

Evidence for Aggressive Hypertension Control in Older Adults

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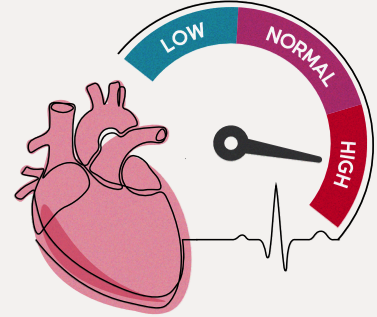


Arterial hypertension is the leading modifiable risk factor for cardiovascular disease and all-cause mortality in the United States and worldwide. Older adults (age 60 and above) have the highest prevalence of hypertension and are at greater risk of complications compared to younger adults, including a significantly higher risk of developing myocardial infarction, stroke, and heart failure.^{1,2}

Current evidence supports aggressive hypertension management for older adults. Data from the Systolic Blood Pressure Intervention Trial (SPRINT) and Strategy of Blood Pressure Intervention in the Elderly Hypertensive Patients (STEP) trials show the advantage of systolic blood pressure targets much lower than the previously recommended < 140-150 mmHg target.^{2,3} Key findings include:

- Lower incidence of orthostatic hypotension in participants with better blood pressure control at baseline or randomized to the < 120 mmHg systolic blood pressure arm.²
- No increased risk of cardiovascular events in participants treated to the lower goal with orthostatic hypotension at baseline or during the trial.
- No difference in rates of serious adverse events in older patients (even in patients older than 75) compared to the overall population.
- Treatment to a lower blood pressure target reduced the incidence of orthostatic hypotension.

For more information, access Cardi-OH’s expanded resource on [managing hypertension in older adults](#).



Nearly all national and international guidelines now recommend a blood pressure target of < 130/80 mmHg in patients younger than 80 years of age.

The 2017 American College of Cardiology (ACC)/American Heart Association (AHA) guideline recommends a target of < 130/80 mmHg in adults regardless of age (though, in those older than 65 years of age “with a high burden of comorbidity and limited life expectancy, clinical judgment, patient preference, and a team-based approach to assess risk/benefit is reasonable”).⁴

References

1. Forouzanfar MH, Liu P, Roth GA, et al. Global burden of hypertension and systolic blood pressure of at least 110 to 115 mm Hg, 1990-2015. JAMA. 2017;317(2):165-182. doi:10.1001/jama.2016.19043.
2. Wright JT Jr, Whelton PK, Johnson KC, Snyder JK, et al. for the SPRINT Research Group. SPRINT revisited: updated results and implications. Hypertension. 2021;78(6):1701-1710. doi:10.1161/HYPERTENSIONAHA.121.17682.
3. Zhang W, Zhang S, Deng Y, et al. Trial of intensive blood-pressure control in older patients with hypertension. N Engl J Med. 2021;385(14):1268-1279. doi:10.1056/NEJMoa2111437.
4. Whelton PK, Carey RM, Aronow WS, et al. 2017 ACC/AHA/AAA/ABC/ACPM/AGS/APHA/ASH/ASPC/NMA/PCNA Guideline for the prevention, detection, evaluation, and management of high blood pressure in adults: executive summary: a report of the American College of Cardiology/American Heart Association Task Force on Clinical Practice Guidelines. Hypertension. 2018;71(6):1269-1324. doi:10.1161/HYP.0000000000000611.

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