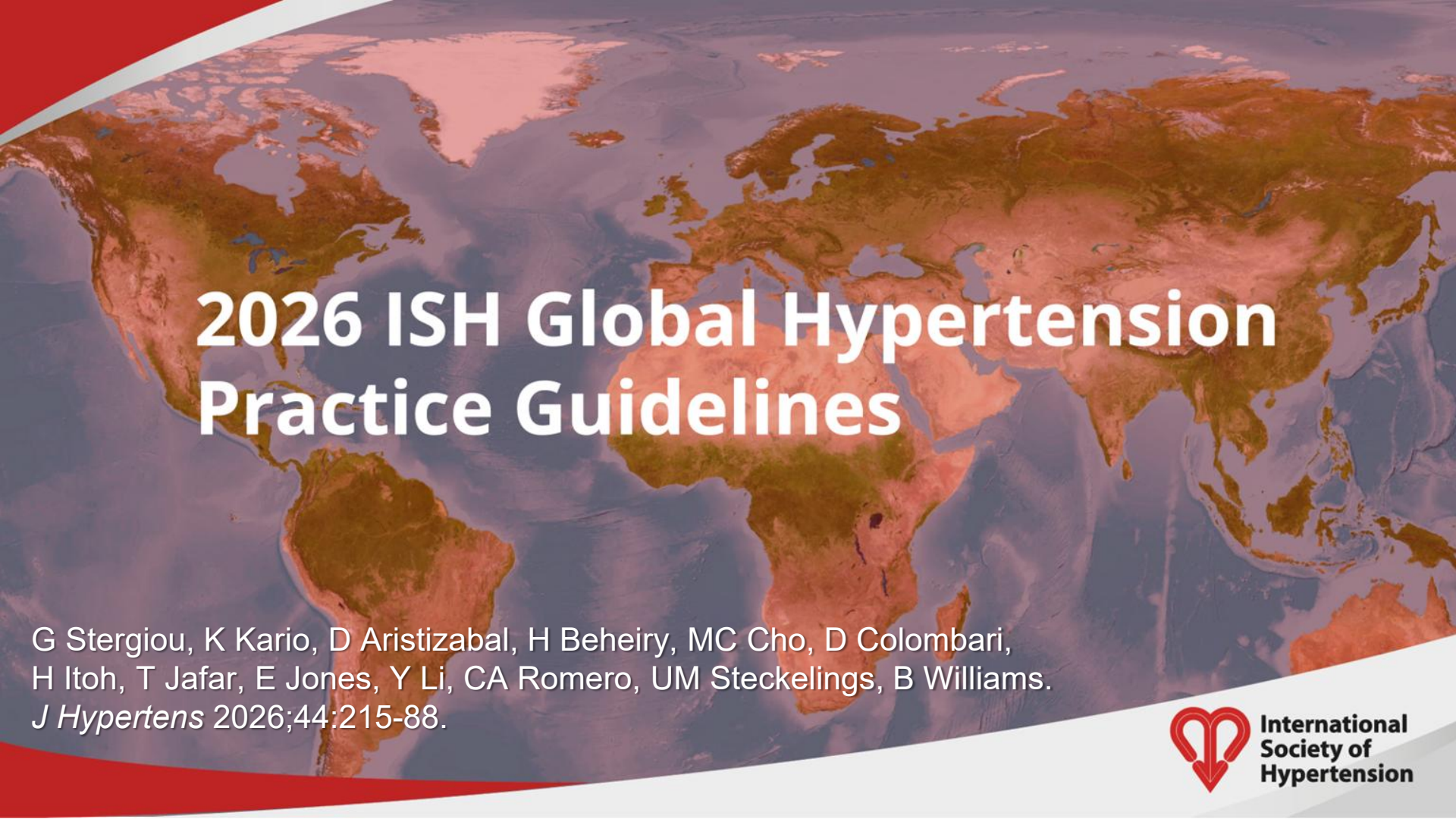
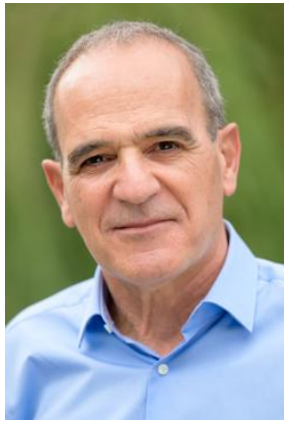


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International Society of Hypertension

INTRODUCTION



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ISH President
Greece

International Society of Hypertension

2026 International Society of Hypertension Global Hypertension Practice Guidelines

George S. Stergiou, Kazuomi Kario, Dagnovar Aristizabal, Hind Beheiry, Myeong-Chan Cho, Débora Simões Almeida Colombari, Hiroshi Itoh, Tazeen H. Jafar, Erika Jones, Yan Li, Cesar A. Romero, U. Muscha Steckelings, and Bryan Williams

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22 pages

16 tables

10 infographics

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Keywords: blood pressure measurement, cardiovascular risk, global health, hypertension, implementation

Abbreviations: ABPM, ambulatory blood pressure monitoring; ACEI, angiotensin-converting enzyme inhibitor; ARB, angiotensin II type 1 receptor blocker; BP, blood pressure; CAD, coronary artery disease; CCB, calcium channel blocker; CKD, chronic kidney disease; CVD, cardiovascular disease; DHP-CCB, dihydropyridine calcium channel blocker; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HMOD, hypertension-mediated organ damage; ISH, International Society of Hypertension; LMIC, low-income and middle-income countries; LVH, left ventricular hypertrophy; MRA, mineralocorticoid receptor antagonist; NPHP, non-physician healthcare professionals; OSA, obstructive sleep apnoea; RAAS, renin–angiotensin–aldosterone system; RAS, renin–angiotensin system; sHBPM, standardised home blood pressure monitoring; SGLT2i, sodium-glucose cotransporter-2 inhibitors; sOBP, standardised office blood pressure; UACR, urinary albumin-to-creatinine ratio

SECTION 1: INTRODUCTION

The global burden of hypertension

High blood pressure (BP) remains a critical global public health issue, accounting for about 11 million deaths annually (16% of all deaths worldwide), more than any other single risk factor for noncommunicable diseases [1,2]. Global estimates for 2021 showed that high BP contributes to 53% of global cardiovascular disease (CVD) mortality, 58% of stroke deaths, and 31% of chronic kidney disease (CKD) deaths [1]. Its prevalence ranges between 30-40% with approximately 1.4 billion people aged 30–79 years having hypertension worldwide [1,2]. This number is double that in 1990 and is projected to rise further, likely exceeding 1.5 billion by 2030 if no action is taken, due to global population growth and ageing [1]. Global BP trends show a clear shift in the highest BP levels from high-income to low-income regions [3,4], with an estimated 349 million people with hypertension living in high-income countries and 1 billion in low-middle-income countries (LMICs) [5].

Despite strong evidence supporting the benefits of effective hypertension management and the availability of many effective, low-cost medications, in about half of all countries, national hypertension control rates remain <20% [1]. Only about 20% of people with hypertension worldwide have their BP controlled to <140/90 mmHg (and substantially fewer to <130/80 mmHg) [1–4]. In low-income countries, control rates are particularly poor, often

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Hypertension: Definition, Screening And Diagnosis – Blood Pressure Monitoring



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Classification Of Hypertension Based On Office BP Measurements

Category	Systolic (mmHg)[a]		Diastolic (mmHg)[a]
Normal BP	<130	and	<80
Elevated BP	130–139	and/or	80–89
Grade 1 hypertension	140–159	and/or	90–99
Grade 2 hypertension	≥160	and/or	≥100

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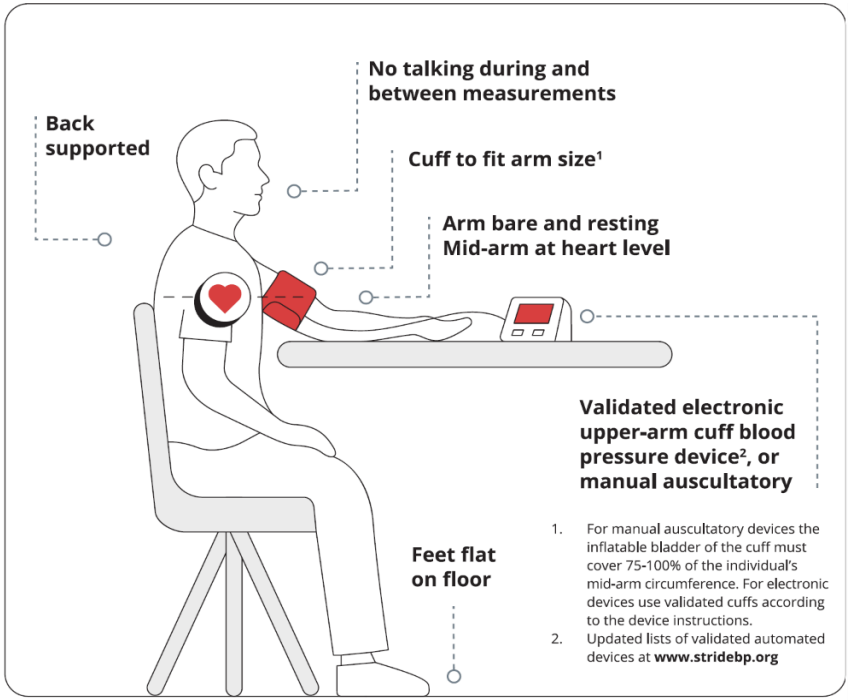
BP Thresholds for Elevated BP and Hypertension

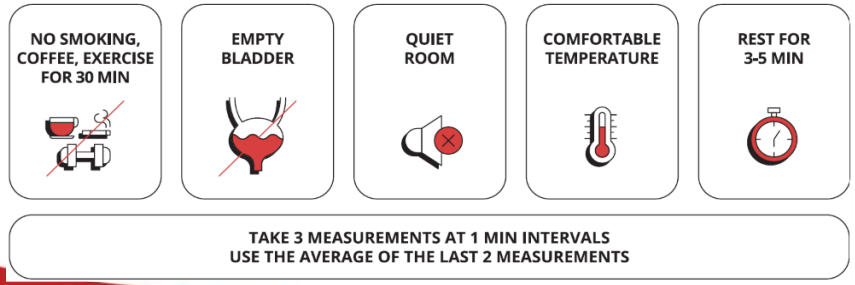
BP Method	Measurement Protocol	Elevated BP SBP and/or DBP (mmHg)	Hypertension SBP and/or DBP (mmHg)
 STANDARDISED OFFICE	Average BP of at least 2 visits with 3 readings per visit (use the last two)	**130-139/80-89**	**≥140/90**
 STANDARDISED HOME	Average BP of 7 days (at least 3 days with 12 readings)	**130-134/80-84**	**≥135/85**
 24-HOUR AMBULATORY	24-hour average Daytime (awake) average Nighttime (asleep) average (at least 20 awake and 7 asleep readings)	**125-129/75-79** **130-134/80-84** **110-119/65-69**	**≥130/80** **≥135/85** **≥120/70**

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Standardised Office BP

Casual office BP is inappropriate

Standardised Home BP

Casual home BP is inappropriate

Standardised Home BP

Main method

24h ABPM

With indications when available

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Strategies and Tools for Hypertension Screening

Strategy/Tool	Application	Limitations
 **SCREENING IN PRIMARY HEALTHCARE***	BP measured during every healthcare visit. Most efficient to confirm and treat	Misses those not attending healthcare settings
 **COMMUNITY SCREENING**	Organised programs (workplaces, public spaces, schools, social gatherings, etc)	Requires planning, time, resources
 **COMMUNITY PHARMACY**	Opportunistic measurement	Uncertain blood pressure thresholds
 **KIOSK BP DEVICES IN PUBLIC SPACES**	Pharmacies, shopping centres, workspaces, community centres	Uncertain blood pressure thresholds, require resources and maintenance
 **HOME BP MONITORING**	Periodic long-term measurements	Requires validated devices and user training
 **CUFFLESS BP MEASURING TECHNOLOGIES**	Occasional self-measurement or automated monitoring	Limited evidence on accuracy and clinical utility
 **AI-ENABLED WEARABLES FOR HYPERTENSION DETECTION**	Occasional self-evaluation or automated monitoring	Limited evidence and variable diagnostic accuracy

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Hypertension Phenotypes
Out-of-Office BP Monitoring



Yan LI
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HYPERTENSION PHENOTYPES

- White-coat hypertension
- Masked hypertension
- Nocturnal hypertension
- High blood pressure variability

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White-coat Hypertension

- Hypertension on sOBP measurement but normal or elevated BP on sHBPM or ABPM
- About 10-30% of individuals attending clinics because of high BP have white-coat hypertension.
- Long-term follow-up with lifestyle modifications and periodic sHBPM (and/or ABPM) is recommended.
- Antihypertensive drug treatment is not recommended when out-of-office BP is clearly normal. However, drug treatment may be considered in selected individuals with HMOD.

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Masked Hypertension

- Is defined as a normal or elevated BP in sOBP measurement but Hypertension in sHBPM or ABPM
- About 10-30% of untreated individuals or individuals treated for hypertension have masked hypertension.
- The diagnosis needs confirmation with repeated office and out-of-office measurements (sHBPM or ABPM).
- In confirmed masked hypertension, drug treatment should be considered, aiming to normalize out-of-office BP.

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Nocturnal Hypertension

- Nocturnal hypertension is defined as an average nighttime (asleep) BP ≥120/70 mmHg assessed by 24-hour ABPM or sHBPM.
- Poor sleep quality and obstructive sleep apnoea (OSA) are common causes of nocturnal BP elevation.
- Recommend using long-acting antihypertensive drugs, along with lifestyle modifications. There is no evidence of a benefit from bedtime dosing of treatment or of treating isolated nocturnal hypertension.

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High Blood Pressure Variability

- Several patients with hypertension, particularly those aged ≥70 years, have excessive BP variability.
- BP variability predicts cardiovascular events independent of the average BP.
- There is no consensus on the optimal method and indices to quantify variability, or on the threshold for defining high values.
- Long-acting dihydropyridine calcium antagonists (DHP-CCBs) seem to be the most effective antihypertensive drugs for reducing variability.

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Other Methods for out-of-office BP Monitoring



- Blood pressure measurement in community pharmacies.
- Kiosk blood pressure monitors in public spaces.
- Wearable wrist-watch cuff oscillometric blood pressure monitors.
- Cuffless devices for blood pressure measurement and hypertension diagnosis.







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BP Measurement in Pharmacies



- BP measurements obtained using automated devices in pharmacies are widely used in several countries.
- It can be useful for hypertension screening and the long-term follow-up of treated hypertensives.
- The BP threshold for hypertension diagnosis is approximately 135/85 mmHg.
- The same instructions as for sOBP measurement should be applied.

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Kiosk BP Measurement in Public Spaces



- Obtained by automated self-measuring devices in public settings.
- CAN be useful for hypertension screening in the general population and for occasional monitoring of individuals treated for hypertension.
- NOT recommended for the diagnosis or management of hypertension.

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Wearable Wrist-Watch Cuff Oscillometric BP Monitors

- Several such devices are available on the market, and a few have been properly validated for accuracy.
- CAN be used for manually activated self-measurement at home, at work, and in other settings, and for automated 24-hour ABPM. These devices appear to disturb sleep less than the upper-arm cuff BP monitors.
- As with all wrist-cuff devices, it is important to measure BP in a standardised position with the arm supported and the wrist at heart level. More research is needed to investigate their clinical use.

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Cuffless BP Measurement





- Cuffless BP devices have considerable potential to transform out-of-office BP evaluation by enabling frequent or continuous, unobtrusive BP monitoring.
- However, they still have issues with accuracy, and they are NOT currently recommended for the diagnosis and management of hypertension.
- Novel AI technologies implemented in smartwatches aim to detect hypertension. They can be useful for hypertension screening.

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Clinical Evaluation Cardiovascular Risk Organ Damage



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SECTION 4: CLINICAL EVALUATION AND DIAGNOSTIC TESTS

Etiology

SECTION 5: CARDIOVASCULAR RISK FACTORS AND RISK ESTIMATION

HMOD

SECTION 6: HYPERTENSION-MEDIATED ORGAN DAMAGE

Risk Stratification

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TABLE 8. Factors contributing to total cardiovascular disease risk

Cardiovascular risk factors	Hypertension-mediated organ damage	Cardiovascular/kidney disease
• Age ≥55 years in men; ≥65 years in women • Sex (men > women at age <65 years) • Family history of premature CVD • BMI ≥30 kg/m^2 (lower in Asian populations) • Diabetes mellitus • Dyslipidaemia (high LDL-C, TG, low HDL-C) • Smoking • Chronic inflammatory diseases • Psychosocial and socioeconomic factors • Obstructive sleep apnoea • Resting heart rate >80 beats/min • Early-onset menopause • Hypertensive disorders of pregnancy • Non-adherence to treatment of CVD risk factors	Heart • Left ventricular hypertrophy (ECG or echocardiography) Kidneys • eGFR <60 ml/min/1.73 m^2 and/or UACR ≥30 mg/g Brain • Cognitive decline (Mini-Mental State Examination) Arteries • Carotid plaque (ultrasonography) or coronary atherosclerosis (calcium score, angiography) • Increased arterial stiffness (pulse wave velocity)	Heart • Coronary artery disease • Heart failure • Atrial fibrillation Kidneys • Chronic kidney disease (eGFR <60 ml/min/1.73 m^2 and/or UACR ≥30 mg/g) Brain • Stroke or transient ischaemic attack • Vascular dementia Arteries • Peripheral artery disease (ankle–brachial index<0.90)

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Diagnostic and Clinical Tests

ESSENTIAL

- **Blood tests**: sodium, potassium, serum creatinine, estimated glomerular filtration rate (eGFR) using the 2021 CKD-EPI equation, lipid profile, fasting glucose, uric acid, thyroid-stimulating hormone.
- **Urine test**: dipstick test (proteinuria, haematuria, glycosuria).
- **12-lead ECG:** left ventricular hypertrophy (LVH), ischaemic heart disease, arrhythmias.

OPTIMAL

- **Echocardiography**: LVH, systolic/diastolic dysfunction, atrial dilation, aortic root dilation, aneurysm or coarctation.
- **Carotid ultrasound**: plaques, stenosis.
- **Kidneys/renal artery and adrenal imaging** (ultrasound/renal artery duplex; **computed tomography** (CT) or magnetic resonance angiography): renal parenchymal disease, renal artery stenosis, adrenal mass or enlargement, aortic aneurysm.
- **Brain CT, magnetic resonance imaging (MRI) or angiography**: ischaemic or haemorrhagic brain injury.
- **Carotid-femoral or brachial–ankle pulse wave velocity:** increased arterial stiffness, early vascular ageing.

Additional investigations

- **Urinary** albumin-to-creatinine ratio (UACR; first-morning spot urine).
- **Ankle–brachial index**: peripheral artery disease (atherosclerosis).
- **Mini-mental state examination** or clock-drawing test for cognitive impairment.
- **Further testing for suspected secondary hypertension**: see Section 9.2.

Restratification

- Carotid plaque detection (ultrasound)
- Lipoprotein(a) [Lp(a)] elevation
- Coronary artery calcium score (CT)

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Risk Calculators

Key for therapeutic initiation and intensity

	Elevated Blood Pressure Systolic/Diastolic BP 130-139/80-89 mmHg	Grade 1 Hypertension Systolic/Diastolic BP 140-159/90-99 mmHg	Grade 2 Hypertension Systolic/Diastolic BP ≥160/100 mmHg
No other risk factors HMOD, or CVD	✓	✓	! / ⚠
1-2 risk factors	✓	!	⚠
≥3 risk factors, CKD G3a	!	⚠	⚠
HMOD, CKD G3b-G5 diabetes, CVD	⚠	⚠	⚠

CKD, chronic kidney disease
CVD, cardiovascular disease
HMOD, hypertension-mediated organ damage

✓ LOW RISK
! MODERATE RISK
⚠ HIGH RISK

[a] Example for a 60-year-old male. Risk categories will vary according to age and sex.

Region specific

Score-2 (Europe)
Prevent (USA)
Score-LAC (LATAM)

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Lifestyle Modifications



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LIFESTYLE RECOMMENDATIONS

- Healthy lifestyle choices can prevent or delay hypertension, reduce the need for drugs in treated patients, and improve several other risk factors, thereby reducing the cardiovascular risk.
- Lifestyle modifications are recommended as a first-line intervention in untreated individuals and in all those treated for hypertension.
- Even smaller lifestyle changes than those recommended can have beneficial effects on BP and overall health.

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FOOD & DRINK



SALT

- Limit total salt intake to a maximum of 1 teaspoon per day (5 g salt or 2 g sodium).
- Reduce salt when cooking and at the table.
- Avoid high-salt foods: soy sauce, fast foods, processed foods, breads, and high-salt cereals.



POTASSIUM

- Increase potassium intake eating more minimally processed foods, fruits, vegetables, low-fat milk, yogurt and legumes.
- Use potassium-enriched, low-sodium salt (caution in patients with kidney disease).



HEALTHY DIET

- Increase intake of leafy vegetables, beans, beetroot, avocados, nuts, seeds, legumes, cocoa and tofu.
- Limit added sugars, particularly sugar-sweetened foods and beverages.
- Adopt a DASH-style diet (http://www.dashforhealth.com)



DIETARY FIBER

- Substitute refined foods with high-fibre foods.
- Eat lentils, beans, wholes grains, broccoli, kale, cabbage, blueberries and avocado.



HEALTHY DRINKS

- Consider moderate consumption of beverages that may help lower BP, including beetroot juice, green and black tea, karkade (Hibiscus) tea, pomegranate juice, and unsweetened cocoa.



ALCOHOL

- Avoid or limit alcohol to 2 standard drinks per week.
- Avoid binge drinking.

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MOVEMENT & BODY WEIGHT

WEIGHT CONTROL

- Weight control and obesity management (particularly abdominal obesity).
- Use a universal waist-to-height ratio <0.5, ethnic specific BMI and waist circumference cut-offs.

PHYSICAL ACTIVITY

- Increase general physical activity during the day.
- Aerobic exercise: walking, jogging, cycling, yoga, or swimming for ≥30 min 5-7 days per week.
- Resistance exercise: High-intensity interval training and muscle-strengthening exercise 2-3 days/week.
- Performing the weekly exercise in 1-2 days is also beneficial, but in more days is preferred.

BODY & MIND

STRESS

- Reduce stress by practicing mindfulness, yoga or meditation and listening to music for ≥30 minutes 3 times per week.

SLEEP

- Maintain regular sleep (7-8 hours/night) with good sleep conditions.
- Avoid alcohol and large meals for ≥3 hours before sleep.
- Identify, and manage sleep disorders, particularly sleep apnea.

OTHERS

SMOKING / VAPING

- Complete cessation of smoking, nicotine-containing products, electronic cigarettes.
- Refer to smoking cessation programs.
- Implement strategies to avoid weight gain when stopping smoking.

ALTERNATIVE / TRADITIONAL MEDICINES

- To be avoided.
- Use only guideline-recommended lifestyle changes and medications to treat hypertension.

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Hypertension Treatment: Initiation, Targets, Choices



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Treatment initiation and BP targets

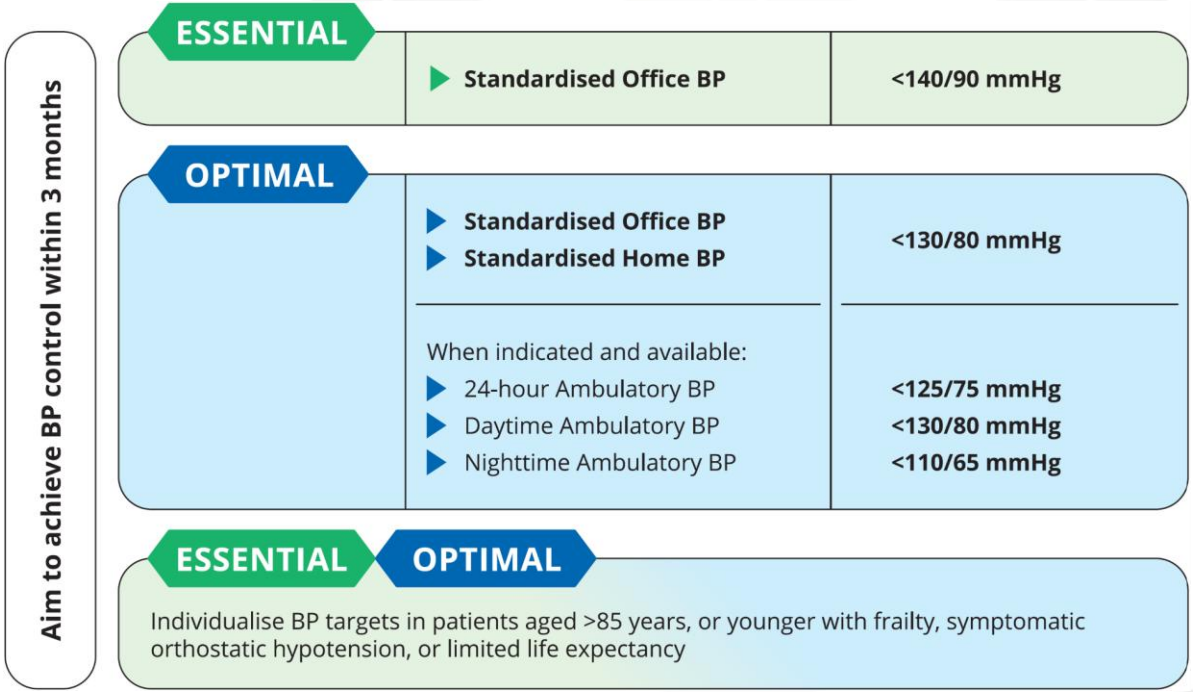
	ESSENTIAL Use standardised office BP	OPTIMAL Use standardised office BP Confirm with home or ambulatory BP
TREATMENT THRESHOLD	≥140/90 mmHg	≥130/80 mmHg* Home & ambulatory BP thresholds in Fig. 1
TARGET	<140/90 mmHg	<130/80 mmHg* Home & ambulatory BP targets in Fig. 7
LIFESTYLE CHANGES	**Apply before and during treatment**	
TIME TO START	**CVD, CKD, DM, HMOD, high CVD risk or BP ≥160/100 mmHg:** Start immediate treatment after diagnosis confirmation	
	Low CVD risk and BP 140-159/90-99 mmHg: Start treatment after 3 months of lifestyle changes	**Low CVD risk and BP 130-159/80-99 mmHg:** Start treatment after 3 months of lifestyle changes
DRUG TREATMENT	Two-drug combination Preferably in a single pill	**BP ≥140/90 mmHg:** Two-drug single-pill combination **BP 130-139/80-89 mmHg:** Monotherapy (preferred). May use low-dose two-drug single-pill combination in high CVD risk with systolic BP close to 140 mmHg
	Individualise treatment initiation and BP targets: In patients aged >85 years, or younger with frailty, symptomatic orthostatic hypotension, or limited life expectancy	

CVD, cardiovascular disease
CKD, chronic kidney disease
DM, diabetes mellitus
HMOD, hypertension-mediated organ damage

** Focus primarily on systolic BP (rather than diastolic if 80-89 mmHg)*

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G Stergiou, K Kario, D Aristizabal, H Beheiry, MC Cho, D Colombari, H Itoh, T Jafar, E Jones, Y Li, CA Romero, UM Steckelings, B Williams. ***J Hypertens*** 2026;44:2157-88.

Office and Out-Of-Office BP targets



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Ideal Characteristics Of Antihypertensive Drugs

ESSENTIAL

- Evidence-based efficacy in reducing morbidity and mortality.
- Once-daily dosing providing 24-h blood pressure control.
- Affordable and cost-effective.
- Well tolerated, with a favourable adverse-effect profile.
- Evidence of benefit in the population in which they are used.

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G Stergiou, K Kario, D Aristizabal, H Beheiry, MC Cho, D Colombari, H Itoh, T Jafar, E Jones, Y Li, CA Romero, UM Steckelings, B Williams. ***J Hypertens*** 2026;44:2157-88.

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Drug-treatment Strategy

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J Hypertens 2026;44:2157-88.

ESSENTIAL

Use whatever drugs are available that match as many ideal characteristics as possible (see ***Table 9***).

ESSENTIAL OPTIMAL

- **Individualise therapy** based on drug indications and contraindications.
- **Give all drugs together** in the morning whenever possible, or at the time most convenient for the individual to improve adherence.
- **Prefer single-pill combination therapy** with 2, 3, or 4 drugs. If unavailable or unaffordable, use free combinations.
- **Use full-dose ACEI or ARB** in HF, CKD, CAD. Do not combine ACEIs, ARBs, renin inhibitors.
- **Consider diltiazem or verapamil** if dihydropyridine CCBs are unavailable or not tolerated.
- **Consider beta-blockers** at any treatment step in:
  - HF
  - Angina
  - Post-myocardial infarction
  - Atrial fibrillation requiring heart rate control
  - Supraventricular tachycardias; certain ventricular arrhythmias
  - Pregnant women or women planning pregnancy.

ACEI, angiotensin-converting enzyme inhibitor
ARB, angiotensin II Type 1 receptor blocker
CAD, coronary artery disease
CKD, chronic kidney disease
CCB, calcium channel blocker
HF, heart failure

OPTIMAL

START WITH 2 DRUGS IN A SINGLE PILL

- A — ACEI or ARB
- C — Dihydropyridine CCB
- D — Thiazide or thiazide-like diuretic

Review monthly until BP is controlled
Intensify treatment whenever BP remains above target

STEP 1 Dual low-dose[a] combination	A + C[b,c]
STEP 2 Dual full-dose or triple low-dose[a] combination	A + C[c] or low-dose[a] A + C + D
STEP 3 Triple full-dose combination	A + C + D
STEP 4 Quadruple combination (Resistant hypertension)	• ***Preferred:*** add-on spironolactone.[d] • ***Other:*** amiloride, eplerenone, beta-blocker, clonidine, doxazosin, sacubitril/valsartan.[d,e] • ***New:*** baxdrostat, lorundrostat, aprocitentan, esaxerenone.[d,e,f]
STEP 5 Resistant hypertension uncontrolled on 4 drugs as above at maximum tolerated doses	• Add any available drug class not already in use. • Consider referral to an expert centre for treatment titration and/or renal denervation

a. Low-dose generally refers to half of the maximum recommended dose.
b. Consider starting with monotherapy in patients with elevated BP *(Optimal recommendation)*, age >85 years, or younger with frailty, symptomatic orthostatic hypotension, or limited life expectancy.
c. Consider A + D in edema, CCB intolerance, or early signs of heart failure.
d. Caution with mineralocorticoid receptor antagonists or other potassium sparing-drugs in estimated eGFR <30 mL/min/1.73m² or K^+ >4.5 mmol/L.
e. As much as possible, select based on the criteria presented in Table 9.
f. Regulatory approval and availability vary by country.

New Pharmacological Options



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New Pharmacologic Treatment Options

✓ Clinical positioning: consider as add-on options in selected patients, particularly difficult-to-control hypertension, when available.

Optimal **STEP 4 Quadruple combination (resistant hypertension)**

STEP 5 Resistant hypertension uncontrolled on 4 drugs

✓ Individualize therapy and apply class-specific safety monitoring.

Targeting mechanisms beyond conventional RAAS blockade

Endothelin receptor antagonist

APROCITENTAN

Dual ETA/ETB blockade
Reduces endothelin-mediated vasoconstriction.
Approved add-on therapy for resistant HTN
Watch-out: fluid retention, oedema and possible HF worsening esp. in CKD, pre-existing CVD

Non-steroidal MRA (3rd generation)

ESAXERENONE

Highly Selective mineralocorticoid-receptor blockade; once-daily add-on option. Proven efficacy in untreated HTN, resistant HTN, and CKD.
Available in Japan.
Monitor serum potassium and renal function, similar to other RASS inhibitors

Aldosterone synthase inhibitors

BAXDROSTAT • LORUNDROSTAT

Inhibit aldosterone synthesis at its source; May add BP lowering for uncontrolled or resistant HTN.
Monitor potassium and also sodium, especially in CKD.

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LONG-ACTING RRAS SILENCING & METABOLICALLY INFORMED BP CARE

Two complementary directions: durable pathway inhibition and treatment of obesity-related risk

Angiotensinogen-targeting siRNA

ZILEBESIRAN

Subcutaneous siRNA suppresses hepatic angiotensinogen production, providing prolonged RAS inhibition;
BP-lowering efficacy reported for at least 6 months.
Potential advantage: infrequent dosing may support adherence.
Not yet marketed in the guideline.

Incretin–based therapies

SEMAGLUTIDE * • TIRZEPATIDE * *

Weight loss and metabolic improvement can contribute to lower systolic BP and cardiovascular-risk reduction, especially in people with obesity or high CV risk.

* GLP-1 receptor agonist
* * Dual GIP/GLP-1 receptor agonist.

Safety & implementation

Watch-out: hypotension, renal-function changes and hyperkalemia;
Prolonged effect cannot be rapidly withdrawn.
Select patients carefully.

How to position incretin–based treatment

Use for appropriate metabolic/obesity indications—
Not as a substitute for established antihypertensive therapy when BP targets are unmet.

Take-home: emerging therapies broaden mechanism-based options, but availability, regulatory status, outcome evidence and patient selection differ by agent and country.

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Renal Denervation and Treatment Adherence



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RENAL DENERVATION

OPTIMAL

Potential Indications

1. **True resistant hypertension:** uncontrolled BP on ≥4 drugs at max doses, (ACEI or ARB, CCB, diuretic, and aldosterone-targeting drug.
2. **Uncontrolled hypertension** on fewer than the above drugs, due to intolerable adverse effects.

Requirements

- ✓ **Exclude** poor adherence, the white-coat effect (ABPM), secondary hypertension.
- ✓ **eGFR** ≥40 ml/min/1.73 m^2.
- ✓ No **renal artery** abnormalities.
- ✓ Consideration of the **individual's** cardiovascular risk, life expectancy and preferences.
- ✓ **Referral to an expert hypertension team** (optimization of therapy, secondary hypertension, suitability for denervation, informed discussion).

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Strategies to Improve Medication Adherence

Nonadherence

A common, neglected, measurable, modifiable cardiovascular risk factor

ESSENTIAL

- Evaluate adherence to treatment as appropriate at each visit, particularly when considering escalation of antihypertensive treatment
- Reduce polypharmacy – use single-pill combinations
- Prefer once-daily dosing to multiple daily dosing
- Link adherence behaviour to daily habits
- Medication reminder packaging (dosette boxes); other reminder systems

OPTIMAL

- Empowerment-based counselling for self-management
- Long-term standardised home BP monitoring
- Electronic adherence aids (mobile health apps or short message services)
- Digital health platforms and regular telemedicine follow-up
- Multidisciplinary healthcare team approach (pharmacists, nurses, community health workers) to enhance monitoring of adherence

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Hypertension with Comorbidities and Complications



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Cardiovascular Risk Factors

- CV risk assessment is important and should be assessed in all hypertensive patients
  - Guides treatment intensity, BP targets, and the need for additional therapies.
- More than 50% of hypertensive patients have additional CV risk factors.
- Most commonly: obesity, T2DM, lipid disorders, CK.
- Consider increased risk with: chronic inflammatory disease, COPD, OSA, psychiatric disorders, psycho-social stressors, hypertensive disorders of pregnancy.

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Hypertension-mediated organ damage (HMOD)

- HMOD defined as structural or functional alterations of arterial vasculature and/or organs it supplies caused by elevated BP.
- **Symptoms of HMOD**: chest pain, shortness of breath, palpitations, claudication, peripheral oedema, headaches, dizziness, blurred vision, nocturia, haematuria.
- Most patients with HMOD during early stages are asymptomatic.
- **HMOD assessment can provide important therapeutic guidance on:**

1. Management for hypertensive patients with low or moderate overall risk through re-classification due to presence of HMOD.
2. Preferential selection of drug treatment based on the specific impact on HMOD.

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Treatment in Patients with CKD

- CKD: eGFR <60 ml/min/1.73m2 and/or UACR 30mg/g persistent for at least 3 months.
- Use 2021 CKD-EPI eGFR equation and early morning urine sample for UACR.
- Most patients with CKD need combination antihypertensive pharmacotherapy.
- RAS blockers should be included, particularly in the presence of albuminuria.
- Sodium and water retention is a major mechanism of hypertension, as kidney function declines, and diuretics are necessary in most cases.
- In eGFR <30 ml/min/1.73 m^2, combination of loop diuretics and chlorthalidone preferred.
- SGLT2i are recommended in patients with eGFR >20 ml/ min/1.73m2 and induce a small SBP reduction.
- If albuminuria is persistent, the following should be added
  - GLP-1 RA in diabetes, obesity, or high risk of ASCVD.
  - Non-steroidal MRAs (finerenone) in diabetes (consider in people without diabetes) with normal potassium.

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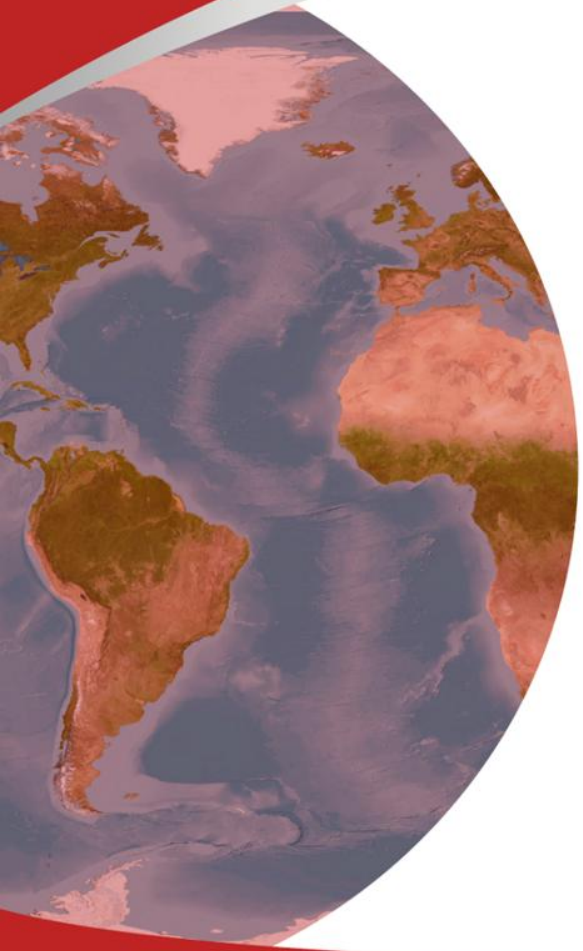
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Monitoring after initiating treatment in CKD

- Check eGFR and electrolytes 2–4weeks after initiating or titrating RAS blockers, SGLT2i, MRA, or diuretic.
- A functional decline in eGFR is expected after initiating or titrating RAS blockers, SGLT2i, or MRA.
- If it is >30%, discontinuation of the drug should be considered, which in most cases is transient as the eGFR decline is usually a reversible haemodynamic effect, and the most common cause is excessive SBP drop (due to using diuretics and other drugs)
- Hyperkalaemia is often manageable.

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Resistant Hypertension
Secondary Hypertension
Paediatric Hypertension



Erika JONES
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Causes of Uncontrolled BP to Exclude before Diagnosing Resistant Hypertension

ESSENTIAL

- Non-standardized office BP measurement.
- White-coat effect (no confirmation by home or ambulatory BP monitoring).
- Non-adherence to drug treatment.
- Suboptimal antihypertensive drug regimen.
- Substance/drug-induced hypertension.
- Secondary hypertension.

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When to Suspect Secondary Hypertension

ESSENTIAL

- Age <25 years, particularly with very high BP, hypertension-mediated organ damage, without obesity and family history of hypertension.
- Hypokalaemia, unprovoked or on a diuretic.
- Obesity, snoring, daytime sleepiness (suspected sleep apnoea).
- True resistant hypertension.
- Malignant hypertension, or very high BP (e.g. >180/120 mmHg).
- Sudden onset or sudden deterioration in BP control.
- High probability of secondary hypertension based on strong clinical and/or laboratory clues.

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Hypertension in Children and Adolescents

ESSENTIAL

- Measurement is similar to adults using validated cuffs
- Diagnosis when the sOBP >95th centile for age, over 16 as for adults
- OOBP measurements are usually necessary (optimal)
- MUST consider secondary causes
- Lifestyle modification is essential, especially with obesity
- Hypertension must be treated with drug recommendations similar to those prescribed in adults

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Hypertensive Disorders of Pregnancy



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Hypertensive Disorders of Pregnancy

1. **Pre-existing hypertension**
   Present before pregnancy or <20 weeks of gestation; persists for >12 weeks postpartum; with/without proteinuria
2. **Gestational hypertension**
   Onset ≥20 weeks of gestation; resolves before 12 weeks postpartum; no proteinuria
3. **Preeclampsia**
   Hypertension ≥20 weeks of gestation plus signs of maternal organ or uteroplacental dysfunction
4. **Eclampsia**
   Preeclampsia + seizures => emergency

ESSENTIAL

- sOBP using manual auscultatory or automated upper-arm cuff device **validated specifically in pregnancy and preeclampsia** (www.stridebp.org)
- Urinalysis, complete blood count, liver enzymes, serum uric acid and serum creatinine.
- Test for proteinuria in early and the second half of pregnancy.
  positive urine dipstick => spot UACR or protein/creatinine.

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Hypertensive Disorders of Pregnancy

1. **Pre-existing hypertension**
   Present before pregnancy or <20 weeks of gestation; persists for >12 weeks postpartum; with/without proteinuria
2. **Gestational hypertension**
   Onset ≥20 weeks of gestation; resolves before 12 weeks postpartum; no proteinuria
3. **Preeclampsia**
   Hypertension ≥20 weeks of gestation plus signs of maternal organ or uteroplacental dysfunction
4. **Eclampsia**
   Preeclampsia + seizures => emergency

OPTIMAL

- **sHBPM or ABPM**
  To detect white-coat and masked hypertension to monitor BP using devices **validated specifically in pregnancy and preeclampsia** (www.stridebp.org)

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Management of Hypertensive Disorders of Pregnancy

- **Target: <140/90mmHg;** avoid too low BP levels. **ESSENTIAL**
- **sOBP 140–159/90–109mmHg:**
  - Beta-blocker (labetalol); CCB (long-acting nifedipine); oral methyldopa; other beta-blockers or CCBs; RAS blockade is contraindicated!
- **sOBP >160/110mmHg: Emergency! Hospitalisation!**
  - Reduce BP to <160/105 mmHg within 2–3h.
  - Intravenous labetalol (or nicardipine, esmolol, hydralazine, urapidil), oral methyldopa, nifedipine or nicardipine. Consider delivery.

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Post-Partum Management of Hypertensive Disorders of Pregnancy

ESSENTIAL

- Week 1: monitor BP daily
- Provide counselling on future pregnancies
- Perform life-long annual check of BP and renal function
- Institute lifestyle changes

- **Hypertension history:** onset, duration, previous BP levels, hypertensive disorders of pregnancy, drugs or substances that increase BP, previous antihypertensive medication, side effects, and adherence to antihypertensive treatment (see **Section 7.5**).

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Cardiovascular risk factors

- Age ≥55 years in men; ≥65 years in women
- Sex (men > women at age <65 years)
- Family history of premature CVD
- BMI ≥30 kg/m^2 (lower in Asian populations)
- Diabetes mellitus
- Dyslipidaemia (high LDL-C, TG, low HDL-C)
- Smoking
- Chronic inflammatory diseases
- Psychosocial and socioeconomic factors
- Obstructive sleep apnoea
- Resting heart rate >80 beats/min
- Early-onset menopause
- Hypertensive disorders of pregnancy
- Non-adherence to treatment of CVD risk factors

Prevention of Preeclampsia

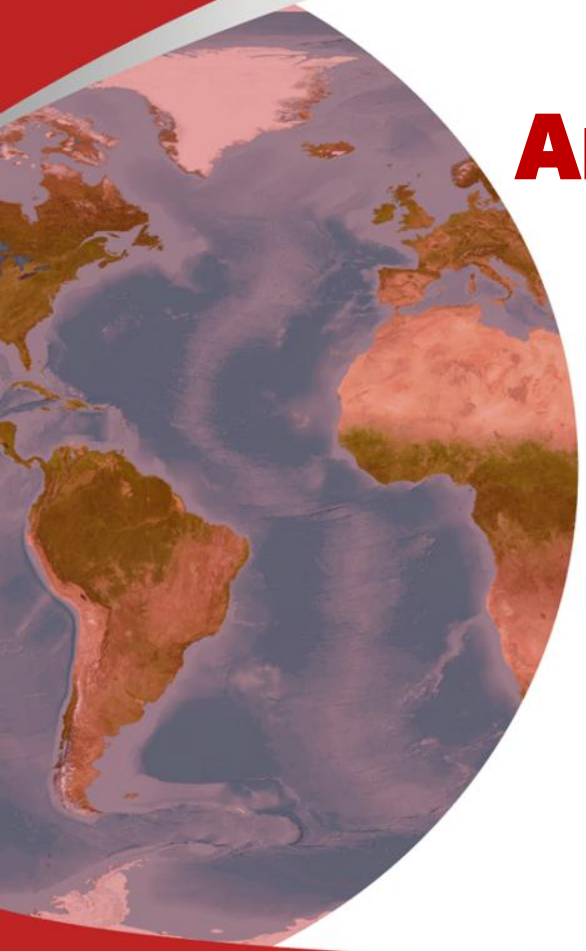
ESSENTIAL

- Low-to-moderate intensity exercise.
- Women at increased risk: 100–150mg aspirin at weeks 12–36.
- Women with low dietary calcium intake (<600mg/day): Oral supplementation with calcium about 1 g/day.

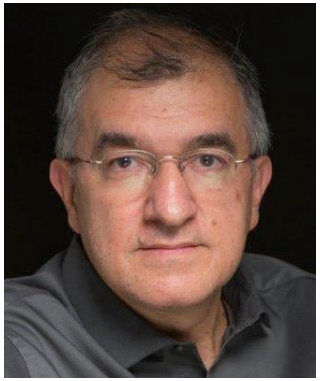
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Hypertensive Emergencies Ambient Temperature And BP



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Hypertensive Emergencies

- ✓ A very high BP (usually 180/120 mmHg) **with** acute organ damage. Sites of organ damage include the retina, brain, heart, large arteries, and kidneys.
- ✓ A rapid diagnostic assessment and immediate BP reduction is mandatory to prevent progressive organ damage and failure.
- ✓ Patients with asymptomatic markedly elevated BP, **without** evidence of acute target-organ damage, are not considered to have a hypertensive emergency.

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Clinical Presentation and Key Diagnostic Work-up for Usual Etiologies of Hypertensive Emergencies

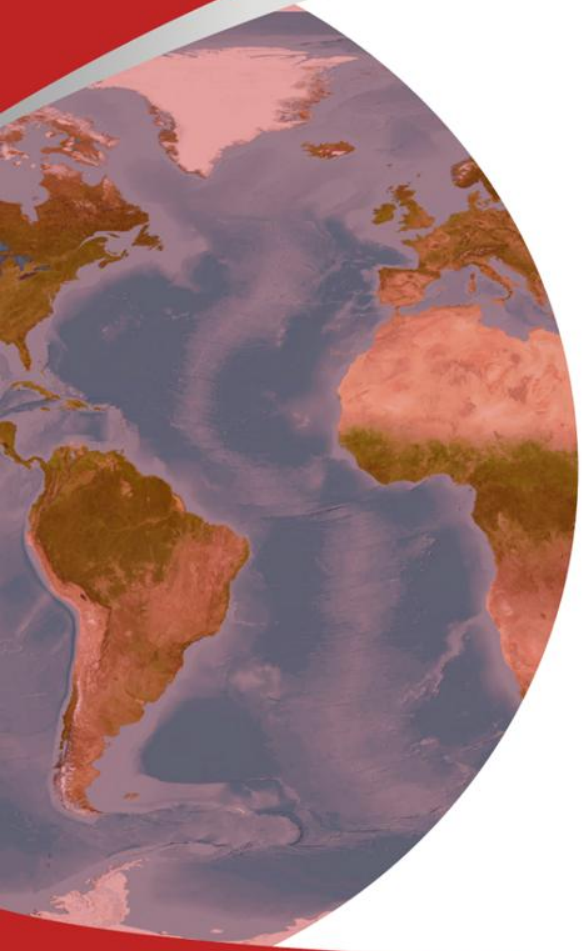
Etiology / suspected target-organ injury	Rapid, high-yield diagnostic tests
Hypertensive encephalopathy	Non-contrast head CT (rule-out bleed/ischaemia) or MRI-brain (more sensitive for PRES) CBC, creatinine, urinalysis (micro-angiopathy, AKI) ECG & chest-X-ray(baseline & pulmonary oedema)
Acute ischaemic stroke	Non-contrast head CT (first-line) ± CT-angiography/CT-perfusion to map vessel occlusion/penumbra Bedside glucose, CBC, INR/PTT before rt-PA
Intracerebral / subarachnoid haemorrhage	Emergent non-contrast CT head (diagnostic within < 6 h) · CT-angiography to screen for aneurysm/AVM · Coagulation panel
Acute aortic dissection	ECG-gated CT-angiography of chest/abdomen(gold standard) Point-of-care echo/POCUS(pericardial effusion, flap) ECG (rule out STEMI)
Acute coronary syndrome	12-lead ECG (immediately, repeat q15-30 min) Serial high-sensitivity troponin I/T (0 h/1–2 h) Chest X-ray (exclude other causes, pulmonary oedema)
Acute cardiogenic pulmonary oedema	Chest X-ray (vascular redistribution, interstitial/alveolar oedema) Lung POCUS(B-lines), bedside echo (LV function) BNP/NT-proBNP, troponin, ECG
Malignant hypertension with acute renal failure or thrombotic microangiopathy	CBC with smear (schistocytes, thrombocytopenia) LDH, haptoglobin(haemolysis) Creatinine/eGFR, urinalysis(proteinuria, haematuria)

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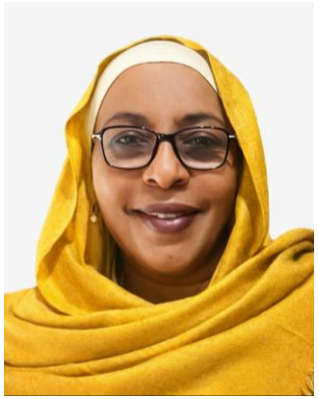
Acute BP Reduction Approach and Preferred Drugs for Common Hypertensive Emergencies

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Clinical presentation	Timeline and target BP	First-line treatment	Alternative
Malignant hypertension	Several hours; mean arterial pressure −20% to −25%	Labetalol, Nicardipine	Nitroprusside, Urapidil
Hypertensive encephalopathy	Immediate; mean arterial pressure −20% to −25%	Labetalol, Nicardipine	Nitroprusside
Acute ischaemic stroke and BP >220/120 mmHg, or >185/110 mmHg with indication for thrombolysis	1 h; mean arterial pressure −15%	Labetalol, Nicardipine	Nitroprusside
Acute haemorrhagic stroke and SBP >180 mmHg	Immediate; systolic 130 < BP < 180 mmHg	Labetalol, Nicardipine	Urapidil
Acute coronary event	Immediate; SBP <140 mmHg	Nitroglycerine, Labetalol	Urapidil
Acute pulmonary oedema	Immediate; SBP <140 mmHg	Nitroprusside or Nitroglycerine with loop diuretic	Urapidil (with loop diuretic)
Acute aortic dissection	Immediate; SBP <120 mmHg and heart rate <60 bpm	Esmolol and Nitroprusside or Nitroglycerine or Nicardipine	Labetalol or Metoprolol
Severe preeclampsia and eclampsia, HELLP	Immediate; SBP <160 mmHg and diastolic <105 mmHg	Labetalol or Nicardipine and magnesium sulphate	



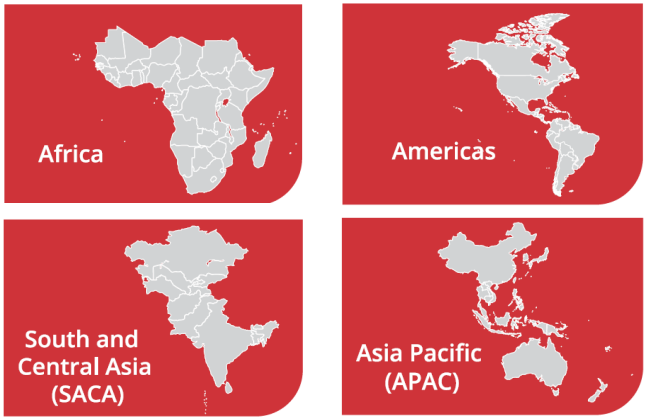
Ethnic and Regional Differences



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Ethnic and Regional Differences in Hypertension



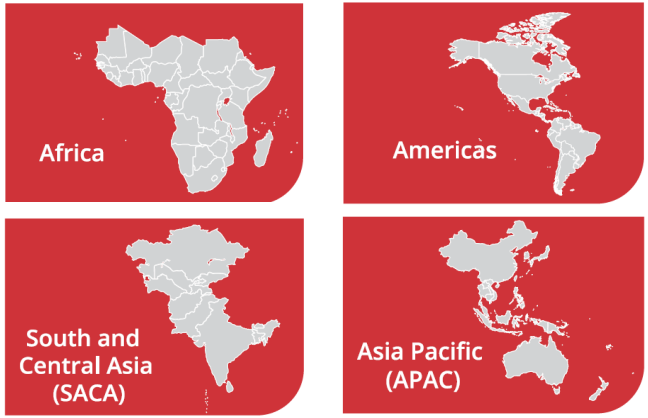
- Genetic
- Environmental
- Cultural
- Lifestyle
- Socioeconomic
- Healthcare

- HMOD and CVD complications
- BP response to antihypertensive drugs
- Frequency of some adverse drug effects

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Ethnic and Regional Differences in Hypertension



- Africa & African-descent populations
- Asian populations
- Eastern European populations
- Latin American populations
- Migrant populations

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Africa And African-descent Populations

- Earlier hypertension and HMOD
- Resistant hypertension
- Higher CKD, stroke, heart failure, and premature CV mortality
- Treatment: CCB + diuretic or ACEi/ARB-based regimens.

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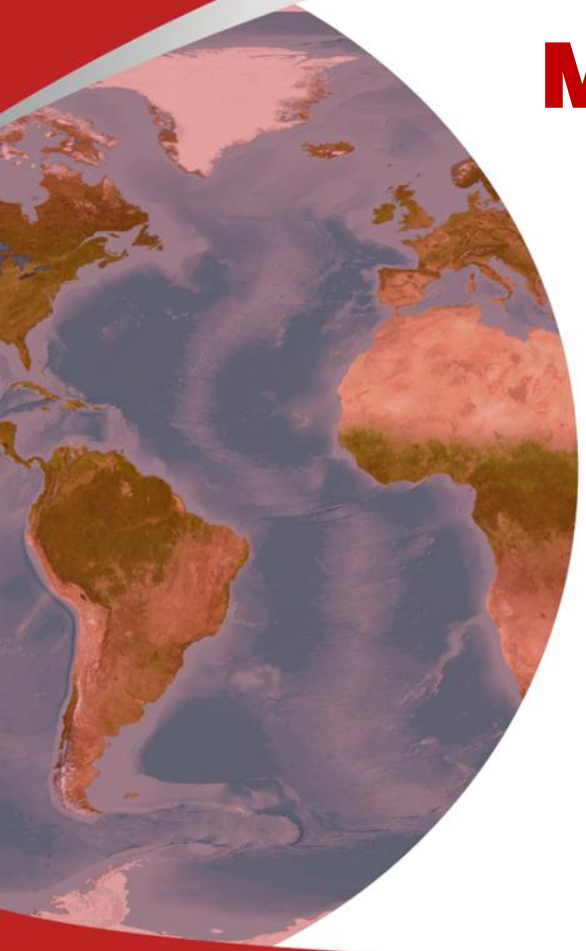
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Asian Populations

- Greater salt sensitivity.
- High sodium and low potassium intake.
- Increased stroke risk.
- Higher hypertension and diabetes risk at any given BMI.
- Earlier onset of CAD and type-2 diabetes (South Asians).

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Models of Hypertension Care
Effective Hypertension Care



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2026 ISH recommendations for task-sharing in hypertension care



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J Hypertens 2026;44:2157-88.

- Identify qualified stakeholders - develop a standardised training curriculum.
- Healthcare workers: nurses, physician assistants, community health workers, pharmacists, other.
- Expand physician-centred, clinic-based care to include community outreach services.
- Hypertension societies: train master trainers, to train NPHPs.
- Dietitians: adapt to locally available/affordable foods.
- Access to psychosocial support.
- Mobile-health technologies

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Effective hypertension care pathway

Diagnosis



- Screen for high BP at every healthcare encounter and through community screening where feasible
- Use validated electronic cuff BP devices
- Use standardised office BP measurement
- Confirm high BP with standardised home or ambulatory monitoring where available and feasible
- Assess organ damage and cardiovascular risk, particularly in apparently low-risk individuals

Treatment



- Implement affordable lifestyle interventions before and during drug treatment
- Do not delay drug treatment beyond the recommended time frame
- Ensure that patients understand and agree with the treatment plan, BP target, and follow-up plan

Control



- Follow evidence-based treatment algorithms and the recommended time frames for treatment intensification
- Review monthly until BP control is achieved, using in-person or virtual visits
- Achieve target BP within 3 months
- Simplify treatment regimen (once-daily dosing; single-pill combinations)
- Check adherence at every visit

Follow up



- Do not accept BP above the target without appropriate action
- Implement long-term standardised home BP monitoring
- Review well-controlled low-risk patients every 6-12 months
- Review well-controlled high-risk patients every 3-6 months, according to clinical status and other comorbidities
- Use digital health and telemedicine where available

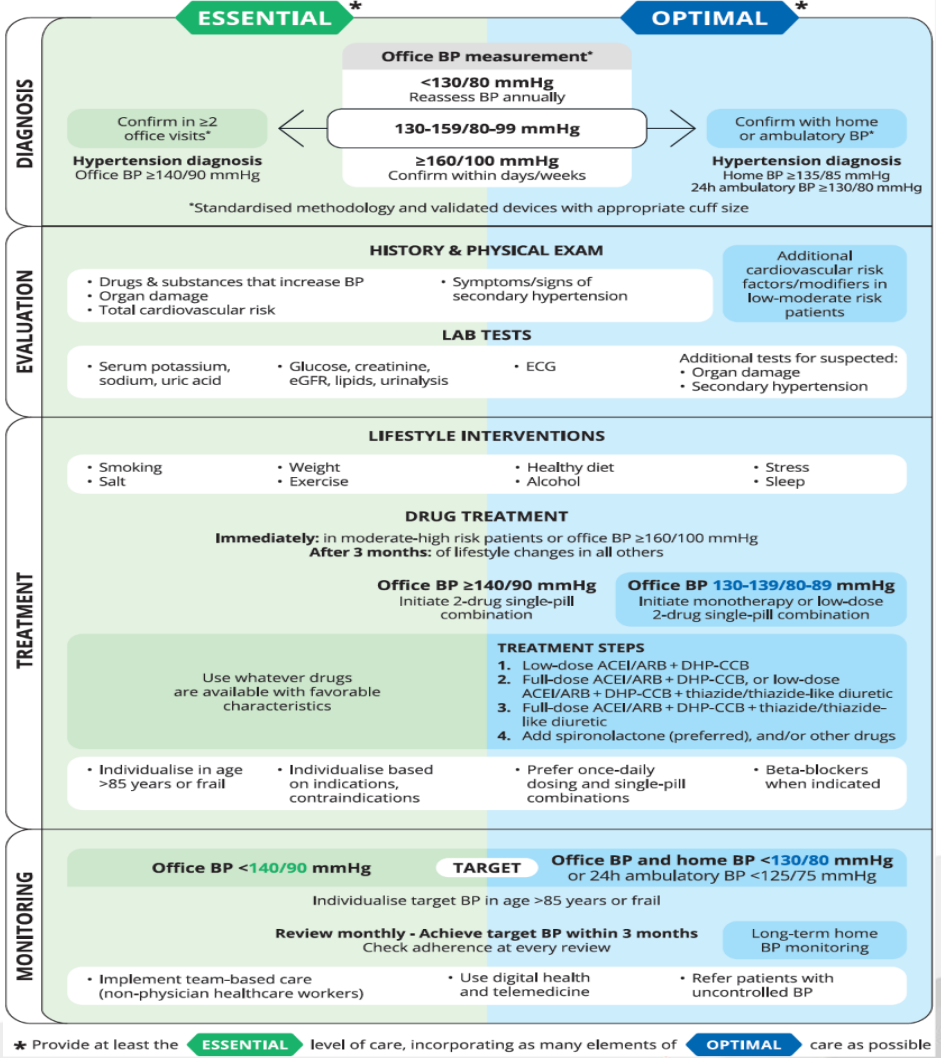
Implement task-sharing models of care involving non-physician healthcare professionals at all stages

2026 ISH Global Practice Guidelines
J Hypertens 2026;44:2157-88.

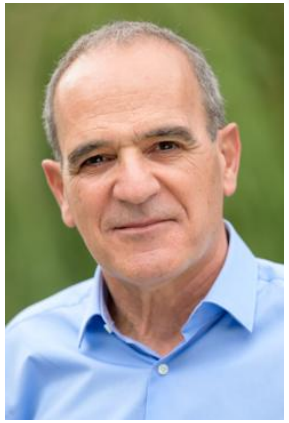
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Hypertension management at a glance

2026 ISH Global Practice Guidelines
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Guidelines Implementation ISH OnTheGo and more



George STERGIOU
ISH President
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2026 International Society of Hypertension Global Hypertension Practice Guidelines

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Keywords: blood pressure measurement, cardiovascular risk, global health, hypertension, implementation

Abbreviations: ABPM, ambulatory blood pressure monitoring; ACEI, angiotensin-converting enzyme inhibitor; ARB, angiotensin II type 1 receptor blocker; BP, blood pressure; CAD, coronary artery disease; CCB, calcium channel blocker; CKD, chronic kidney disease; CVD, cardiovascular disease; DHP-CCB, dihydropyridine calcium channel blocker; eGFR, estimated glomerular filtration rate; GLP-1 RA, glucagon-like peptide-1 receptor agonist; HMOD, hypertension-mediated organ damage; IH, International Society of Hypertension; LMICs, low-income and middle-income countries; LVH, left ventricular hypertrophy; MRA, mineralocorticoid receptor antagonist; NPHP, non-physician health care professionals; OSA, obstructive sleep apnoea; RAAS, renin–angiotensin–aldosterone system; RAS, renin–angiotensin system; sHBPM, standardised home blood pressure monitoring; SGLT2i, sodium–glucose transporter-2 inhibitors; sOBP, standardised office blood pressure; UACR, urinary albumin-to-creatinine ratio.

2021 showed that high BP contributes to 53% of global cardiovascular disease (CVD) mortality, 58% of stroke deaths, and 31% of chronic kidney disease (CKD) deaths [1]. Its prevalence ranges between 30–79 years with approximately 1.4 billion people aged 30–79 years having hypertension worldwide [1,2]. It is believable that in 1990 and is projected to rise further, likely exceeding 1.5 billion by 2030 if no action is taken, due to global population growth and ageing. Global trends show a clear shift in the highest prevalence levels from high-income to low-income regions [3], with an estimated 349 million people with hypertension living in high-income countries and 1 billion in low-income countries (LMICs) [5].

Despite strong evidence supporting the benefits of effective hypertension management and the availability of many effective, low-cost medications, in about half of all countries national hypertension control rates remain <20% [4]. Only about 20% of people with hypertension worldwide have their BP controlled to <140/90 mmHg (and substantially fewer to <130/80 mmHg) [1–4]. In low-income countries, control rates are particularly poor, often

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SECTION 1: INTRODUCTION

The global burden of hypertension

High blood pressure (BP) remains a critical global

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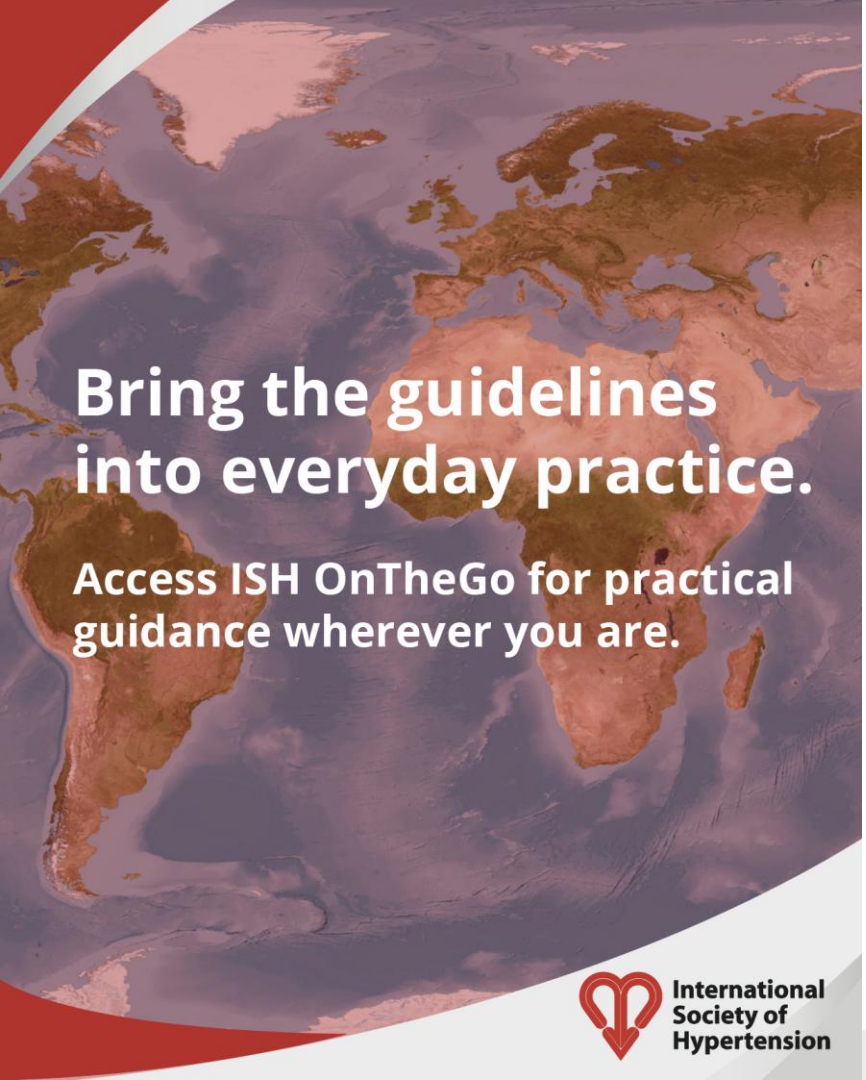
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