

Key Features of the European Society of Hypertension-European Society of Cardiology 2007 Guidelines for the Management of Arterial Hypertension

Definition and Classification of Hypertension

- Proper blood pressure measurement *plus* assessment of total cardiovascular (CV) risk is required to diagnose high blood pressure and guide treatment.
- Absolute risk is used to guide treatment in the elderly and relative risk in younger patients.
- Emphasis on the importance of blood pressure reduction *per se* for protecting hypertensive patients.
- Classification of blood pressure in the 2003 ESH/ESC Guidelines has been retained, with three provisos:
 - If a systolic and diastolic blood pressure fall into different categories, the higher category is used to quantify total CV risk, decisions about drug treatment, and estimation of treatment efficacy.
 - Isolated systolic hypertension should be graded (grades 1, 2, 3) according to the same systolic blood pressure values indicated for systolic-diastolic blood pressure. The association with a low diastolic blood pressure should be considered an additional risk.
 - The threshold for defining and treating hypertension should be considered flexible, based on the blood pressure level and total CV risk.
- Multiple risk factors, diabetes, or organ damage places a person with hypertension (even high normal) in the high-risk category.

Goals of Treatment

- Reduce blood pressure to reduce risk and prevent CV events.
- Prevent worsening of organ damage.
- Prevent appearance of high-risk conditions, such as diabetes, proteinuria, among others.

Treatment

- Emphasis on a "flexible threshold" for initiating drug treatment: >140/90 mmHg in all hypertensive patients, and <140/90 mmHg in high-risk patients.
- Drug treatment should be initiated in persons who were considered as normotensive in the previous guidelines.
- Lifestyle changes are recommended for everyone.
- Several drug classes can be used to initiate and maintain antihypertensive treatment.
 - Evidence supports the importance of BP reduction *per se* rather than the drug selected to initiate treatment to obtain the greatest benefit.
- Evidence supports the use of some drugs versus others in various conditions, outlined in the Guidelines.
- Combination treatment should also be considered as a very good first treatment option.
- In high-risk patients, the degree of BP reduction in the first 6 months is crucial to prevent events.
- Target BP <130/80 mmHg for patients with diabetes, renal disease, cerebrovascular disease, and coronary heart disease.
- The therapeutic approach in special conditions is detailed in the Guidelines, along with simplified recommendations in the position statements.

Identification of Organ Damage

- More tests of organ damage, with more evidence supporting the recommendations for routine and recommended assessments.
- Measure organ damage in more tissues (heart, blood vessels, kidney, brain) because multiorgan damage is associated with worse prognosis.
- Routine assessment of organ damage now includes microalbuminuria, along with serum creatinine, estimated glomerular filtration rate (GFR) or estimated creatinine clearance, among others.
- Recommended assessments of organ damage now includes ankle-brachial ratio and pulse wave velocity.
- Organ damage should be assessed throughout treatment.

(http://www.eshonline.org/education/congresses/2007/esh/esh_esc_2007_special_section2.asp
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