

REGIONAL STATEMENTS

Why Asia-Pacific needed its own playbook for diabetes and high blood pressure

A new joint consensus from the Asian-Pacific Society of Hypertension (APSH) and the Diabetes Asia Study Group (DASG) sets out region-specific targets and treatment choices for a combination that affects hundreds of millions of people across the region.



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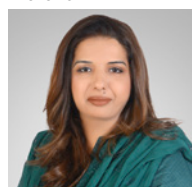
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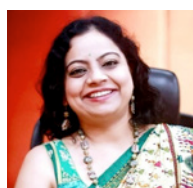
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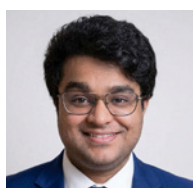
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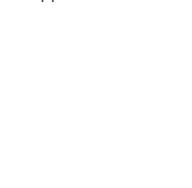
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When we sat down as a panel of endocrinologists, cardiologists, nephrologists, internists, basic scientists and diabetologists from 15 countries across the Asia-Pacific region, one thing became clear quite quickly: the hypertension guidelines our patients were being treated according to simply weren't written with them in mind.

Most international guidelines are built on trial populations where Asian patients are a small minority. Yet look at the numbers: China, India, Pakistan, Indonesia, Bangladesh, and Japan are all among the world's top ten countries for adult diabetes cases.¹ And when diabetes and high blood pressure occur together, which happens often, since someone with diabetes is roughly twice as likely to also have hypertension, the risks to the heart, kidneys, and blood vessels compound.² A review of Southeast Asian data found hypertension affecting anywhere from 29.4% to 93.4% of people with diabetes, depending on the setting, with control rates often below 40%.³

That gap, and the absence of a regional guideline that really addressed it, is why APSH and DASG brought together this consensus. We used a modified Delphi process: multiple rounds of literature review, drafting, and voting, retaining only statements on which at least 75% of the panel agreed, and grading each recommendation based on the strength of the supporting evidence.

So, what does the consensus actually say?

First, lifestyle still comes first. A diet built around whole grains, vegetables, fruit, nuts, and low-fat dairy, with sodium kept under 1,500 mg a day (ideally closer to 1,000 mg), regular physical activity, and cutting out tobacco and alcohol, forms the foundation of care to be tried before medication, not instead of it.⁴

Second, when medication is needed, we recommend starting most patients on a combination rather than a single drug: typically an ACE inhibitor or ARB paired with a calcium channel blocker, ideally as a single-pill combination so people actually stick with treatment. If blood pressure isn't controlled, a diuretic is added as a third agent. We were deliberately cautious about older thiazide diuretics like hydrochlorothiazide, since they can nudge blood glucose and HbA1c

upward; low-dose thiazide-like agents such as chlorthalidone or indapamide are preferred instead.

Third, we're recommending tighter blood pressure targets than many clinicians have been used to. For most people with type 2 diabetes, the new target is below 130/80 mmHg.⁵ This isn't an arbitrary tightening; it's driven by three major recent trials. STEP, in older adults, found that lowering systolic blood pressure to 110-130 mmHg reduced cardiovascular events by 26% compared with a standard target of 130-150 mmHg.⁶ ESPRIT, in over 11,000 high-risk adults, including more than 4,000 with diabetes, showed a 12% reduction in major cardiovascular events when systolic pressure was brought below 120 mmHg.⁷ And BPROAD, run specifically in nearly 13,000 people with type 2 diabetes, found a 21% relative risk reduction in stroke, heart attack, heart failure, or cardiovascular death with intensive control below 120 mmHg, versus a standard target below 140 mmHg.⁸ For older or frail patients, we still allow a gentler target of up to 140/90 mmHg, because the risk of falls or kidney strain from over-treatment is real.

Fourth, we made room for the newer cardio-renal protective drugs. SGLT2 inhibitors, GLP-1 receptor agonists, mineralocorticoid receptor antagonists, and even ARNI (sacubitril-valsartan) all earned a place in the algorithm for the right patient, not to replace the core three drug classes, but to add to them when heart failure, kidney disease, or resistant hypertension is part of the picture. The treatment pathway we settled on is summarized below.

Finally, we leaned hard into home blood pressure monitoring. It reflects a patient's real-world blood pressure far better than a single clinic reading, and it's practical; measuring twice daily for at least three days gives a reliable estimate.⁹ Getting it right matters, though: posture, arm position, and avoiding caffeine, alcohol, or exercise beforehand can all change the number on the cuff. We've set out the technique below.

We know cost and access to validated home devices remain real barriers in parts of the region, and we've said so plainly in the consensus, calling for government programs, public-private

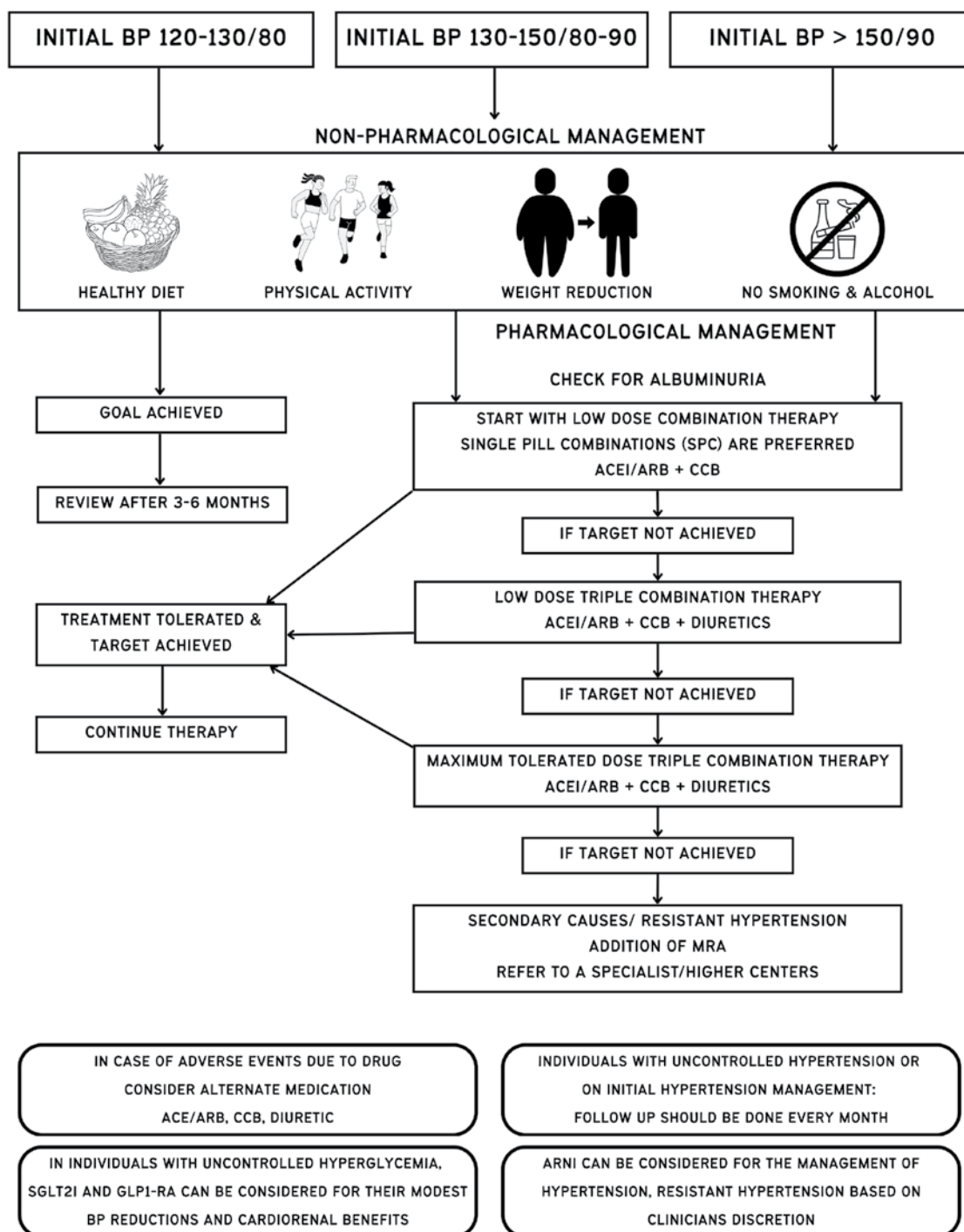


partnerships, or manufacturer pricing support to close that gap.

None of this is meant to replace clinical judgment; every recommendation carries a grade reflecting the strength of the underlying evidence, and

treatment must always be individualized to the patient in front of you. But we hope this consensus gives clinicians across the Asia-Pacific something that's been missing until now: guidance that actually reflects the patients walking into their clinics.

Simplified treatment pathway for hypertension in people with diabetes, adapted from the consensus.



Getting an accurate reading: technique for office, home, and ambulatory blood pressure measurement, adapted from the consensus.



SIT COMFORTABLY WITH BACK SUPPORT, FEET ON THE GROUND FOR 5 MINUTES IN A QUIET ROOM



ARMS ON THE TABLE, CUFF AT THE HEART LEVEL



NO SMOKING, ALCOHOL, CAFFEINE & EXERCISE 30 MINUTES BEFORE



USE VALIDATED DEVICE WITH APPROPRIATE CUFF SIZE & CALIBRATE IT PERIODICALLY

OFFICE BLOOD PRESSURE MEASUREMENT (OBPM)



- RECORD BP IN BOTH THE ARMS & CONSIDER ONE WITH HIGHER READING
- MEASURE BP 3 TIMES (1-2 MINUTES APART) AND AVERAGE THE LAST 2 READING.
- MINIMUM OF 2-3 VISITS AT 1-4 WEEKS INTERVALS TO CONFIRM THE DIAGNOSIS.
- DOCUMENT THE READINGS

HOME-BASED BLOOD PRESSURE MEASUREMENT (HBPM)



BEFORE VISITING THE HEALTHCARE PROFESSIONAL:

- 2 READING 1 MINUTE APART IN THE MORNING BEFORE TAKING MEDICATION, & IN THE EVENING FOR AT LEAST 3 & IDEALLY 7 DAYS.
- DOCUMENT THE READING & AVERAGE THE READING EXCLUDING FIRST DAY.

AMBULATORY BLOOD PRESSURE MEASUREMENT (ABPM)



- READINGS ARE OBTAINED AT 15-30 MINUTES INTERVALS DURING THE DAY & 30-60 MIN INTERVALS AT NIGHT.
- TO IDENTIFY MASKED AND WHITE COAT HYPERTENSION

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