Recommandations ESC – Actualisation

Hypertension Artérielle (ESH 2023)

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Prises en charge pour des congrès et des soirées de formation des correspondants :

- Servier, Medtronic, Novartis, Novonordisk, Bouchara-recordati, Bayer, Astrazeneca.

Certaines choses ne changent pas

2023 ESH Guidelines for the management of arterial hypertension

TABLE 1. Classification of office BP and definitions of hypertension grades

Category	Systolic (mmHg)		Diastolic (mmHg)
Optimal	<120	and	<80
Normal	120–129	and	80–84
High-normal	130–139	and/or	85–89
Grade 1 hypertension	140–159	and/or	90–99
Grade 2 hypertension	160–179	and/or	100–109
Grade 3 hypertension	≥180	and/or	≥110
Isolated systolic hypertension[a]	≥140	and	<90
Isolated diastolic hypertension	<140	and	≥90

The BP category is defined by the highest level of BP, whether systolic or diastolic.
[a]Isolated systolic or diastolic hypertension is graded 1, 2 or 3 according to SBP and DBP values in the ranges indicated. The same classification is used for adolescents ≥16 years old (Section 15.1).

TABLE 4. Definitions of hypertension according to the correspondence of home and ambulatory BP values with office BP

Method	SBP (mmHg)		DBP (mmHg)
Office BP[a]	≥140	and/or	≥90
Ambulatory BP			
Awake mean	≥135	and/or	≥85
Asleep mean	≥120	and/or	≥70
24 h mean	≥130	and/or	≥80
Home BP mean	≥135	and/or	≥85

Sécuriser la mesure de la PA

2023 ESH Guidelines for the management of arterial hypertension

Recommendations and statements	CoR	LoE
Office BP is recommended for diagnosis of hypertension, because it is the one method by which hypertension-related risk, benefits of antihypertensive treatment, and treatment-related BP thresholds and goals are based.		A
Office BP measurements should be performed in standardized conditions, using a standard measurement protocol. Triplicate measurements should be taken and the average of the last two should be referred to as the representative value.	I	C
It is recommended to diagnose hypertension during at least 2 separate office visits (within 4 weeks) unless office BP indicates grade 3 hypertension (≥180/110 mmHg) or patients presents with hypertension related symptoms or there is evidence of HMOD or CVD.	I	C
At the first office visit, BP should be measured in both arms. A consistent between-arm SBP difference >15-20 mmHg suggests atheromatous disease and is associated with increased CV risk. All subsequent measurements should be made on the arm with the highest BP readings.	I	C
Out-of-office BP is a source of multiple BP-related information before and during treatment. It is therefore recommended to obtain additional information on BP values by ABPM or HBPM or both if available.	I	C

Recommendations and statements	CoR	LoE
Automatic electronic, upper-arm cuff devices are recommended for office and out-of-office BP measurement (home and ambulatory).	I	B
Hybrid manual auscultatory devices with LCD or LED display, or digital countdown, or shock-resistant aneroid devices can be used for office BP measurement if automated devices are not available.	I	B
Only properly validated devices should be used. www.stridebp.org	I	B
Cuffless BP devices should not be used for the evaluation or management of hypertension in clinical practice.	III	C

Eliminer une HTA secondaire

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Elargissement des indications ++

TABLE 13. Patient characteristics that should raise the suspicion of secondary hypertension

Younger patients (<40 years) with grade 2 or 3 hypertension or hypertension of any grade in childhood
Sudden onset of hypertension in individuals with previously documented normotension
Acute worsening of BP control in patients with previously well controlled by treatment
True resistant hypertension hypertension
Hypertensive emergency
Severe (grade 3) or malignant hypertension
Severe and/or extensive HMOD, particularly if disproportionate for the duration and severity of the BP elevation
Clinical or biochemical features suggestive of endocrine causes of hypertension
Clinical features suggestive of renovascular hypertension or fibromuscular dysplasia
Clinical features suggestive of obstructive sleep apnea
Severe hypertension in pregnancy (>160/110 mmHg) or acute worsening of BP control in pregnant women with preexisting hypertension

Il faut screener au moins 30% des hypertendus

Toxique proHTA – HAP – Néphropathie – Sténose artérielle rénale

Evaluer le risque cardiovasculaire

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Hypertension disease staging	Other risk factors, HMOD, CVD or CKD	BP (mmHg) grading			
		High-normal SBP 130–139 DBP 85–89	Grade 1 SBP 140–159 DBP 90–99	Grade 2 SBP 160–179 DBP 100–109	Grade 3 SBP ≥ 180 DBP ≥ 110
Stage 1	No other risk factors[a]	Low risk	Low risk	Moderate risk	High risk
	1 or 2 risk factors	Low risk	Moderate risk	Moderate to high risk	High risk
	≥3 risk factors	Low to moderate risk	Moderate to high risk	High risk	High risk
Stage 2	HMOD, CKD grade 3, or diabetes mellitus	Moderate to high risk	High risk	High risk	Very high risk
Stage 3	Established CVD or CKD grade ≥4	Very high risk	Very high risk	Very high risk	Very high risk

	<50 years	60–69 years	≥70 years
	<2.5%	<5%	<7.5%
	2.5 to <7.5%	5 to <10%	7.5 to <15%
	≥7.5%	≥10%	≥15%

Complementary risk estimation in Stage 1 with SCORE2/SCOR2-OP

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Grâce au BILAN INITIAL

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History of possible secondary hypertension

- Young onset of grade 2 or 3 hypertension (<40 years), or sudden development of hypertension or rapidly worsening BP in older patients
- History of repetitive renal/urinary tract disease
- Repetitive episodes of sweating, headache, anxiety or palpitations, suggestive of pheochromocytoma
- History of spontaneous or diuretic-provoked hypokalemia, episodes of muscle weakness and tetany (hyperaldosteronism)
- Symptoms suggestive of thyroid disease or hyperparathyroidism
- History of or current pregnancy, postmenopausal status and oral contraceptive use or hormonal substitution

Signs of secondary hypertension (Section 6)

- Skin inspection: cafe-au-lait patches of neurofibromatosis (pheochromocytoma)
- Kidney palpation for signs of renal enlargement in polycystic kidney disease
- Auscultation of heart and renal arteries for murmurs or bruits indicative of aortic coarctation, or renovascular hypertension
- Signs of Cushing's disease or acromegaly
- Signs of thyroid disease

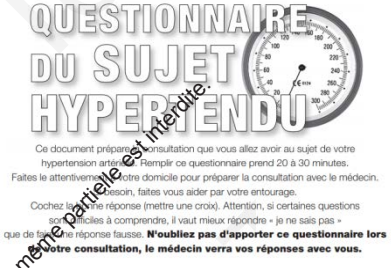

TABLE 8. Selected standard laboratory tests for work-up of hypertensive patients[a]

- Hemoglobin and/or hematocrit
- Fasting blood glucose and HbA1c
- Blood lipids: total cholesterol, LDL cholesterol, HDL cholesterol, triglycerides
- Blood potassium and sodium
- Blood uric acid
- Blood creatinine (and/or cystatin C) for estimating GFR with eGFR[a] formulas
- Blood calcium
- Urine analysis (first voided urine in the morning), multicomponent dipstick test in all patients, urinary albumin/creatinine ratio, microscopic examination in selected patients

Ne pas oublier le RAC !

eGFR, estimated glomerular filtration rate; HDL, high-density lipoprotein; LDL, low-density lipoprotein.
[a]Can be adapted according to the clinical circumstance.

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Traiter immédiatement !

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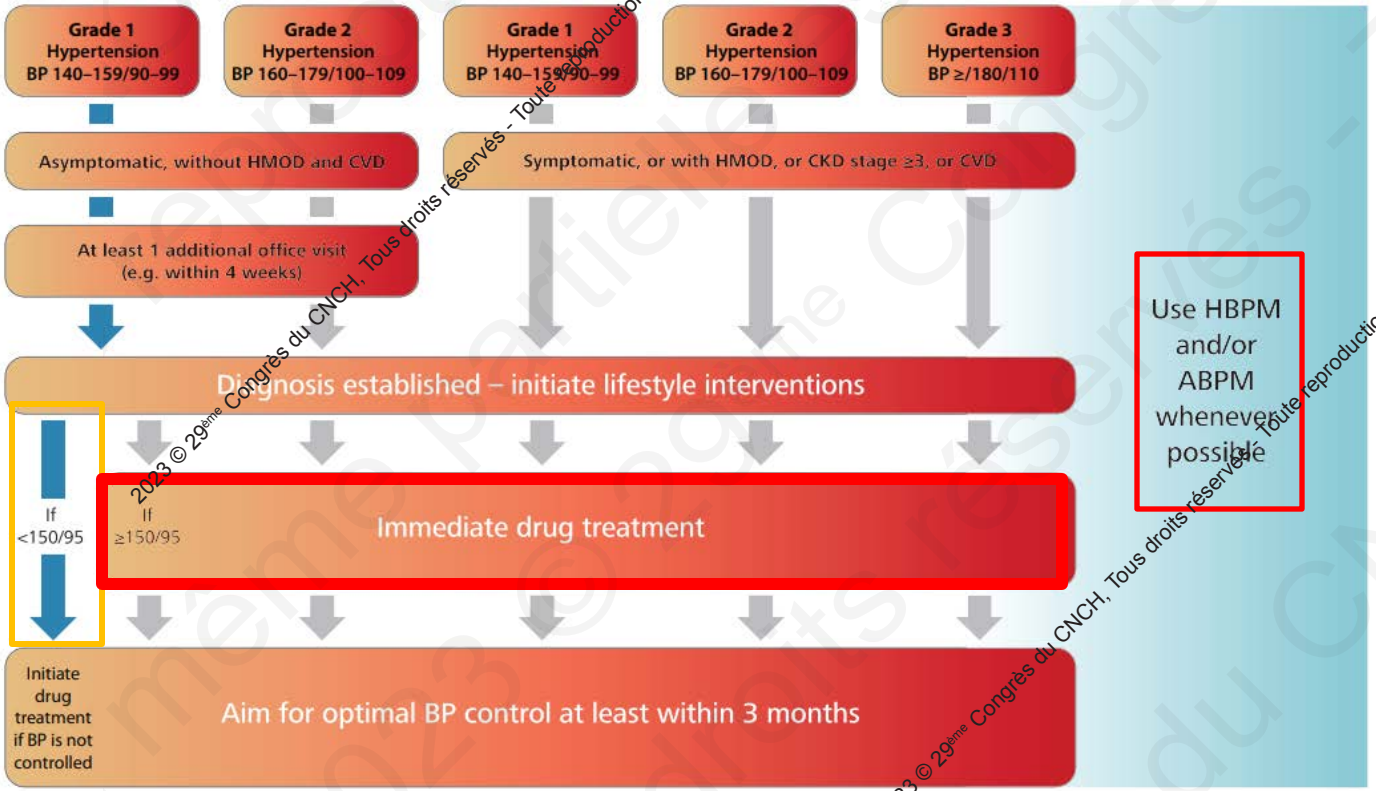

Diagnosis by office BP and initial management of hypertension.

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Titrer rapidement le traitement

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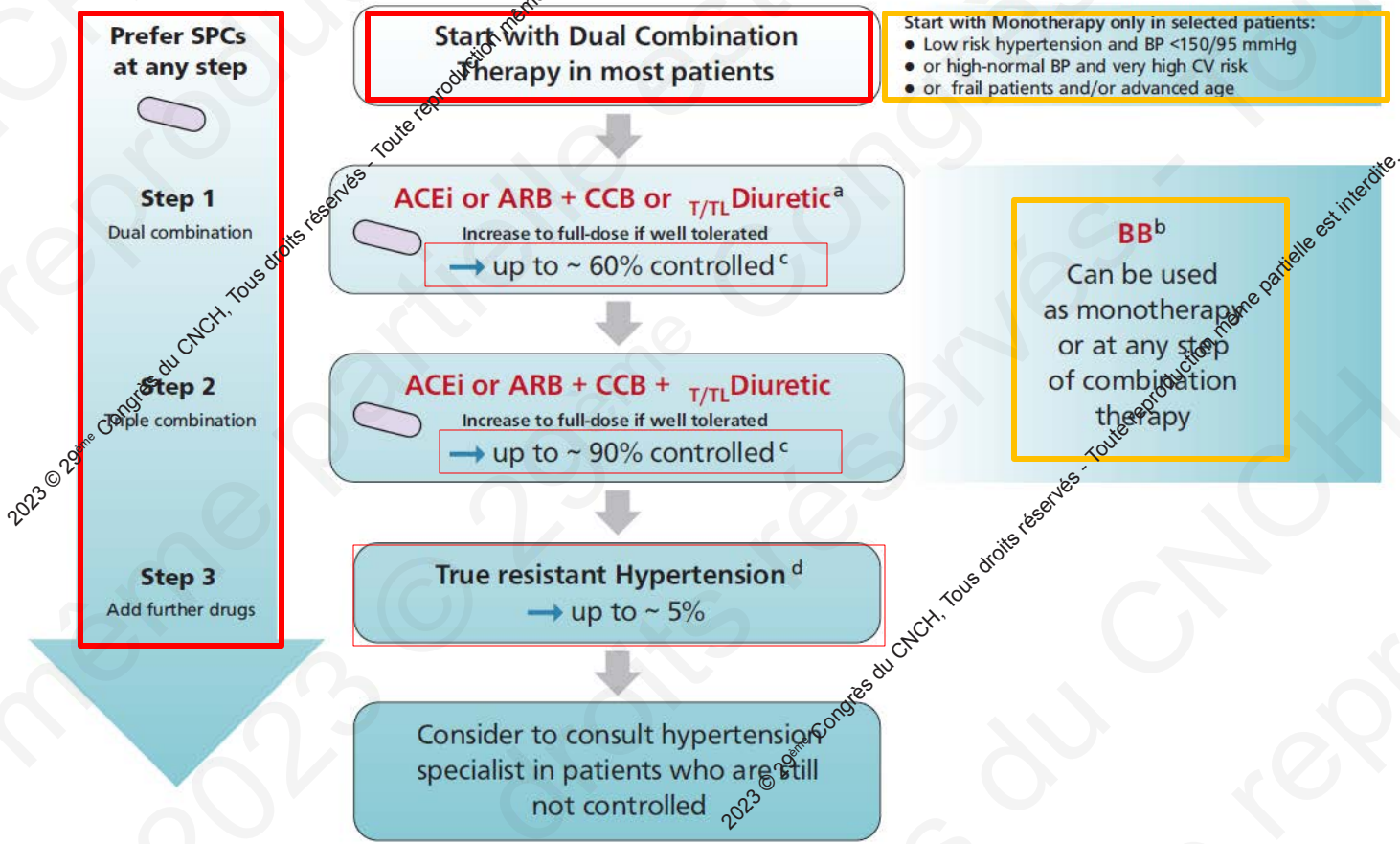

Et quand l'HTA résiste ?

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Sodium and fluid retention | Activation of SNS and RAAS | Impaired vascular function

Apparent resistant hypertension
up to 10–20%

Confirm true resistant hypertension
ABPM or HBPM
Verify medication adherence
Exclude secondary hypertension

True resistant hypertension
→ up to ~ 5%

Adapt and intensify lifestyle interventions and drug treatment

Consider to consult hypertension specialist in patients who are still not controlled

www.SFHTA.eu

European Society of Hypertension

Et quand l'HTA résiste ?

2023 ESH Guidelines for the management of arterial hypertension

Patients not controlled with
ACEi or ARB + CCB + Diuretic[b]

CKD stage 1 to 3, eGFR ≥30 ml/min/1.73 m²

Add
I) **Spironolactone**[d] (preferred) or other **MRA**[d]
or
II) **BB**[e] or **Alpha1-blocker**
or
III) **Centrally acting agent**

Consider Renal Denervation
If eGFR >40 ml/min/1.73 m²

CKD stage 4 and 5 (not on dialysis), eGFR <30 ml/min/1.73 m²

SGLT2is inhibitors are recommended for patients with diabetic and non-diabetic nephropathies CKD if eGFR is at least 20 ml/min/1.73².[a]	I	A
The non-steroidal MRA finerenone is recomended in patients with CKD and albuminuria associated with type 2 diabetes mellitus if eGFR is at least 25 ml/min/1.73² and serum potassium <5.0 mmol/L.	I	A
In CKD patients with hyperkalemia a potassium binder can be used to maintain normal or near normal serum potassium levels (<5.5 mmol/L) in order to allow optimal treatment with a RAS-blocker or a MRA to continue.	II	B

Quelles cibles viser ?

2023 ESH Guidelines for the management of arterial hypertension

Recommendations and statements	CoR	LoE
Patients 18 to 64 years old		
The goal is to lower office BP to <130/80mmHg	I	A
Patients 65 to 79 years old		
The primary goal of treatment is to lower BP to <140/80mmHg	I	A
However, lowering BP to below 130/80mmHg can be considered if treatment is well tolerated.	I	B
Patients ≥80 years old		
Office BP should be lowered to a SBP in the 140 to 150 mmHg range and to a DBP <80mmHg.	I	A
However, reduction of office SBP between 130 to 139 mmHg may be considered if well tolerated, albeit cautiously if DBP is already below 70 mmHg.	II	B
Additional safety recommendations		
In frail patients, the treatment target for office SBP and DBP should be individualised.	I	C
Do not aim to target office SBP below 120 mmHg or DBP below 70 mmHg during drug treatment.	III	C
However, in patients with low office DBP, i.e. below 70 mmHg, SBP should be still lowered, albeit cautiously, if on-treatment SBP is still well above target values	II	C
Reduction of treatment of can be consider in patient aged 80 years or older with a low SBP (< 120 mmHg) or in the presence of severe orthostatic hypotension or a high frailty level	III	C

In adult patients with a history of CVD, predominantely CAD drug treatment should be initiated in the high-normal BP range (SBP ≥130 or DBP ≥80 mmHg).	I	A

Et chez les patients porteurs d'un cancer ?

2023 ESH Guidelines for the management of arterial hypertension

Recommendations	CoR	LoR
In patients with cancer, the same definition of hypertension, thresholds, targets, lifestyle interventions and drug treatment strategies are recommended as for the general hypertension population.	I	C
In patients with uncontroilled hypertension and BP values ≥180 mmHg for systolic and/or ≥110 mmHg for diastolic BP, it is not recommended to initiate anticancer therapy.	III	
Thiazide/Thiazide-like diuretics may be used only if needed for BP control and in patients with fluid retention, because of their potential to cause unwanted effects in cancer patients including increases in serum calcium concentration in patients with bone metastasis, increased risk of cardiac arrhythmias due to prolonging the QT interval by inducing hypokalaemia, increase the risk of hyponatremia, and potential worsening of hypovolaemic states or dehydration.	II	C
Non-DHP CCBs should be avoided in cancer patients who are treated with anticancer drugs that are susceptible to pharmacokinetic interactions mediated by CYP3A4 and/or P-gp.	III	B
Hypertension induced by VEGF inhibitors may be treated with either RAS-inhibitors (ACEis or ARBs) or DHP-CCBs.	II	B
In severely ill cancer patients, treatment of hypertension should be individualised according to symptoms, co-morbidities and polypharmacy in a shared-decision making process.	I	C

Les **4 clés** pour contrôler tous vos patients

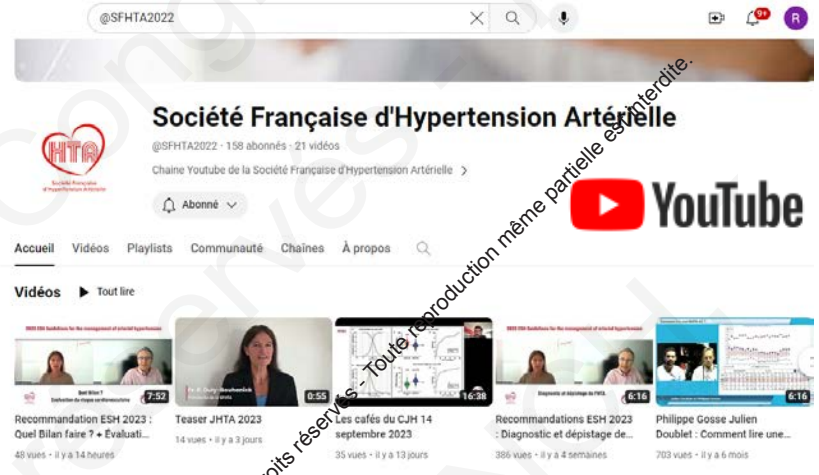
2023 ESH Guidelines
for the management
of arterial hypertension

- **Sécuriser la mesure**
  - Pas de cuffless
- **Dépister d'emblée les causes secondaires**
  - Indications élargies
- **Titrer rapidement la thérapeutique**
  - Pas d'inertie, cibler 130/80 mmHg
- **Adresser les patients sélectionnés**

Merci pour votre attention !

Cardio-online

HTA secondaires et phénotype cardiovasculaire …



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