HYPERTENSION TARGETS - MOVING THE GOALPOSTS AGAIN!

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Hypertension, defined as blood pressure ≥140/90 mmHg, is the leading risk factor for mortality and disability-adjusted life years.[1] To promote earlier intervention and reduce the risk of complications that occur at lower blood pressure levels recent US guidelines have reduced the threshold for diagnosis to ≥130/80 mmHg (Stage 1 Hypertension)[2]. Intervention includes lifestyle advice and risk modification. They advocate that only those with Stage 1 Hypertension with a previous cardiac event or a 10 year atherosclerotic cardiovascular risk of 10% or higher should be commenced on pharmacological treatment. In the UK, NICE https://www.nice.org.uk/guidance/indevelopment/gid-ng10054/documents are also advocating for similar changes to hypertension guidelines.

It is predicted that half the US population will have hypertension with the new guidelines (compared to one third at present). The largest increase in prevalence will be amongst younger adults (doubling in women <45 years old and tripling in men <45 years old).[3] There is no comparable UK data available yet.

Guideline authors stressed that increasing the prevalence of hypertension will heighten awareness, promote healthy lifestyles and reduce cardiovascular and renal risks. They argue that medication use will only rise modestly, but will be more focused and aggressive in those deemed to have established cardiovascular risk.

The defining blood pressure levels have been lowered but arguably the approach to hypertension is changing too. Reference is made to "resource constrained populations" and the need to consider socio-economic context when developing management strategies. In instances where more than one medication is required, preference should be given to combination formulations in order to promote patient adherence. Telehealth and mobile phone communication are cited as ways to promote health literacy.

Publication of the SPRINT study potentially favours more aggressive treatment aims for hypertension, although not without considerable risk of adverse events from medications.[4] There are also broader questions to ask. Are we too quick to deal with numbers instead of real people when it comes to treatment strategies and how can we improve the experience of living, not just by reducing mortality?

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2. Whelton PK, Carey RM, Aronow WS, Casey DE, Collins KJ, Himmelfarb CD, et al. 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: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. *Journal of the American College of Cardiology*. 2017; **13**: 24430.

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