

Medical News

What to Know About the New Blood Pressure Guidelines

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Some things haven't changed in the new high blood pressure (BP) guideline for adults released this August by the American Heart Association (AHA) and the American College of Cardiology. The definitions of normal, elevated, and stage 1 and 2 hypertension are the same, for example. And the recommended first-line antihypertensives are unchanged from the 2017 guideline.

But many updates with the potential to change patient care were included in the new guideline, which incorporates the latest data and emphasizes both earlier treatment and tighter control of BP.

"With heart health, brain health, kidney health...overall we have really great evidence that lower blood pressure is better," said guideline coauthor Sadiya S. Khan, MD, MSc. "Start blood pressure treatment earlier and get to lower targets."

Plus, there's much more attention on prevention in the new guideline—meaning recommendations even for people with normal BP.

Here are some of the most important takeaways:

Lower the Target

The BP goals for people with hypertension remain generally the same in the new guideline, but the wording of the recommendation has been tweaked to make the message stronger. The 2017 guideline recommended a systolic goal of less than 130 mm Hg for people with hypertension at increased risk of cardiovascular disease (CVD). Now, the phrasing for people with hypertension with heightened CVD risk is to achieve *at least* less than 130 mm Hg, with encouragement to achieve less than 120 mm Hg. For those with hypertension who are not at increased risk of CVD, the same goal "may be reasonable" to forestall their BP from climbing higher, the guideline states.

The new language is a recognition that, after the previous guideline's release,



"there was not a big sweeping uptake by the clinical community or patients to achieve lower blood pressures," explained Daniel W. Jones, MD, who chaired the current guideline writing committee and served on the committee for the 2017 version. "We don't want to discourage our clinicians. We don't want to discourage patients. But we want to be honest about what the evidence is. And the evidence clearly says 120 is better for reducing heart disease and stroke and kidney disease."

The guideline addresses safety concerns, noting that adverse events related to intensive antihypertensive therapy are "infrequent and usually mild." Clinicians should, however, exercise their judgement and use shared decision-making when selecting how low to go for individual patients, who should be monitored carefully.

Finally, whether or not a patient has achieved their target BP goal should be deter-

mined based on at least 2 readings during at least 2 visits, not on a single measurement.

Treat Earlier

Earlier treatment is a big addition to the new guideline. People with stage 1 hypertension who don't have clinical CVD and who also have a low 10-year risk should use lifestyle changes to try to bring down their BP, but they should start antihypertensives if they're not at goal in 3 to 6 months. The previous guideline recommended that this lower-risk population wait until stage 2 hypertension to initiate drug therapy.

The 2017 guideline also advised treating stage 1 hypertension with drug therapy only for secondary prevention of recurrent CVD events or for primary prevention in people with a heightened 10-year risk. The update expands on this by also recommending immediate medication initiation for people with stage 1 hypertension who don't

have clinical CVD but do have diabetes or [chronic kidney disease](#).

Skip Monotherapy for Some

For people with stage 2 hypertension or higher at the time of diagnosis, "one drug is not going to cut it," said Khan, who is an associate professor of cardiology and preventive medicine at Northwestern University and a *JAMA Cardiology* associate editor. Over the past 5 years, she noted, trials have demonstrated that initiating treatment with a combination of BP-lowering drugs gets patients to target faster and keeps them there for longer stretches, thereby reducing their accumulated risk.

The new guideline advises this approach and takes it a step further by recommending the use of widely available single-pill combinations—2 medications combined in a single pill—to improve adherence. If a patient experiences an adverse effect, the physician can stop the combination therapy and reassess, Khan said.

Adopt the PREVENT Risk Calculator

As for determining CVD risk to make decisions about treatment initiation and goals, the updated BP guideline adopts the AHA's new PREVENT (Predicting Risk of CVD Events) risk calculator, [released in 2023](#), replacing the pooled cohort equations (PCEs) introduced a decade prior.

With PREVENT, a 10-year predicted CVD risk of 7.5% or higher defines increased risk and is equivalent to 10% risk using the PCEs, according to Khan.

Khan was among the researchers who developed the PREVENT model with more contemporary data from larger and more diverse cohorts. The guideline notes that the new tool predicts CVD risk more accurately than the PCEs. Among its improvements is that it factors in kidney function and estimates the risk for heart failure in addition to atherosclerotic CVD.

Emphasize Dementia Prevention

The previous BP guideline acknowledged that lowering BP was "reasonable" to prevent cognitive decline and dementia. Since then, the strength of evidence has grown, and the revised recommendation is to bring systolic BP below 130 mm Hg to prevent mild cognitive impairment and dementia.

In fact, dementia prevention is one of the reasons why the new guideline advises medication initiation for stage 1 hyperten-

sion that doesn't resolve within a few months of lifestyle intervention, even for patients with low CVD risk.

"We've known for years that...people in middle age who had high BP were more likely to have dementia as they aged," Jones said. "Now we know with certainty that taking those people and lowering blood pressure below 130 mm Hg systolic blood pressure reduces the risk of dementia."

It's believed that high BP causes damage to small blood vessels in regions of the brain responsible for cognitive function, similar to how it damages the microvasculature of the brain leading to ischemic stroke, explained Jones, who is an emeritus professor of medicine at the University of Mississippi Medical Center.

Add New Labs

There are 2 important updates to laboratory testing in the new guideline. The first is the addition of urine albumin to creatinine ratio testing as part of the standard workup for all people with high BP. According to Jones, this previously optional test is a more sensitive indicator of early kidney disease than serum creatinine testing, which is still recommended. The additional laboratory test "will allow an earlier detection of chronic kidney disease and allow patients to have appropriate therapy for reducing their risk of going on to renal failure," he said.

There's also a new recommendation to screen more patients for primary aldosteronism, a condition that leads to hypertension and low potassium levels. The guideline recommends the plasma aldosterone to renin ratio test for people with resistant hypertension or obstructive sleep apnea, as well as a few other conditions, regardless of whether hypokalemia is present. Clinicians can also consider screening patients with stage 2 hypertension to increase detection.

Why the change? It turns out that aldosteronism is more common than previously recognized: it's present in up to 10% of patients with stage 1 hypertension and up to around 20% of patients with stage 2 or resistant hypertension, but very few people—only 1% or 2%—who should be screened for it are. "We just don't check it enough to pick it up," Khan said. Importantly, she added, the new guidance clarifies that patients can safely continue most antihypertensives leading up to screening. Older guidance to withdraw these medications before screening

created an unnecessary barrier that contributed to low uptake.

Less Salt and More Salt Substitutes— for Everyone

Reducing the amount of salt in the diet has long been a staple of hypertension treatment. But the new guideline advises a low-sodium diet for all patients—with or without high BP. The specific recommendation is for adults to reduce dietary sodium intake to less than 2300 mg/d (about a teaspoon), but ideally less than 1500 mg/d (about two-thirds of a teaspoon).

The update also comes out stronger in favor of potassium-enriched salt substitutes, which lower the level of sodium in the diet and increase the level of potassium, "both of which are useful in lowering blood pressure," Jones said. Most adults, with or without hypertension, can consider swapping out regular table salt for these products, which he noted are available in grocery stores and online but are underused in the US. (They're not advised for patients with chronic kidney disease.)

Shoot for At Least 5% Weight Loss

Adults who are overweight or obese should aim to lose at least 5% of their bodyweight or reduce their body mass index (BMI) by at least 3 in the new guideline. Previously, no specific target was given for weight or BMI reduction, which was only recommended for people who were carrying extra weight and already had elevated BP or hypertension. The new recommendation is based on data demonstrating that reducing at least this amount of body weight or BMI is more effective for lowering BP in people with and without hypertension than reducing less.

This is also the first update to mention glucagon-like peptide-1, or GLP-1, receptor agonist medications. It notes that these drugs "when used for weight management may be effective as an adjunct to lower BP."

The Ideal Amount of Alcohol Is None

Whereas the prior guideline recommended limiting alcohol intake for people with elevated BP or hypertension, the update advises all adults to abstain from drinking. That's because both systolic and diastolic BP "increase over time with any amount of baseline alcohol intake."

For those who continue to imbibe, the limit hasn't changed: no more than 1 drink

per day for women and 2 for men. (The different limits aren't based on weight, Jones said, but on differences in alcohol metabolism in the liver for women and men.)

According to Jones, the observational evidence on alcohol consumption and BP continues to grow stronger. "The guideline committee is convinced that the relation-

ship is clear," he said. "And so our new recommendation is that the ideal for people who have high blood pressure or want to prevent high blood pressure is no alcohol intake—abstinence."

The guideline does note that reducing alcohol intake appears to have bigger BP reduction benefits for people who

drink more, regardless of whether they have hypertension. ■

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