Perspective:

The following are 10 key points to remember from the 2013 European Society of Hypertension (ESH)/European Society of Cardiology (ESC) guidelines for the management of arterial hypertension:

1. Out-of-office blood pressure (BP) measurements, as with ambulatory BP monitoring (ABPM) and home BP monitoring (HBPM), have prognostic significance and are closely correlated to end-organ damage and cardiovascular (CV) events.

2. Recommendations for HBPM include daily measurement of BP on at least 3-4 days and preferably on 7 consecutive days in the mornings as well as in the evenings. Patients should be instructed to take readings after 5 minutes of rest and with two measurements per occasion (taken 1-2 minutes apart). Devices worn on the wrist should be discouraged for HBPM.

3. A systolic BP (SBP) goal <140 mm Hg is recommended in those patients at low to moderate CV risk or with diabetes, previous stroke or transient ischemic attack, coronary heart disease, or chronic kidney disease.

4. In the fragile elderly population, SBP goals (of <140 mm Hg) should be adapted to individual circumstances. However, in elderly patients less than 80 years old with a SBP >160 mm Hg, SBP ideally should be reduced to 140-150 mm Hg. In octogenarians in good physical and mental condition and an SBP >160 mm Hg, a target of 140-150 mm Hg is recommended.

5. A diastolic BP (DBP) target <90 mm Hg is always recommended. DBP should be <85 mm Hg in diabetics.

6. A daily intake/salt restriction of 5-6 g of salt is recommended

for the general population (vs. the usual salt intake of 9 and 12 g/day in many countries). A reduction in daily salt intake to 5 g per day is associated with 4-5 mm Hg reduction in SBP in hypertensive individuals.

7. While some data may suggest superiority of one class of antihypertensive agents over another for select outcomes, the ESH/ESC guidelines provide latitude for the initiation and maintenance of antihypertensive treatment, indicating, 'Diuretics, beta-blockers, calcium antagonists, angiotensin-converting enzyme (ACE) inhibitors, and angiotensin-receptor blockers (ARBs) are all suitable and recommended.' Concomitant administration of two antagonists of the renin-angiotensin system (RAS)—ACE inhibitors, ARBs, and direct renin inhibitors—is discouraged.

8. In patients with metabolic syndrome (a 'prediabetic' state), antihypertensive agents that may improve (or at least not exacerbate) insulin resistance, such as RAS blockers or calcium antagonists, should be considered preferred therapy.

9. Resistant hypertension (hypertension that is resistant to appropriate lifestyle measures and pharmacotherapy with a diuretic and two other antihypertensive drugs belonging to different classes and at adequate doses) may be responsive to therapy with mineralocorticoid receptor antagonists, amiloride, or the alpha-1 block doxazosin.

10. While renal denervation may be a 'promising' nonpharmacologic approach to the management of resistant hypertension, additional data are necessary to more firmly establish its safety and longer-term efficacy. For now, this procedure may be best restricted to experienced operators.

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