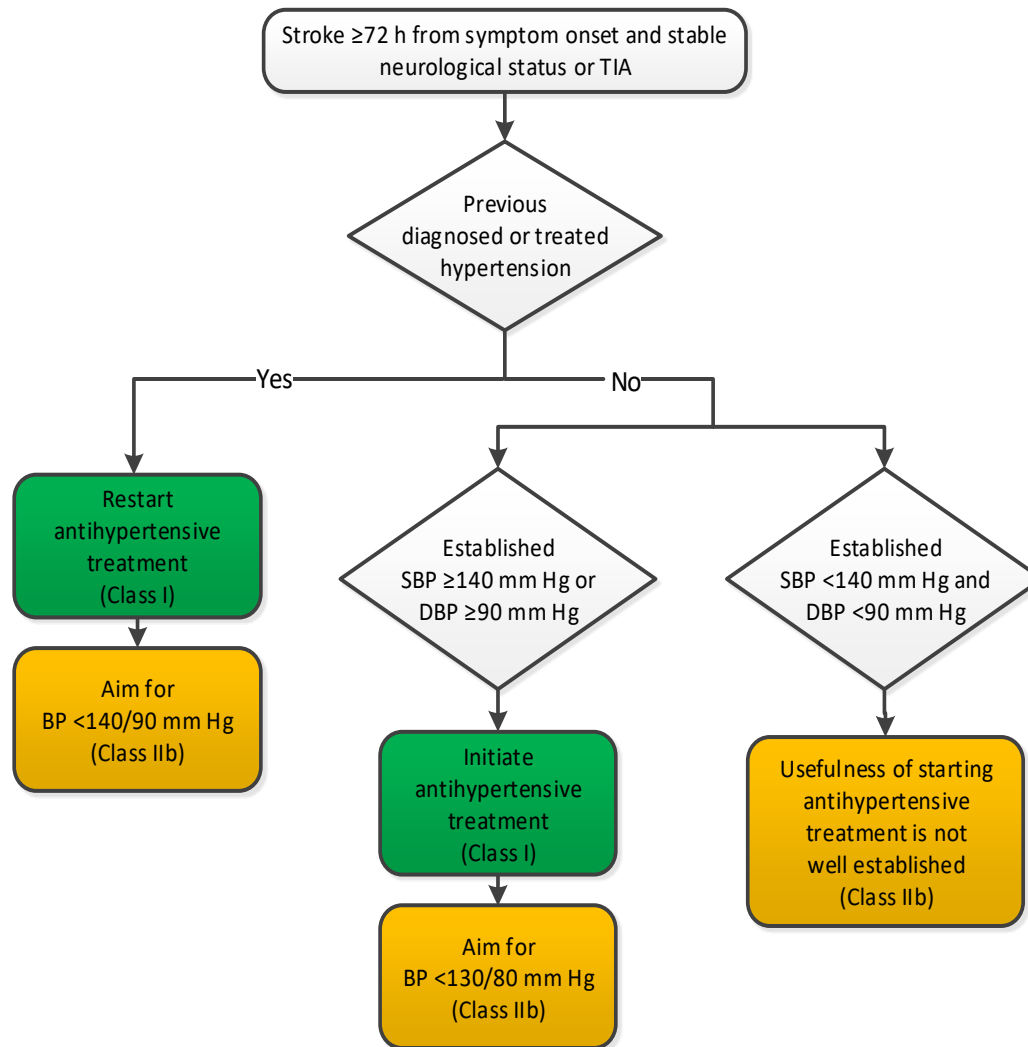
Secondary Stroke Prevention

COR	LOE	Recommendations for Treatment of Hypertension for Secondary Stroke Prevention
I	A	Adults with previously treated hypertension who experience a stroke or transient ischemic attack (TIA) should be restarted on antihypertensive treatment after the first few days of the index event to reduce the risk of recurrent stroke and other vascular events.
I	A	For adults who experience a stroke or TIA, treatment with a thiazide diuretic, ACE inhibitor, or ARB, or combination treatment consisting of a thiazide diuretic plus ACE inhibitor, is useful.
I	B-R	Adults not previously treated for hypertension who experience a stroke or TIA and have an established BP of 140/90 mm Hg or higher should be prescribed antihypertensive treatment a few days after the index event to reduce the risk of recurrent stroke and other vascular events.

Secondary Stroke Prevention (cont.)

COR	LOE	Recommendations for Treatment of Hypertension for Secondary Stroke Prevention
I	B-NR	For adults who experience a stroke or TIA, selection of specific drugs should be individualized on the basis of patient comorbidities and agent pharmacological class.
IIb	B-R	For adults who experience a stroke or TIA, a BP goal of less than 130/80 mm Hg may be reasonable.
IIb	B-R	For adults with a lacunar stroke, a target SBP goal of less than 130 mm Hg may be reasonable.
IIb	C-LD	In adults previously untreated for hypertension who experience an ischemic stroke or TIA and have a SBP less than 140 mm Hg and a DBP less than 90 mm Hg, the usefulness of initiating antihypertensive treatment is not well established.

Management of Hypertension in Patients With a Previous History of Stroke (Secondary Stroke Prevention)



Peripheral Arterial Disease

COR	LOE	Recommendation for Treatment of Hypertension in Patients With PAD
I	B-NR	Adults with hypertension and PAD should be treated similarly to patients with hypertension without PAD.

Diabetes Mellitus

COR	LOE	Recommendations for Treatment of Hypertension in Patients With DM
I	SBP: B-R ^{SR}	In adults with DM and hypertension, antihypertensive drug treatment should be initiated at a BP of 130/80 mm Hg or higher with a treatment goal of less than 130/80 mm Hg.
	DBP: C-EO	
I	A ^{SR}	In adults with DM and hypertension, all first-line classes of antihypertensive agents (i.e., diuretics, ACE inhibitors, ARBs, and CCBs) are useful and effective.
IIb	B-NR	In adults with DM and hypertension, ACE inhibitors or ARBs may be considered in the presence of albuminuria.

SR indicates systematic review.

Atrial Fibrillation

COR	LOE	Recommendation for Treatment of Hypertension in Patients With AF
Ia	B-R	Treatment of hypertension with an ARB can be useful for prevention of recurrence of AF.

Valvular Heart Disease

COR	LOE	Recommendations for Treatment of Hypertension in Patients With Valvular Heart Disease
I	B-NR	In adults with asymptomatic aortic stenosis, hypertension should be treated with pharmacotherapy, starting at a low dose and gradually titrating upward as needed.
Ila	C-LD	In patients with chronic aortic insufficiency, treatment of systolic hypertension with agents that do not slow the heart rate (i.e., avoid beta blockers) is reasonable.

Aortic Disease

COR	LOE	Recommendation for Management of Hypertension in Patients With Aortic Disease
I	C-EO	Beta blockers are recommended as the preferred antihypertensive agents in patients with hypertension and thoracic aortic disease.

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Special Patient Groups

Racial and Ethnic Differences in Treatment

COR	LOE	Recommendations for Race and Ethnicity
I	B-R	In black adults with hypertension but without HF or CKD, including those with DM, initial antihypertensive treatment should include a thiazide-type diuretic or CCB.
I	C-LD	Two or more antihypertensive medications are recommended to achieve a BP target of less than 130/80 mm Hg in most adults with hypertension, especially in black adults with hypertension.

Pregnancy

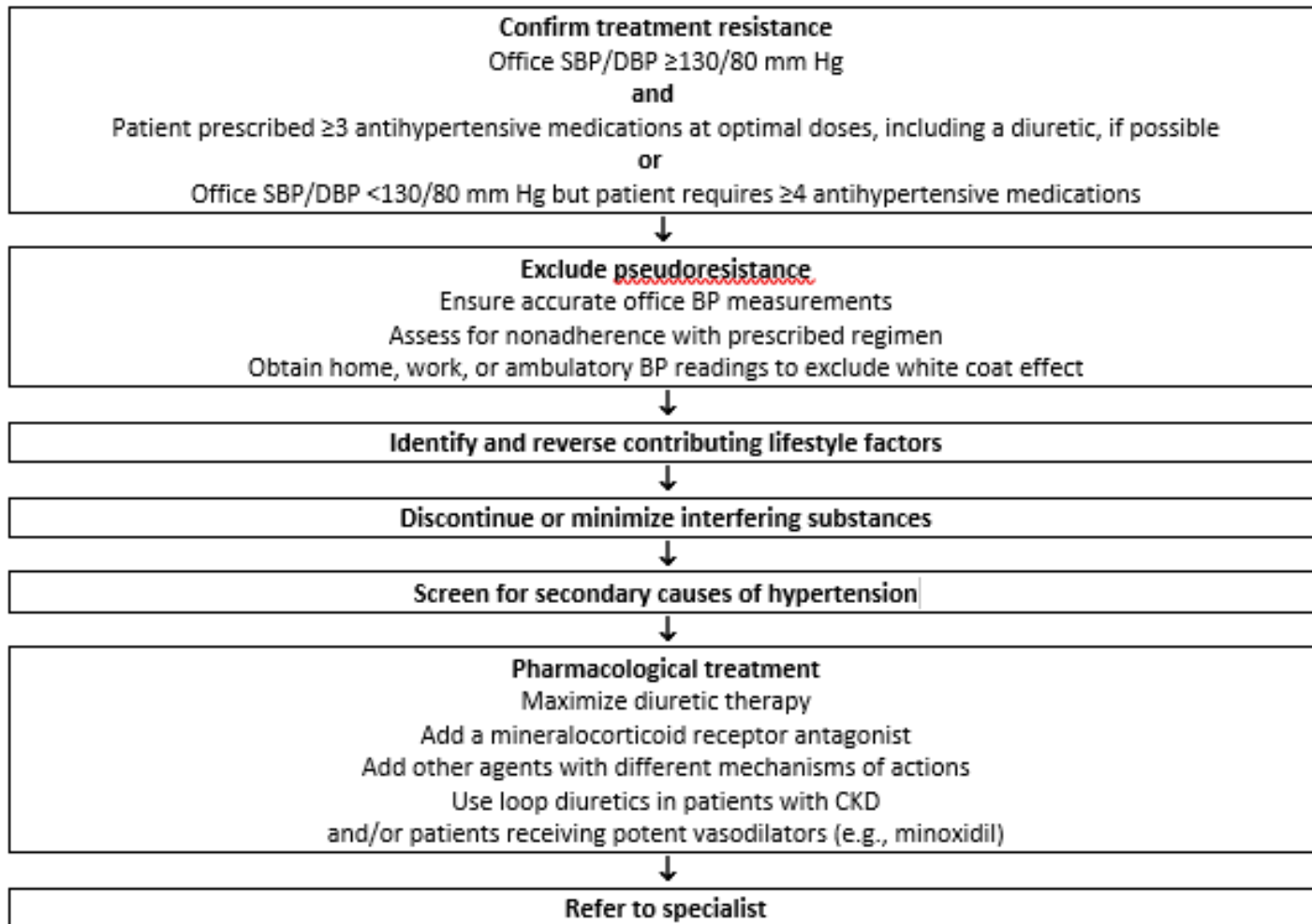
COR	LOE	Recommendations for Treatment of Hypertension in Pregnancy
I	C-LD	Women with hypertension who become pregnant, or are planning to become pregnant, should be transitioned to methyldopa, nifedipine, and/or labetalol during pregnancy.
III: Harm	C-LD	Women with hypertension who become pregnant should not be treated with ACE inhibitors, ARBs, or direct renin inhibitors.

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Other Considerations

Resistant Hypertension: Diagnosis, Evaluation, and Treatment

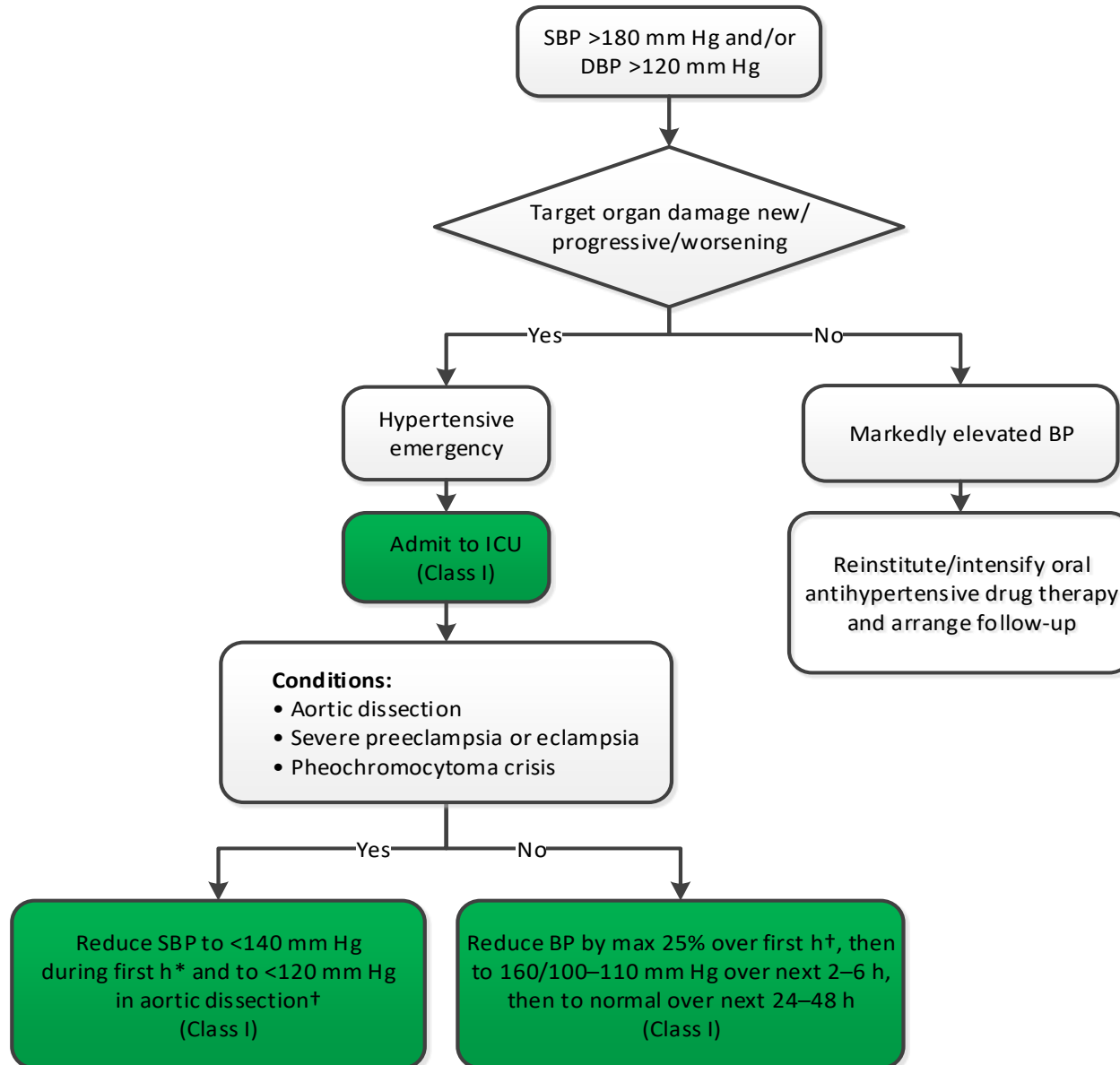
Figure 10. Resistant Hypertension: Diagnosis, Evaluation, and Treatment



Hypertensive Crises: Emergencies and Urgencies

COR	LOE	Recommendations for Hypertensive Crises and Emergencies
I	B-NR	In adults with a hypertensive emergency, admission to an intensive care unit is recommended for continuous monitoring of BP and target organ damage and for parenteral administration of an appropriate agent.
I	C-EO	For adults with a compelling condition (i.e., aortic dissection, severe preeclampsia or eclampsia, or pheochromocytoma crisis), SBP should be reduced to less than 140 mm Hg during the first hour and to less than 120 mm Hg in aortic dissection.
I	C-EO	For adults without a compelling condition, SBP should be reduced by no more than 25% within the first hour; then, if stable, to 160/100 mm Hg within the next 2 to 6 hours; and then cautiously to normal during the following 24 to 48 hours.

Diagnosis and Management of a Hypertensive Crisis



Cognitive Decline and Dementia

COR	LOE	Recommendation for Prevention of Cognitive Decline and Dementia
IIa	B-R	In adults with hypertension, BP lowering is reasonable to prevent cognitive decline and dementia.

Patients Undergoing Surgical Procedures

COR	LOE	Recommendations for Treatment of Hypertension in Patients Undergoing Surgical Procedures
Preoperative		
I	B-NR	In patients with hypertension undergoing major surgery who have been on beta blockers chronically, beta blockers should be continued.
IIa	C-EO	In patients with hypertension undergoing planned elective major surgery, it is reasonable to continue medical therapy for hypertension until surgery.
IIb	B-NR	In patients with hypertension undergoing major surgery, discontinuation of ACE inhibitors or ARBs perioperatively may be considered.

Patients Undergoing Surgical Procedures (cont.)

COR	LOE	Recommendations for Treatment of Hypertension in Patients Undergoing Surgical Procedures
Preoperative		
IIb	C-LD	In patients with planned elective major surgery and SBP of 180 mm Hg or higher or DBP of 110 mm Hg or higher, deferring surgery may be considered.
III: Harm	B-NR	For patients undergoing surgery, abrupt preoperative discontinuation of beta blockers or clonidine is potentially harmful.
III: Harm	B-NR	Beta blockers should not be started on the day of surgery in beta blocker–naïve patients.
Intraoperative		
I	C-EO	Patients with intraoperative hypertension should be managed with intravenous medications until such time as oral medications can be resumed.

Antihypertensive Medication Adherence Strategies

COR	LOE	Recommendations for Antihypertensive Medication Adherence Strategies
I	B-R	In adults with hypertension, dosing of antihypertensive medication once daily rather than multiple times daily is beneficial to improve adherence.
Ila	B-NR	Use of combination pills rather than free individual components can be useful to improve adherence to antihypertensive therapy.

2017 Hypertension Guideline

The Plan of Care for Hypertension

Clinician's Sequential Flow Chart for the Management of Hypertension

Clinician's Sequential Flow Chart for the Management of Hypertension
Measure office BP accurately
Detect white coat hypertension or masked hypertension by using ABPM and HBPM
Evaluate for secondary hypertension
Identify target organ damage
Introduce lifestyle interventions
Identify and discuss treatment goals
Use ASCVD risk estimation to guide BP threshold for drug therapy
Align treatment options with comorbidities
Account for age, race, ethnicity, sex, and special circumstances in antihypertensive treatment
Initiate antihypertensive pharmacological therapy
Insure appropriate follow-up
Use team-based care
Connect patient to clinician via telehealth
Detect and reverse nonadherence
Detect white coat effect or masked uncontrolled hypertension
Use health information technology for remote monitoring and self-monitoring of BP

ASCVD indicates atherosclerotic cardiovascular disease; BP, blood pressure; CVD, cardiovascular disease; and SBP, systolic blood pressure.

2017 Hypertension Guideline

Summary of BP Thresholds and Goals for Pharmacological Therapy Plan of Care for Hypertension

BP Thresholds for and Goals of Pharmacological Therapy in Patients With Hypertension According to Clinical Conditions

Clinical Condition(s)	BP Threshold, mm Hg	BP Goal, mm Hg
General		
Clinical CVD or 10-year ASCVD risk $\geq 10\%$	$\geq 130/80$	$< 130/80$
No clinical CVD and 10-year ASCVD risk $< 10\%$	$\geq 140/90$	$< 130/80$
Older persons (≥ 65 years of age; noninstitutionalized, ambulatory, community-living adults)	≥ 130 (SBP)	< 130 (SBP)
Specific comorbidities		
Diabetes mellitus	$\geq 130/80$	$< 130/80$
Chronic kidney disease	$\geq 130/80$	$< 130/80$
Chronic kidney disease after renal transplantation	$\geq 130/80$	$< 130/80$
Heart failure	$\geq 130/80$	$< 130/80$
Stable ischemic heart disease	$\geq 130/80$	$< 130/80$
Secondary stroke prevention	$\geq 140/90$	$< 130/80$
Secondary stroke prevention (lacunar)	$\geq 130/80$	$< 130/80$
Peripheral arterial disease	$\geq 130/80$	$< 130/80$

ASCVD indicates atherosclerotic cardiovascular disease; BP, blood pressure; CVD, cardiovascular disease; and SBP, systolic blood pressure.

Thank You

