BREAKING NEWS

32nd EUROPEAN MEETING ON HYPERTENSION AND CARDIOVASCULAR PROTECTION

Day 2

Top Takeaways – ESH 2023

I. Extended Guideline Risk Assessment

Factors Influencing CV Risk in Patients with Hypertension have included additional clinical conditions or co-morbidities as listed below

- Resistant hypertension
- Sleep disorders (including OSA)
- COPD
- Gout
- Chronic inflammatory diseases
- Nonalcoholic fatty liver disease (NASH)
- Chronic infections (including long COVID-19)
- Migraine
- Depressive syndromes
- Erectile dysfunction

II. Hypertension Management

- **Initiation of two-drug combination therapy is recommended for most hypertensive patients (Grade IA)**
- **Preferred combinations should comprise a RAAS Blocker (either an ACEi or ARB) with a CCB or Thiazide/Thiazide like Diuretics (Grade IA)**
- **The use of single-pill combination (SPCs) should be preferred at any treatment step i.e., during initiation of therapy with a two-drug combination and at any other step of treatment (Grade IB)**
- **Thiazide/ Thiazide like Diuretics are recommended in resistant hypertension if estimated e-.GFR. is > 30 ml/min/1.73 m2 (Grade IB)**
- **Chlorthalidone (12.5 mg to 25 mg once daily) could be used with or without a loop diuretic if e-.GFR is < 30 ml/min/1.73 m2 (Grade IIB)**

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III. Reappraisal of Beta Blockers

- Beta Blockers can be used as monotherapy or at any step of combination therapy or at any treatment step as Guideline Directed Medical Therapy (Grade IA)
- Selected other conditions in which therapy with Beta Blockers (BBs) can be favorable

  - Hypertension with elevated resting heart rate >80 bpm
  - Emergency, urgency, and parenteral administration
  - Perioperative hypertension Major noncardiac surgery
  - Excessive pressor response to exercise and stress
  - Hyperkinetic heart syndrome
  - Postural orthostatic tachycardia syndrome Orthostatic hypertension
  - Obstructive Sleep Apnoea (OSA)
  - Peripheral arterial disease with claudication
  - COPD
  - Portal hypertension, cirrhosis-related esophageal varices, and recurrent variceal bleeding
  - Glaucoma
  - Thyrotoxicosis, hyperthyroidism Hyperparathyroidism in uremia
  - Migraine headache
  - Essential tremor
  - Performance anxiety and anxiety disorders Psychiatric disorders (posttraumatic stress)

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IV. Diversified HMOD Markers & Their Prognostic Value

Marker of HMOD	Sensitivity to changes	Reproducibility and operator independence	Time to Changes	Prognostic value of changes
LVH by ECG	Low	High	Moderate (>6 months)	Yes
LVH by echocardiogram	Moderate	Moderate	Moderate (>6 months)	Yes
LVH by MRI	High	High	Moderate (>6 months)	No data
eGFR	Moderate	High	Moderate (>6 months)	Yes
UACR	High	Moderate	Fast (weeks to months)	Yes
RRI	Low	High	Slow (>12 months)	Yes
Carotid IMT	Very Low	Low	Slow (>12 months)	Limited Data
PWV	High	Low	Fast (weeks to months)	Limited Data
ABI	Low	Moderate	Slow (>12 months)	Limited Data
Retina Microvasculatura	High	High	Moderate (>6 months)	No Data

COR:I
COR:II
COR:III

IMT: Intima Media thickness, PWV: pulse wave velocity,ABI: ankle-brachial index, E-GFR: Estimated Glomerular Filtration Rate,\UACR: Urine albumin-to-creatinine ratio, RRI: Renal Resistive Index, LVH: Left ventricular hypertrophy,HMOD: Hypertension-Mediated Organ Damage, ECG: Electrocardiogram,MRI: Magnetic resonance imaging, COR: Class of Recommendations

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V. Night Time Blood Pressure Significance

- Information on CV Modulation during sleep in health & disease, including sleep-disordered breathing (SDB)
- Diagnose Masked Hypertension due to isolated nocturnal hypertension (HT)
- Allows to check the occurrence of smooth and effective BP control over 24-h, including the night
- Strong prognostic value in predicting CV outcomes

VI. Ten Commandments for Single Pill Combination

Ten Commandments for Single-Pill Combination Treatment

- Avoid monotherapy trap
- Select an optimal core drug
- Select optimal companions for the core drug
- Choose the appropriate double drug single-pill combination (SPC)
- Base decision-making based on both – Office & Out of Office Blood Pressure
- Verify compliance before you intensify treatment
- Be prepared for the need for a triple single-pill combination (SPC)
- Do not prematurely diagnose resistant hypertension
- Seek to Evidence-Based Medicine (EBM) data
- Follow the Guidelines

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VII. Elderly & Frail Population: What's New ?

Recommendations in the 2023 ESH Guidelines: What is new?

65-79 years group

- Initiation of treatment should be considered for most patients when office SBP ≥ 140 mmHg or DBP ≥ 90 mmHg (I/A). In patients with ISH, SBP threshold could be 160 mmH in the most frail or if DBP <70 mmHg.
- Therapeutic strategies and BP targets are similar to those proposed for middle-aged patients: SBP<140 mmlg and in some cases <130 and DBP<80 mmHg (I/A). Initiation of treatment with a two-drug combination is also recommended in most patients who are not frail (I/C).
- The rhythms to reach these targets will be inversely correlated to the frailty levels of the patients, starting at lower doses and up-titrating more slowly if necessary (I/C).
- The search for orthostatic hypotension in all patients >65 years should be systematic, even in the absence of symptoms (I/C).
- In these guidelines, we identified two age-groups of "older adults": 65-79 years and ≥80 years.
- Most individuals in the "65-79 group" have preserved functional status, low frailty level, whereas the "280 group" presents a large functional heterogeneity with a substantial percentage of very frail/dependent individuals.
- Therefore, an initial assessment of the functional status/frailty level should be performed with simple and rapid methods (I/C). This assessment should be repeated often since health status can rapidly deteriorate in older people.

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