

# NEW PAPERS

## 2025 position statement by the British and Irish Hypertension Society on BP treatment thresholds and targets: lower, better, or just moving?



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This year, the British and Irish Hypertension Society (BIHS) is the latest Hypertension Society to call for more aggressive BP treatment and target thresholds. They call for a treatment threshold of  $\geq 135/85$  mmHg and a BP target of  $<130/80$  mmHg for all people with hypertension, irrespective of patient risk level and the method used to measure BP.<sup>1</sup> This represents a significant shift from earlier guidelines and highlights an overall global trend towards earlier, more aggressive, and streamlined management of hypertension.

The Society's position statement raises three important points for us to consider. The first is the lower BP target of  $<130/80$  mmHg or lower if tolerated. Recent major randomized clinical trials, beginning with the SPRINT study, demonstrated that a more intensive BP target  $<120$  mmHg was associated with a significant reduction in composite cardiovascular events across age groups 50 years and older compared with less intense, historical targets of  $140/90$  mmHg.<sup>2</sup> These findings were recently corroborated with the publication of three key trials from China, which confirmed benefits of lower BP targets across diverse clinical populations. The STEP trial in 2021 randomized 8,511 patients aged 60–80 years to a systolic BP target of 110–130 mmHg vs. 130–150 mmHg.<sup>3</sup> The more intensive targets were associated with a significant reduction (Hazard Ratio [HR] 0.74; 95% Confidence Interval [CI] 0.60–0.92) in major composite cardiovascular events. The ESPRIT trial in 2024 randomized 11,255 people aged 50 years and older with hypertension and increased CV risk (e.g., prior stroke, diabetes) to a systolic target

of  $<120$  mmHg or  $<140$  mmHg.<sup>4</sup> After 3.4 years, intensive SBP control was associated with reduced MACE outcomes (HR 0.88; 95% CI 0.78–0.99). The BPROAD trial in 2024 enrolled 12,821 adults aged  $\geq 50$  years with type 2 diabetes to an intensive systolic target of  $<120$  mmHg vs.  $<140$  mmHg.<sup>5</sup> Over approximately 5 years, tight BP targets was associated with a significantly lower risk of MACE compared to a higher target (HR 0.79; 95% CI 0.69–0.90). On the basis of these accumulated data from RCTs and long-standing observational data demonstrating increased CV risk beginning even as low as in the 120s mmHg, Hypertension Societies advocated for tighter BP control (**Table 1**).

The second important aspect was setting the treatment threshold for hypertension to  $\geq 135/85$  mmHg irrespective of office, attended or unattended, 7-day home reading, or daytime ambulatory BP measurements. This lowering of the definition of hypertension, much like the 2017 ACC/AHA hypertension guidelines, increases the number of people who will be diagnosed with hypertension.<sup>6</sup> In the US, where the diagnosis of hypertension was set at  $\geq 130/80$  mmHg, almost 13% of patients (~30 million) were labelled as hypertensive overnight. These reclassified hypertensive patients are typically younger, aged  $<45$  years. This could translate to increased health resource utilization with follow-up visits, medication use or intensification, resulting in greater medication-related adverse effects for low-risk individuals. The position statement also assumes an equivalency between office, 7-day



home average, and average daytime ambulatory BP readings. While studies report only modest reproducibility between different modalities, Yeh et al. found measurement discrepancies between these modalities were greatest at higher BP but reduced to minor differences at SBPs in the 120s mmHg range.<sup>7</sup> Cost-analysis models demonstrate even accounting for BP measurement errors, reaching intensive targets of <120 mmHg or <130 mmHg remains cost-effective.<sup>8</sup>

The third important aspect of these guidelines is that the recommended thresholds to treat and targets apply regardless of patient risk level. In an era of increasing patient complexity, this greatly simplifies treatment thresholds and targets and better approximates recent evidence. These trials converge on the premise that lower BP is better across a variety of important subgroups that we had applied varying targets for, such as prior CVD, type 2 diabetes, stroke, chronic kidney disease, and the elderly. The guideline authors further contend it is unethical to withhold antihypertensive therapy until irreversible subclinical or clinical sequelae of hypertension emerge. However, it is important to note that the clinical trials only included moderate to high-risk patients and patients older than 50 years. According to these

guidelines and others, if a 26-year-old man has a BP of 138/85 mmHg, they would be diagnosed with hypertension and started on long-term antihypertensive therapy. Their overall 10-year CV risk, although cannot be precisely estimated using Framingham risk calculators, would be approximately <2%. Extrapolating a CV relative risk reduction of 25% with antihypertensive therapy, we would recommend that this low-risk person take medication daily for 10 years to reduce their absolute CV risk from 2% to 1.4%. For an individual low risk patient, this cost benefit ratio may not be worthwhile.

The British and Irish Hypertension Society's position statement reflects a broader global shift toward earlier and more aggressive BP management through simplified and streamlined approaches. This strategy is promising to reduce therapeutic inertia, save lives and reduce health care costs at a population level. However, simplification also risks overtreatment for some, especially younger and low risk populations. In an era of augmented intelligence tools, simplification may not come at a cost of personalizing hypertension management while still providing earlier and more aggressive care as called on by BIHS for those who need it.

**Table 1.** Blood Pressure Targets Among Various Hypertension Societies

Society	Year	Recommended BP Target*
BIHS	2025	<130/80 mmHg
ACC/AHA	2017/2025	<130/80 mmHg
Hypertension Canada	2025	<130 mmHg, No diastolic target
ESC/EAC	2024	120–129/70–79 mmHg (but note <120/70 mmHg in research conditions optimal)
ESH	2023	<140/80 mmHg initially for most; if well tolerated, aim <130/80 mmHg in adults up to ~79 years; SBP of 120–129 mmHg may be considered but not below 120 mmHg
ISH	2020	<130/80 mmHg, if tolerated and for patients <65 years Persons ≥65 years or those with frailty, the target is less stringent e.g., <140/90 mmHg (or <140/80 mmHg for some elderly)

\*Guideline bodies recommend raising the target if not tolerated or for frail elderly to as low as reasonably achievable

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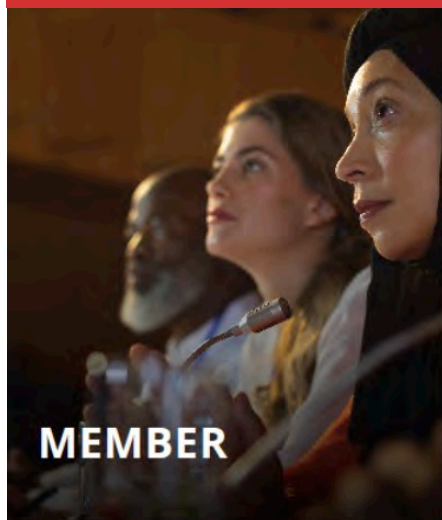
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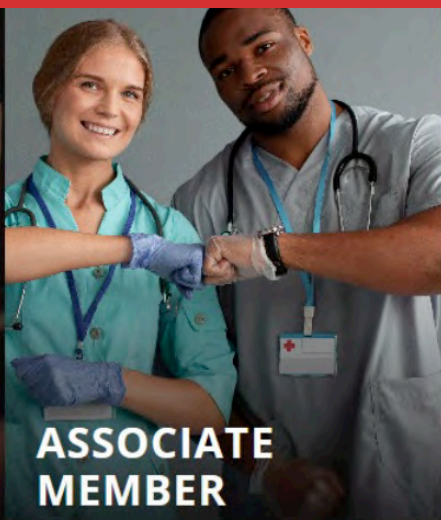
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