

Hipertensión Arterial, enfoques prácticos según las últimas guías.

***Dr. Manuel Castillo Vázquez. FACC
2025***



Conflictos de interés:

No tengo conflicto de interés para esta ponencia

- Speaker: Boehringer-Ingelheim, Adium, Quimfa, Sanofi, Farmedis/Servier, Novo Nordisk.
- Advisory: Novartis, Fapasa, Eticos, Bristol-Myers-Squibb.



Clara, de 45 años, profesión arquitecta, consulta por cefalea holocraneana sin otro síntoma, no consume medicación habitual y no padece ninguna enfermedad crónica.

Antecedentes familiares con padre hipertenso y fallecido a los 65 años por IAM.

Al exámen físico: PA: 158/98, FC: 85, IMC: 31, circunferencia abdominal 114. Resto dentro de parámetros normales.

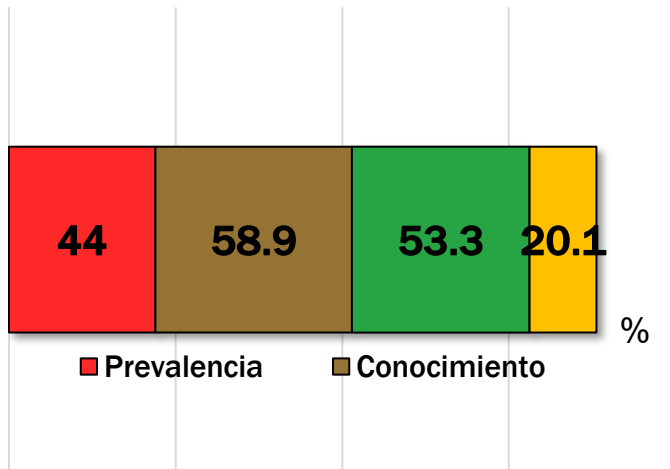


Epidemiología de la HTA en América Latina

Estudios PURE-CESCAS-CRÓNICA



- N = 33276
- 111 poblaciones urbanas y 93 rurales
- Edad: 52 años
- 60% mujeres
- 32.7% habitan zonas rurales



MMM 17-19 MANUSCRIPT TEMPLATE

PLEASE DO NOT CHANGE THE FORMAT OF THIS DOCUMENT



Title: May Measurement Month 2017-2019: an analysis of blood pressure screening results from

PARAGUAY

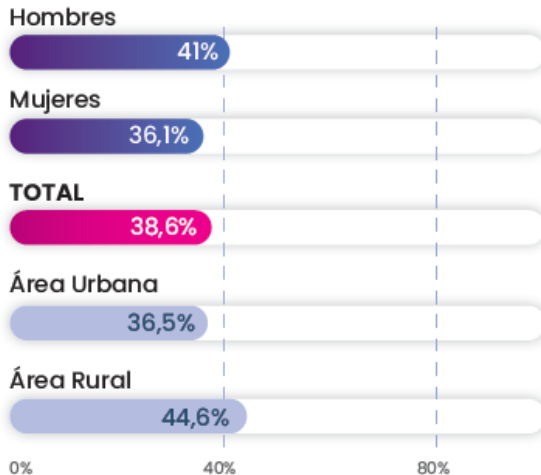
Authors: Wei Wang¹, Thomas Beaney^{1,2}, Neil R. Poulter, Graciela González, María Paniagua, Manuel

Castillo, Rocío Aparicio, Abdón Villamayor, Jose Ortellado

Total participants	Number with hypertension	Proportion of all participants with hypertension (%)	Proportion of hypertensives aware (%)	Proportion of hypertensives on medication (%)	Proportion of those on medication with controlled BP (%)	Proportion of all hypertensives controlled (%)
7782	3323	42,7%	61,8%	49,6%	43,8%	21,7%
Statement 1	Of all 7782 participants, 3323 (42.7%) had hypertension					
Statement 2	Of all 2615 participants with hypertension in 2018/2019 where data was collected, 61.8% were aware					
Statement 3	Of all 3323 participants with hypertension, 49.6% were on antihypertensive medication					
Statement 4	Of 1649 participants on antihypertensive medication, 43.8% had controlled BP					
Statement 5	Of all 3323 participants with hypertension, 21.7% had controlled BP					

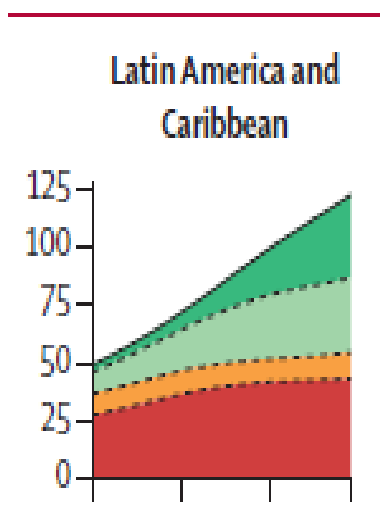
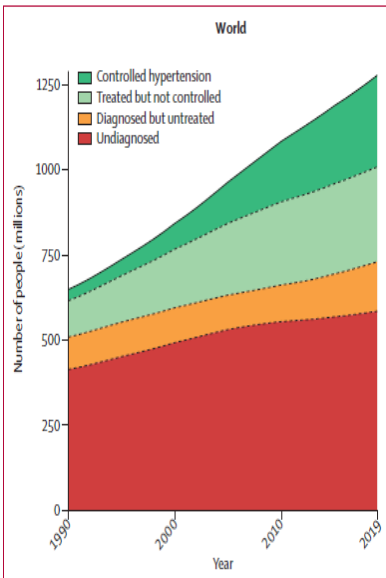
HIPERTENSIÓN

Porcentaje de la población que presenta presión arterial alta.



Clasificación de la presión arterial	LASH		ESC/ESH		AHA/ACC		CANADIENSES	ISH	
	Sistólica	Diastólica	Sistólica	Diastólica	Sistólica	Diastólica		Sistólica	Diastólica
Normal/óptima	<120	<80	<120	<80	<120	<80			
Normal/elevada	120-129	80-84	120-129	80-84	120-129	<80		<130	<85
Alta normal	130-139	85-89	130-139	85-89				130-139	85-89
Grado 1	140-159	90-99	140-159	90-99	130-139	80-89	≥140/≥90	140-159	90-99
Estadio 1									
Grado 2	160-179	100-109	160-179	100-109	>140	>90		≥160	≥100
Estadio 2									
Grado 3	≥180	≥110	≥180	≥100					
Crisis hipertensiva					>180	>120			
Hipertensión sistólica aislada	≥140	<90	≥140	<90				≥140	<90





Lancet 2021; 398: 957-80



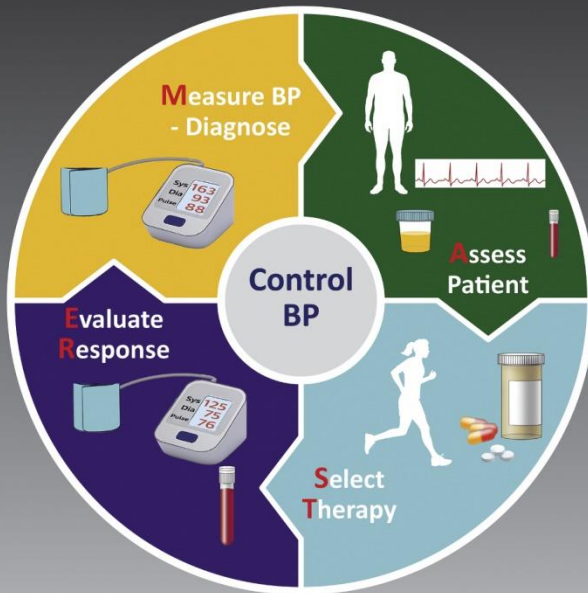
		Year 2017		Year 2018		Year 2019		2017-2019	
Participant characteristics		Total	Percentage	Total	Percentage	Total	Percentage	Total	Percentage
Gender									
	Female	591	49,4%	1340	58,6%	2629	61,1%	4560	58,6%
	Male	605	50,6%	945	41,4%	1671	38,9%	3221	41,4%
	Other	0	0,0%	0	0,0%	1	0,0%	1	0,0%
	Unknown	0	0,0%	0	0,0%	0	0,0%	0	0,0%
Age (years)									
	Mean (SD)			40.7 (16.2)		42.2 (17.8)		41.7 (17.2)	
	Median (IQR)			38.0 (27.0 - 53.0)		40.0 (25.0 - 57.0)		40.0 (26.0 - 56.0)	
	18-29			711	31,1%	1401	32,6%	2112	27,1%
	30-39			479	21,0%	694	16,1%	1173	15,1%
	40-49			406	17,8%	621	14,4%	1027	13,2%
	50-59			336	14,7%	696	16,2%	1032	13,3%
	60-69			230	10,1%	583	13,6%	813	10,4%
	70 or more			122	5,3%	306	7,1%	428	5,5%
	Unknown			1	0,0%	0	0,0%	1	0,0%
Ethnicity									
	South Asian	0	0,0%	0	0,0%	0	0,0%	0	0,0%
	East Asian	0	0,0%	0	0,0%	0	0,0%	0	0,0%
	Black	1	0,1%	3	0,1%	3	0,1%	7	0,1%
	South-east Asian	0	0,0%	0	0,0%	0	0,0%	0	0,0%
	White	1182	98,8%	2272	99,4%	1763	41,0%	5217	67,0%
	Mixed	0	0,0%	1	0,0%	2480	57,7%	2481	31,9%
	Arabic	0	0,0%	0	0,0%	2	0,0%	2	0,0%
	Other	13	1,1%	1	0,0%	44	1,0%	58	0,7%



HTA ESTADIOI.COMO
AVANZAMOS EN ESTE
CASO?



ESH **MASTER**plan for Hypertension Management



Measure Blood Pressure - Diagnose

In Office

Office BP measurement (OBPM)



*SBP ≥ 140
and/or
DBP ≥ 90

Conditions

1. Use validated automated electronic upper-arm cuff device^a (www.stridebp.org).
2. Select appropriate cuff to fit arm size according to instructions by device manufacturer^b.
3. Quiet room with comfortable temperature.
4. No smoking, caffeine, food, or exercise 30 min before measurement.
5. Start measurement after patient remained seated and relaxed for 3-5 min^c.
6. No talking during and between measurements.

Posture

7. Sitting with back supported on chair.
8. Legs uncrossed, feet flat on floor.
9. Bare arm resting on table with mid-arm at heart level.

Measurement

10. Take 3 readings with 1 min intervals between them. Use the average of the last 2 readings for BP and also for pulse rate^d.

Relevance

- Was used in outcome trials and provides the basis for diagnosis and BP targets.

Out-of-office

Home BP monitoring (HBPM)



*SBP ≥ 135
and/or
DBP ≥ 85

Conditions and Posture

- 1.-9. From OBPM apply also to HBPM.

Measurement

10. Propose a standardized protocol to the patient:
 - Educate the patient on how to use a validated device and report the data.
 - Take 2 readings with 1 min intervals between them.
 - Measure in the morning and the evening (before drug intake if treated).
 - Measure for 3-7 days before office visits.
 - Use the average of all readings excluding the first day for both BP and pulse rate.
11. For long-term follow-up of treated hypertension, make duplicate measurements once or twice per week or month.

Relevance

- Recommended for long-term follow-up of treated hypertension, because it improves BP control, especially when combined with education and counseling.
- Confirmation of hypertension diagnosis and of true resistant hypertension, particularly if ABPM is not available.

Ambulatory BP monitoring (ABPM)



*24-h mean BP:
SBP ≥ 130
and/or
DBP ≥ 80

*Daytime (awake):
SBP ≥ 135 mmHg
and/or
DBP ≥ 85

*Nighttime (asleep):
SBP ≥ 120 mmHg
and/or
DBP ≥ 70

Conditions

- 1.-2. From OBPM applies also to ABPM.
3. Use fully automated devices programmed to record BP automatically at preselected intervals for 24 h.

Measurement

4. The recommended optimal time interval between measurements should be 20 minutes during day (awake) and night (sleep).
5. Measure during a routine workday for 24 h.
6. Instruct patients to keep a diary of their activities, symptoms, meals, drug intake times, sleep times or any unusual problems.

Relevance

- Obtaining 24-h BP profile and especially BP during night (sleep) not captured by OBPM or HBPM
- Confirmation of hypertension diagnosis and of true resistant hypertension.

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^aDefinition of hypertension ^aA device that takes triplicate readings automatically is preferred. ^bThe selection of an appropriate cuff size is crucial. A smaller than required cuff overestimates BP and a larger underestimates BP. ^cUse of electronic devices allowing automated storage and data transfer is encouraged. ^dAt initial visit measure on both arms. An interarm SBP difference >10 mmHg must be confirmed with repeated measurements. If confirmed, the arm with the higher BP should be used for all subsequent measurements. If any two sequential BP readings in one arm differ by >10 mmHg, additional measurements are recommended. See also Table 1.



Assessment of patients should be adapted according to the severity of hypertension and clinical circumstances.

Basic

History

- Personal
 - Hypertension related, including sex-specific aspects, e.g. HDP
 - Co-morbidities
- Cardiovascular risk factors
- Symptoms of HMOD, CVD, stroke or CKD
- Possible secondary hypertension
- Other drug treatments or use including OTCs (See also Table 2 and Table 3)



Physical Examination

- Body habitus and BMI
- Signs of HMOD
- Signs of secondary hypertension
- Resting pulse rate (see BP measurement)
- Level of frailty/functionality in older persons (e.g. >80 years) (See also Table 4 and Table 5)



Lab Test

- Blood (serum/plasma)**
- Creatinine, eGFR
 - Potassium and sodium
 - (Fasting) glucose and HbA1c
 - Total-, LDL, HDL-Cholesterol



Urine

- Urine analysis multicomponent dipstick test
- Urinary albumin-creatinine ratio (See also Table 6)



Other Investigations

- 12 lead ECG



Extended

HMOD

Select if deemed necessary and available

- Echocardiography
- MRI
- Coronary calcium score



- Ultrasound
- Doppler ultrasound



- Carotid ultrasound



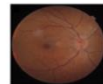
- Pulse wave velocity
- Ankle-brachial index



- CT
- MRI
- Cognitive function tests



- Fundoscopy
- Retina microvasculature



(See also Table 3)



Select Therapy: Lifestyle Interventions

Relevance

- Prevent or delay onset of hypertension
- Improve overall/CV health and well-being
- Reduce BP
- Booster BP lowering effects of medications
- Reduce the number/dose of drugs needed for BP control

Prescribing

- To all patients with diagnosed hypertension
- To patients with white-coat or masked hypertension
- To patients with high-normal BP
- Individual patient counseling and support
- Prescribe with specific instructions, e.g. intensity and type of exercise
- Assess, adapt, and reinforce during follow-up

Supportive additional interventions

Smoking cessation

- Smoking cessation, supportive care and referral to smoking cessation programs are recommended for all smokers



Key interventions to reduce BP

Healthy diet

Prefer:

- DASH or Mediterranean type diets
- A healthy dietary pattern including more plant-based and less animal-based food
- Vegetables, fruits, beans, nuts, seeds, and vegetable oils
- Lean protein (e.g. fish, poultry)



Limit:

- Fatty meats, full-fat dairy
- Sugar, sweets and sweetened beverages

Daily physical activity and regular exercise

- Incorporate physical activity (e.g. walking, cycling) into everyday life and reduce sedentary behavior (e.g. sit less)
- Aim for:
 - 150-300 min of aerobic exercise per week performed at a moderate intensity or
 - 75-150 min of aerobic exercise per week performed at a vigorous intensity or
 - an equivalent combination of moderate and vigorous physical activities
- Add dynamic resistance (muscle strengthening) exercise 2-3 times per week
- Start slow and gradually to build up the amount/intensity of activity



Weight reduction

- Combine a low-caloric diet with daily physical activity in patients with overweight or obesity
- Monitor waist circumference and weight



Restriction of sodium intake

- Sodium is mainly consumed as salt, which comes from processed foods or is added to the food during cooking or at the table
- Salt (NaCl) restriction to < 5 g (~2g sodium) or 1 teaspoon per day is recommended



Augmentation of potassium intake

- Increase potassium consumption, preferably via dietary modification, except for hypertensive patients with advanced CKD
- Foods high in potassium are for example white cannellini beans (1200 mg/cup), unsalted boiled spinach (840 mg/cup), avocado (708 mg/cup) and bananas (450 mg per medium fruit)
- Use salt substitutes replacing NaCl with KCl in patients consuming a high sodium diet



Limit alcohol intake

- Limit alcohol intake close to abstinence, particularly if intake is ≥ 3 drinks/day*
- Avoid excessive (binge) drinking

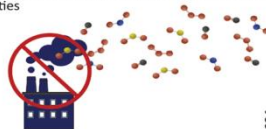
Improve stress management

- Reduce stress by use of
 - Regular physical activity
 - Mindfulness-based exercise
 - Relaxation techniques, e.g. deep breathing, meditation, yoga or Tai Chi
- Get enough sleep (7-9 hours)
- Find individual ways to cope with stress, e.g. practicing mindfulness, engaging in hobbies or talking to a therapist
- Moderate alcohol and caffeine intake, avoid drugs



Minimize exposure to noise and air pollution

- Reduce indoor exposure to noise and air pollution.
- Consider to reduce exposure to air pollution by modifying the location, timing and type of outdoor activities



*About 350 ml of regular beer containing 5% alcohol by volume or 150 ml of wine containing 12% alcohol by volume per drink.



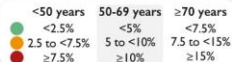
Evaluate Response

	Initiation (3 months)	Short-term FU (3 months - 1 year)	Long-term FU (>1 year)
Objective	Aim for BP control	Establish optimal BP control	Maintain optimal BP control
	1-2 visits (4-6 weeks)	1-2 visits depending on CV risk (4-6 weeks) More frequently in patients with high-risk and difficult to control BP	Low-risk: 1 visit per year High risk and difficult to control BP: more frequent visits (2-3/year)
	Office BP and Home BP	Office BP and Home BP (before visits); verify consistency of BP control; consider seasonal variability ABPM in apparent treatment resistance hypertension; consider to refer to a specialist	
	Selected lab tests to address safety of drug therapy or risk factors	Depending on baseline profile and condition periodic re-assessment of parameters with impact on drug safety and selection, e.g. eGFR, potassium or important risk factors, e.g. glucose, HbA1c, LDL-cholesterol	
	Re-Assess modifiable risk factors and HMOD (Table 2 and Table 3)	In patients with pre-existing HMOD verify BP-induced changes (depending on sensitivity to change), e.g. eGFR, albuminuria, pulse wave velocity or left ventricular hypertrophy.	In patients without pre-existing HMOD re-assess in longer intervals, e.g. every 3 years In patients with pre-existing HMOD more frequent re-assessments of BP-induced changes
	Verify and adapt lifestyle interventions and recommended drug therapy prescribing patterns	Support implementation of lifestyle interventions. Consider adjustment of medications depending on BP control, tolerability and change in co-morbidities, avoid inertia. Consider deprescribing in symptomatic very old and frail patients with low BP	
	Verify initiation and discuss adherence	Monitor adherence/persistence to drug therapy: assess barriers, e.g. changes in co-morbidities, side-effects, polypharmacy including OTC use	
	Support individual needs and shared decision making	Organize and implement patient support: consider use of team-based care, telehealth, virtual visits, self-monitoring and patient empowerment	Maintain patient support



SCORE2 & SCORE2-OP

10-year risk of (fatal and non-fatal) CV events in populations at low CVD risk



Women



Men

Non-smoking

Smoking

Non-smoking

Smoking

Non-HDL cholesterol

Systolic blood pressure (mmHg)
SCORE2-OP

3.0-3.9
150 200 250

4.0-4.9
150 200 250

5.0-5.9
150 200 250

6.0-6.9
150 200 250

mmol/L
mg/dL

Age (y)

85-89

80-84

75-79

70-74

65-69

60-64

55-59

50-54

45-49

40-44

35-39

30-34

25-29

20-24

15-19

10-14

5-9

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Paraguay  ▼



Estimar el Riesgo Cardiovascular

<https://www.paho.org/cardioapp/web/#/cvrisk>



Género

Femenino

Masculino

Edad

40

Tabaquismo

Si

No

Diabetes

Si

No

Colesterol Total
(mg/dl):

140

Presión sistólica
(mmHg)

90

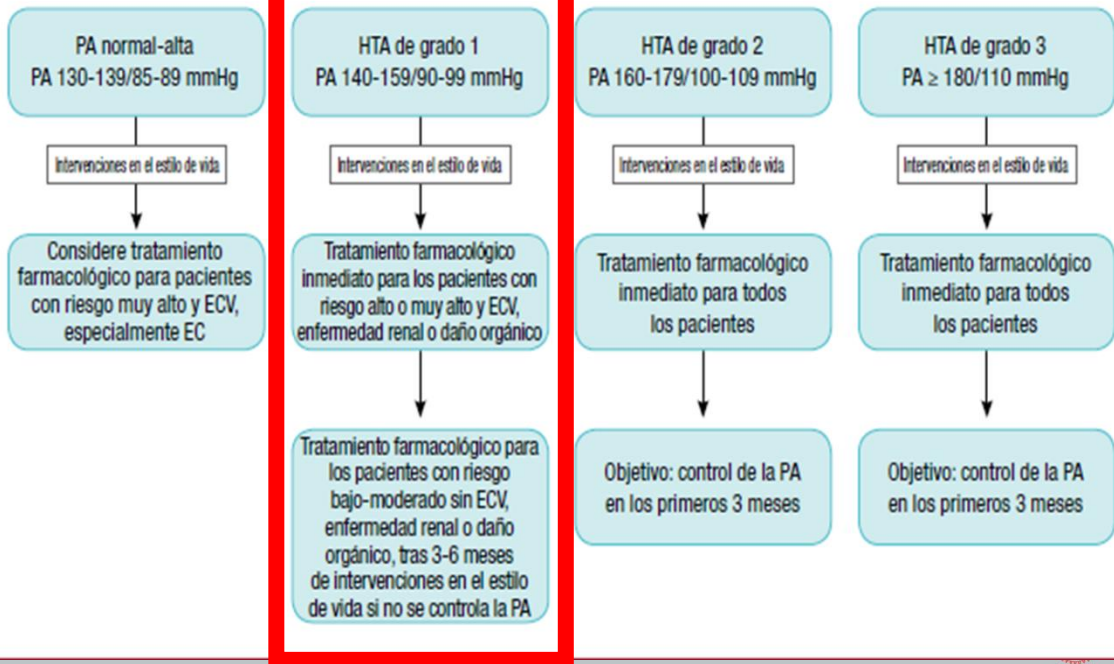


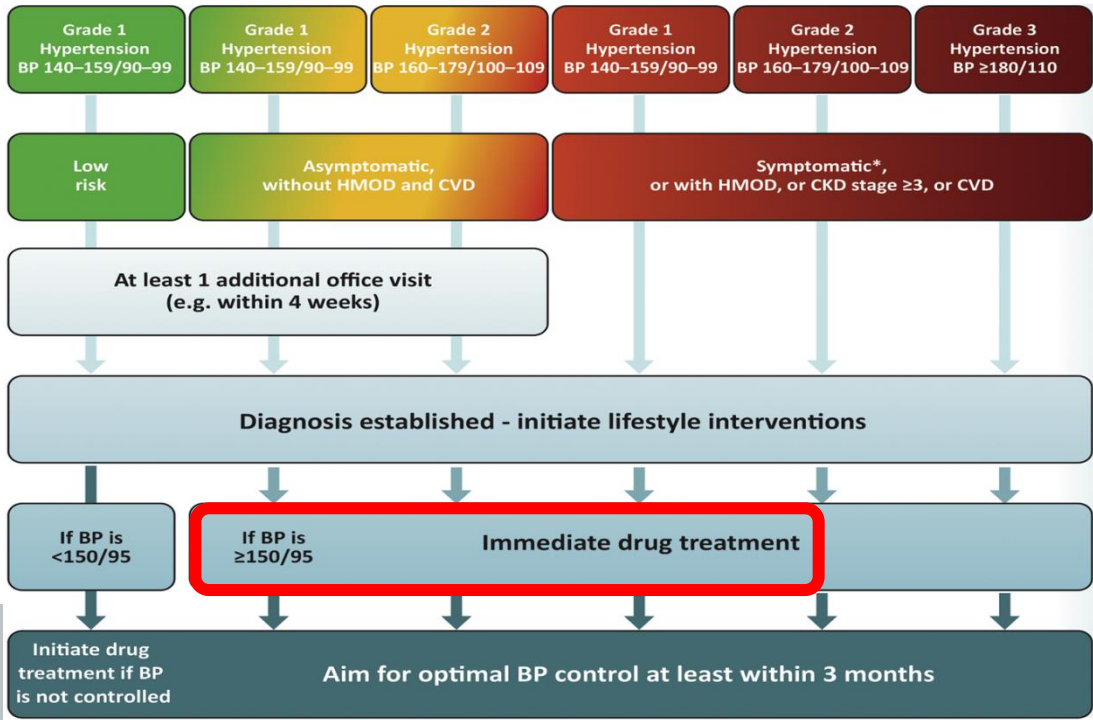
- ASCVD score: 3,3% (riesgo de evento CV en los próximos 10 años (bajo riesgo).
- PREVENT score: 4,4% de probabilidad de eventos CV en los 10 sgtes años (bajo riesgo), PERO 25,6% de probabilidad de un evento CV a los 30 años.
- SCORE: 3,3% de riesgo de un evento CV en los sgtes 10 años (bajo riesgo).
- HEARTS AMERICAS: 4% de eventos CV a los 10 años (bajo riesgo).



Fases de la HTA	Otros factores de riesgo, daño orgánico o enfermedades	Grado de PA			
		Normal alta PAS 130-139 mmHg PAD 85-89 mmHg	Grado 1 PAS 140-159 mmHg PAD 90-99 mmHg	Grado 2 PAS 160-179 mmHg PAD 100-109 mmHg	Grado 3 PAS ≥ 180 mmHg PAD ≥ 110 mmHg
Fase 1 (sin complicaciones)	Sin otros factores de riesgo	Riesgo bajo	Riesgo bajo	Riesgo moderado	Riesgo alto
	1 o 2 factores de riesgo	Riesgo bajo	Riesgo moderado	Riesgo moderado-alto	Riesgo alto
	≥ 3 factores de riesgo	Riesgo bajo-moderado	Riesgo moderado-alto	Riesgo alto	Riesgo alto
Fase 2 (enfermedad asintomática)	Daño orgánico, ERC de grado 3 o DM sin daño orgánico	Riesgo moderado-alto	Riesgo alto	Riesgo alto	Riesgo alto a muy alto
Fase 3 (enfermedad establecida)	ECV establecida, ERC de grado ≥ 4 o DM con daño orgánico	Riesgo muy alto	Riesgo muy alto	Riesgo muy alto	Riesgo muy alto







Once daily dosing
(preferred in the morning)

**Prefer SPCs
at any step**



Step 1
Dual
combination

**Start with Dual Combination
Therapy in most patients**

Start with Monotherapy only in selected patients:

- Low risk hypertension and BP <150/95 mmHg
- or high-normal BP and very high CV risk
- or frail patients and/or advanced age

ACEi or ARB + CCB or T/TL Diuretic^a
Increase to full-dose if well tolerated
→ **up to ~60% controlled^c**

ACEi or ARB + CCB + T/TL Diuretic
Increase to full-dose if well tolerated
→ **up to ~90% controlled^c**

True resistant Hypertension^d
→ **up to ~5%**

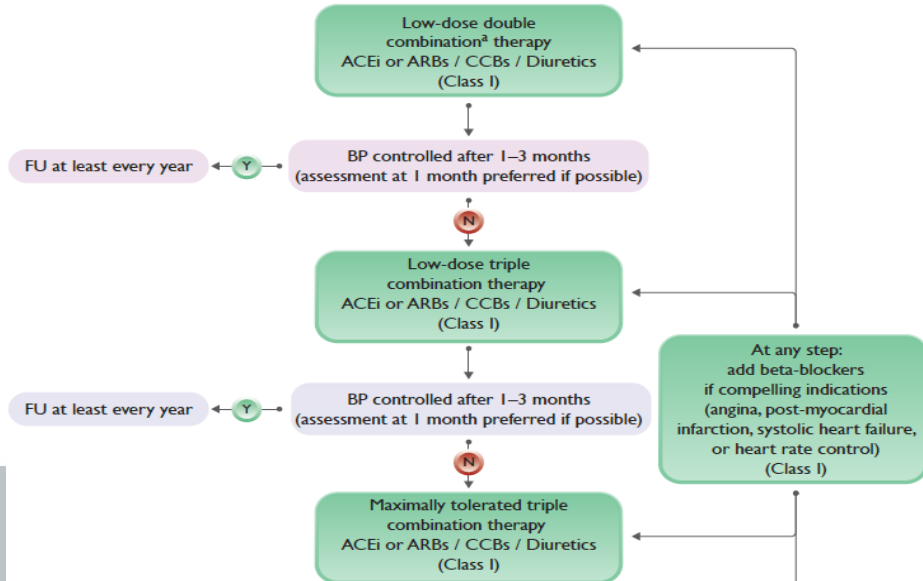
**Consider to consult hypertension
specialist in patients who are still
not controlled**

BB^b
Can be used
as monotherapy
or at any step
of combination
therapy

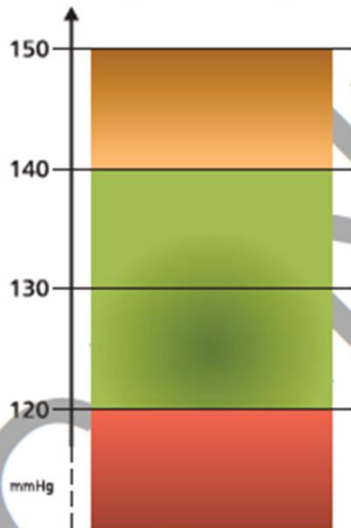


^aInitial monotherapy preferred

- Elevated BP category (120/70–139/89 mmHg)
- Moderate-to-severe frailty
- Symptomatic orthostatic hypotension
- Age ≥ 85 years

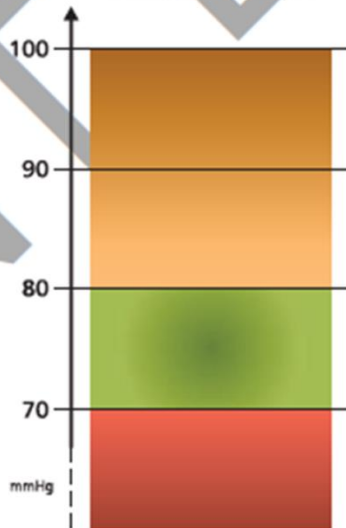


Systolic BP target



Most patients^a

Diastolic BP target



Most patients^a

Target

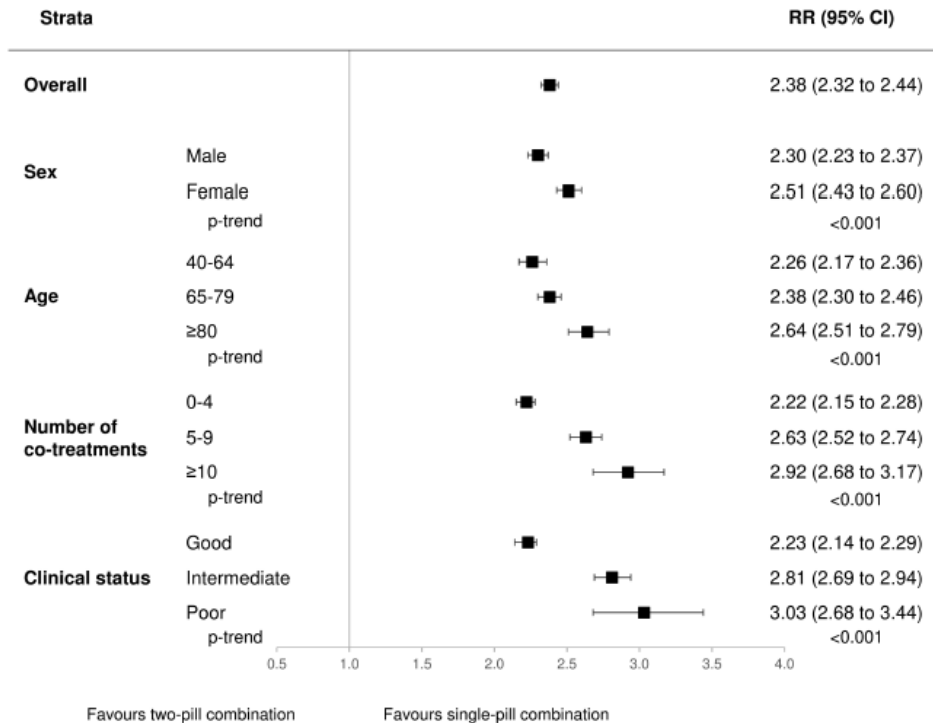


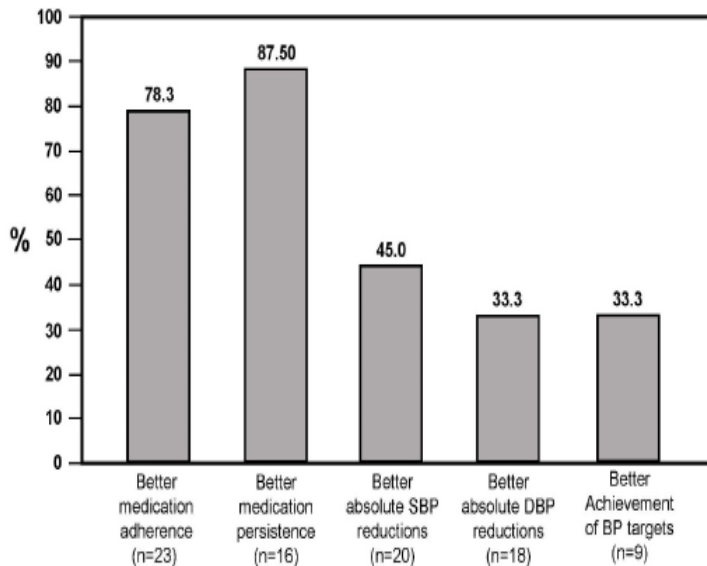
Avoid



Table 1. Recommendations of the most recent guidelines about the use of combination therapy of antihypertensive drugs in a single pill to start treatment in most patients.

2020 ISH hypertension practice guidelines ⁸ .	2021 WHO hypertension guidelines ⁹ .	2023 ESH hypertension guidelines ¹⁰ .	2024 ESC hypertension guidelines ¹¹ .	2024 LASH hypertension guidelines ¹² .
- Initiation of therapy with two agents of different classes (ACEi or ARB plus a DH-CCB) - If BP not at target with full dose of dual therapy, add a T/TL diuretic.	- Initiation of therapy with two agents chosen from the following four drug classes: T/TL diuretic, ACEi/ARB, long-acting DH-CCBs. - If BP not at target with full dose of dual therapy, add a third drug.	- Dual combination as initial therapy for most hypertensive patients. - Preferred combinations are ACEi or ARB plus a DH-CCB or a T/TL diuretic. - All five major drug classes (ACEi, ARB, β-blockers, CCBs, T/TL diuretics) can be combined with one another, except for ACEi and ARB. - If BP not at target with full dose of dual therapy, add a third drug.	- Dual combination therapy at low dose to start treatment. - Preferred combinations are ACEi or ARB plus a DH-CCB or a T/TL diuretic. - The major four drug classes (ACEi, ARB, DH-CCBs, and thiazide or thiazide-like diuretics) are recommended as first-line BP-lowering medications, either alone or in combination	- Dual combination of ARB or ACEi plus DH-CCBs or T/TL diuretic at low dose as initial therapy in most patients. - If BP not at target with low dose dual combination increase to full dose or add a third drug in a triple low dose SPC. - If BP is not controlled with a dual combination at full-tolerated doses, add a third drug in a triple SPC
- Preferred use of SPC. - Use free combinations if SPCs are not available or unaffordable. - Reduce polypharmacy using SPC in once daily dosing over multiple times per day dosing.	Preferred use of SPC of these four major drug classes to improve adherence and persistence.	The use of 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.	A SPC initially containing two of these four major drug classes at low dose recommended for most.	Fixed dose SPC of two or three drugs are preferred over free combinations with multiple drugs to increase adherence and persistence on treatment.



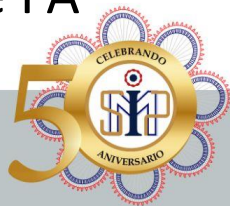


Coca A. Single-Pill Combination for Treatment of Hypertension: Only Better Adherence or Best Cardiovascular Prevention?. J Cardiol and Cardiovasc Sciences. 2025;6(1):1-6



Volvamos a Clara.....

- En screening de DOB se detectó HVI en ecocordio y ECG además de leve engrosamiento intimal de las arterias femorales.
- Se decide iniciar Tto farmacológico con telmisartan/amlo 80/5 mg.
- Al mes en el control persistió con cifras de PA 142/89 por lo que se escaló a tel/am/hctz 80/5/12,5.



The 'ten commandments' for the 2024 European Society of Cardiology guidelines on elevated blood pressure and hypertension

1 BP Classification

Non-elevated BP: Office BP
<120/70 mmHg

Elevated BP: Office BP 120–
139/70–89 mmHg

Hypertension: Office BP
≥140/90 mmHg

2 Diagnosis



Out-of-office
measurement
recommended

3 Risk Assessment for elevated BP

Step 1: Assess for high-risk
CVD conditions

Step 2: Predict 10-year risk of
CVD

Step 3: Evaluate for risk
modifiers

Step 4: Consider risk tools

4 Elevated BP + low CVD risk



Lifestyle measures
recommended

5 Elevated BP + high CVD risk



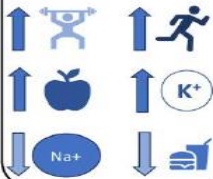
Lifestyle measures ±
pharmacological BP
lowering treatment

6 Hypertension



Lifestyle measures +
pharmacological BP
lowering treatment

7 Lifestyle measures



8 BP target



Target SBP
120 – 129 mmHg
(including non-frail older
individuals < 85 years).
If not tolerated -> ALARA.

9 Resistant Hypertension

Consider referral to specialist
center

Consider spironolactone, beta
blockers, and other
medications (Class IIa)

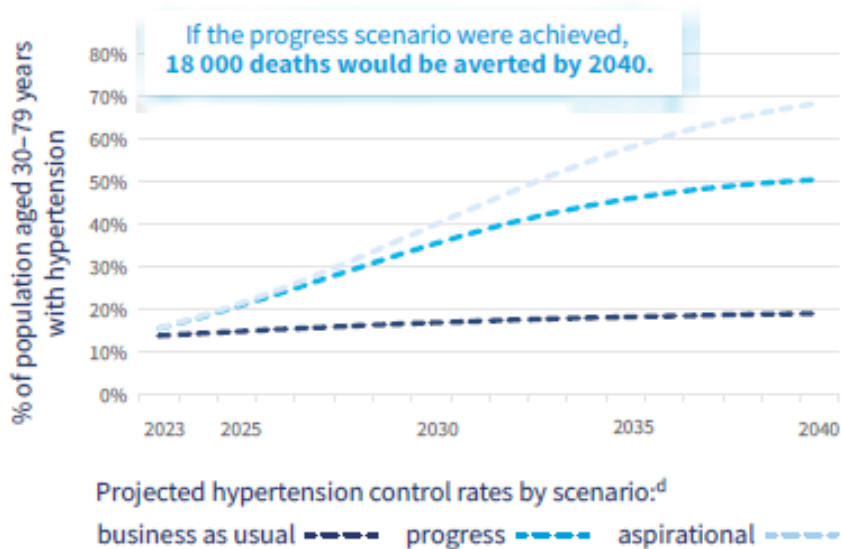
Consider renal denervation
(Class IIb)

10 Multi-disciplinary



Multi-disciplinary team
including task shifting
to non-physicians

Hypertension control rate scenarios



Suggested citation. Global report on hypertension: the race against a silent killer. Geneva: World Health Organization; 2023. Licence: CC BY-NC-SA 3.0 IGO.



Mensajes finales

- La Hipertensión Arterial continua siendo el principal enemigo en nuestra población.
- El tratamiento de la HTA debe buscar objetivos claros y utilizar combinaciones fijas en single pill en la mayoría de los pacientes.
- Debemos trazar objetivos cercanos y no caer en la inercia terapéutica.
- Lo importante es reducir el riesgo CV a futuro, **NO** específicamente las cifras como tal.



¡Muchas gracias por su
atención!

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