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2025 High Blood Pressure Guideline-at-a-Glance

Martha Gulati, MD, MS, FACC, FAHA, FASPC, FESC*
Mykela M. Moore, MPH
Morgane Cibotti-Sun, MPH

INTRODUCTION

The 2025 AHA/ACC/AANP/AAPA/ABC/ACCP/ACPM/AGS/AMA/ASPC/NMA/PCNA/SGIM Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults (AHA/ACC/Multisociety HBP Guideline)[1] contextualizes the most recent clinical evidence in treating patients with one of the most modifiable cardiovascular disease (CVD) risk factors, high blood pressure (HBP). The discussion around HBP is quite expansive, and this guideline highlights the impact of HBP globally, provides guidance on multidisciplinary team-based care, and encourages the use of a new tool to calculate risk. The guideline contains updated, evidence-based recommendations that replaces those from the 2017 HBP guideline.[2] This Guideline-at-a-Glance highlights practice-changing recommendations from the guideline to accelerate adoption.

American College of Cardiology (ACC) guideline dissemination is an organization-wide effort facilitated by the Solution Set Oversight Committee to ensure the integration of guideline content throughout ACC's clinical policy, education, registry, membership, and advocacy efforts. For each guideline, an individual ACC Guideline Dissemination Workgroup is created to influence dissemination strategy and to develop tools to facilitate the implementation of key changes in practice. These tools include a **Central Illustration** to graphically convey key concepts, as well as tables highlighting updates in the AHA/ACC/Multisociety HBP Guideline and comparisons to the 2024 European Society of Cardiology (ESC) Guidelines for the Management of Elevated Blood Pressure and Hypertension.[3]

TOP TAKE-HOME MESSAGES

The following Top Take-Home Messages are taken directly from the AHA/ACC/Multisociety HBP Guideline. Messages 1, 5, and 7 (in **bold** below) were selected as key themes for this Guideline-at-a-Glance because they outline the most impactful changes and address established gaps in clinical practice.

1. **HBP is the most prevalent and modifiable risk factor for the development of CVDs, including coronary artery disease, heart failure, atrial fibrillation, stroke, dementia, chronic kidney disease, and all-cause mortality. The overarching blood pressure treatment goal is <130/80 mm Hg for all adults, with additional considerations for those who require institutional care, have a limited predicted lifespan, or are pregnant.**
2. Clinicians should collaborate with community leaders, health systems, and practices to implement screening of all adults in their communities and implement guideline-based recommendations regarding prevention and management of HBP to improve rates of blood pressure control.
3. Multidisciplinary team-based care is effective in assessing and addressing patient access to medications and other structural barriers to support individual patient needs and thereby reduce barriers to achieving hypertension control. Team members may include physicians, pharmacists, nurse practitioners, nurses, physician assistants/associates, dieticians, community health workers, and other health care professionals.
4. Blood pressure is classified by the following framework: normal blood pressure is defined

*On behalf of the ACC Solution Set Oversight Committee.

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CENTRAL ILLUSTRATION **2025 High Blood Pressure Guideline-at-a-Glance**

Chris Mendoza

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BP = blood pressure; CVD = cardiovascular disease; HF = heart failure; MI = myocardial infarction; PREVENT = Predicting Risk of cardiovascular disease EVENTs; SDI = social deprivation index.

TABLE 1 Select Differences Between 2017 and the 2025 AHA/ACC/Multisociety High Blood Pressure Guidelines

	2017[2]		2025[1]	
	COR*	Old Recommendations	COR*	New Recommendations
Overarching BP treatment goal (Top Take-Home Message 1)	1	Use of BP-lowering medications is recommended for primary prevention of CVD in adults with no history of CVD and with an estimated 10-y ASCVD risk <10% and an SBP of 140 mm Hg or higher or a DBP of 90 mm Hg or higher.	1	In all adults with hypertension, initiation of medications to lower BP is recommended when average SBP is ≥140 mm Hg to reduce the risk of cardiovascular events and total mortality.
			1	In all adults with hypertension, initiation of medications to lower BP is recommended when average DBP is ≥90 mm Hg to reduce the risk of cardiovascular events and total mortality.
	1	Use of BP-lowering medications is recommended for secondary prevention of recurrent CVD events in patients with clinical CVD and an average SBP of 130 mm Hg or higher or an average DBP of 80 mm Hg or higher, and for primary prevention in adults with an estimated 10-y ASCVD risk of 10% or higher and an average SBP 130 mm Hg or higher or an average DBP 80 mm Hg or higher.	1	In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of cardiovascular events and total mortality.
			1	In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of cardiovascular events and total mortality.
			1	In adults with hypertension without clinical CVD but with diabetes or CKD or at increased short-term CVD risk (ie, estimated 10-y CVD risk ≥7.5% based on PREVENT†), initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of CVD events and total mortality.
			1	In adults with hypertension without clinical CVD but with diabetes or CKD or at increased 10-y CVD risk (ie, ≥7.5% based on PREVENT†), initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of CVD events and total mortality.
Lifestyle changes to prevent and treat elevated BP (Top Take-Home Message 5)	1	Weight loss is recommended to reduce BP in adults with elevated BP or hypertension who are overweight or obese.	1	In adults who have overweight or obesity, weight loss is recommended with a goal of at least 5% of body weight reduction to prevent or treat elevated BP and hypertension.
	1	A heart-healthy diet, such as the DASH diet, that facilitates achieving a desirable weight is recommended for adults with elevated BP or hypertension.	1	In adults with or without hypertension, a heart-healthy eating pattern, such as the DASH eating plan, is recommended to prevent or treat elevated BP and hypertension.
	1	Sodium reduction is recommended for adults with elevated BP or hypertension.	1	In adults with or without hypertension, reduction of dietary sodium intake‡ is recommended to <2,300 mg/d, moving toward an ideal limit of <1,500 mg/d. to prevent or treat elevated BP and hypertension.
	1	Potassium supplementation, preferably in dietary modification, is recommended for adults with elevated BP or hypertension, unless contraindicated by the presence of CKD or use of drugs that reduce potassium excretion.	2a	In adults with or without hypertension, potassium-based salt substitutes§ can be useful to prevent or treat elevated BP and hypertension, particularly for patients in whom salt intake is related mostly to food preparation or flavoring at home, except in the presence of CKD or use of drugs that reduce potassium excretion where monitoring of serum potassium levels is indicated.‖
			1	In adults with elevated BP or hypertension, moderate potassium supplementation¶, ideally from dietary sources, is recommended to prevent or treat elevated BP and hypertension, except in the presence of CKD or use of drugs that reduce potassium excretion where monitoring of serum potassium levels is indicated.‖
	1	Adult men and women with elevated BP or hypertension who currently consume alcohol should be advised to drink no more than 2 and 1 standard drinks# per day, respectively.	1	Adults with or without hypertension who currently consume alcohol should be advised to pursue a recommended goal of abstinence, or at least to reduce alcohol intake to ≤1 drink/d for women and ≤2 drinks/d for men to prevent or treat elevated BP and hypertension.#
	1	Increased physical activity with a structured exercise program is recommended for adults with elevated BP or hypertension.	1	In adults with or without hypertension, increasing physical activity, through a structured exercise program that includes aerobic exercise and/or resistance training, is recommended to prevent or treat elevated BP and hypertension.
		No corresponding recommendation	2b	In adults with or without hypertension, stress reduction through transcendental meditation may be reasonable to prevent or treat elevated BP and hypertension, as an adjunct to lifestyle or medication interventions.
		No corresponding recommendation	2b	In adults with or without hypertension, other forms of stress management, such as breathing control techniques or yoga, may be reasonable to prevent or treat elevated BP and hypertension, as an adjunct to lifestyle or medication interventions.

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TABLE 1 Continued

	2017[2]		2025[1]	
	COR*	Old Recommendations	COR*	New Recommendations
Initial 3- to 6-mo trial of lifestyle modification before medication (Top Take-Home Message 7)	1	Adults with an elevated BP or stage 1 hypertension who have an estimated 10-y ASCVD risk less than 10% should be managed with nonpharmacological therapy and have a repeat BP evaluation within 3 to 6 mo.	1	In adults with hypertension without clinical CVD and with estimated 10-y CVD risk <7.5% based on PREVENT†, initiation of medications to lower BP is recommended if average SBP remains ≥130 mm Hg after a 3- to 6-mo trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.
			1	In adults with hypertension without clinical CVD and with estimated 10-y CVD risk <7.5% based on PREVENT†, initiation of medications to lower BP is recommended if average DBP ≥80 mm Hg after a 3- to 6-mo trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.

*Colors in this table align with the classification system found in Table 3, "Applying American College of Cardiology/American Heart Association Class of Recommendation and Level of Evidence to Clinical Strategies, Interventions, Treatments, or Diagnostic Testing in Patient Care," in the AHA/ACC/Multisociety HBP Guideline.[1]
†Increased short-term or 10-y risk is defined as a 10-y predicted risk for CVD events of ≥7.5% based on PREVENT (Predicting Risk of cardiovascular disease EVENTs).
‡Dietary sodium reduction may be contraindicated in patients with severe, symptomatic orthostatic hypotension.
§This recommendation refers to potassium-based salt substitutes, which typically contain 25% to 30% potassium chloride, 65% to 75% sodium chloride, and 0% to 10% flavoring agents. Products that refer to themselves as "salt substitutes" that do not contain potassium chloride as a substitute for sodium chloride have unknown effects on BP.
‖Drugs that reduce potassium excretion include: potassium-sparing diuretics (eg, amiloride, triamterene), mineralocorticoid receptor antagonists (eg, spironolactone, eplerenone, finerenone), angiotensin-converting enzyme inhibitors (eg, captopril, enalapril, lisinopril, benazepril, and others), angiotensin receptor blockers (eg, losartan, valsartan, candesartan, telmisartan, and others), and some immunosuppressive agents (eg, cyclosporine, tacrolimus).
¶Moderate potassium supplementation is <80 mmol/d (<80 mEq/d).
#One standard drink (12-14 g alcohol) is equivalent to 12 oz of beer (5% alcohol by volume), 5 oz of wine (12% alcohol by volume), or 1.5 oz of distilled spirits (40% alcohol by volume).
ACC = American College of Cardiology; AHA = American Heart Association; ASCVD = atherosclerotic cardiovascular disease; BP = blood pressure; CKD = chronic kidney disease; COR = Class of Recommendation; CVD = cardiovascular disease; DASH =Dietary Approaches to Stop Hypertension; DBP = diastolic blood pressure; PREVENT = Predicting Risk of Cardiovascular Disease EVENTs; SBP = systolic blood pressure.

as <120 mm Hg systolic and <80 mm Hg diastolic; elevated blood pressure as 120 to 129 mm Hg systolic and <80 mm Hg diastolic; stage 1 hypertension as 130 to 139 mm Hg systolic or 80 to 89 mm Hg diastolic; and stage 2 hypertension as ≥140 mm Hg systolic or ≥90 mm Hg diastolic.

5. **For all adults, lifestyle changes, including maintaining or achieving a healthy weight, following a heart-healthy eating pattern (such as DASH [Dietary Approaches to Stop Hypertension]), reducing sodium intake, increasing dietary potassium intake, adopting a moderate physical activity program, managing stress, and reducing or eliminating alcohol intake are strongly recommended to prevent or treat elevated blood pressure and hypertension**.
6. Initiation of medication therapy to lower blood pressure in addition to lifestyle interventions is recommended for all adults with average blood pressure ≥140/90 mm Hg and/or for selected adults with average blood pressure ≥130/80 mm Hg who have clinical CVD, previous stroke, diabetes, chronic kidney disease, or increased 10-year predicted cardiovascular risk of ≥7.5% defined by PREVENT™ (Predicting Risk of cardiovascular disease EVENTs).
7. **In adults with average blood pressure ≥130/80 mm Hg and at lower 10-year CVD risk defined by PREVENT of <7.5%, initiation of medication therapy to lower blood pressure is recommended if average blood pressure remains ≥130/80 mm Hg after an initial 3- to 6-month trial of lifestyle modification**.
8. For all adults with stage 2 hypertension, the initiation of antihypertensive drug therapy with 2 first-line agents of different classes in a single-pill, fixed-dose combination is preferred over 2 separate pills to improve adherence and reduce time to achieve blood pressure control.
9. Home blood pressure monitoring combined with frequent interactions with multidisciplinary team members using standardized measurement and treatment protocols and home measurement protocols is an important integrated tool to improve rates of blood pressure control. Reliance on cuffless devices, including smartwatches, for accurate blood pressure measurements should be avoided until these devices demonstrate greater precision and reliability.
10. Severe hypertension in nonpregnant individuals, defined as blood pressure >180/120 mm Hg, without evidence of acute target organ damage, should be evaluated and treated in the outpatient setting with initiation, reinstitution, or intensification of oral antihypertensive medications in a timely manner.

TABLE 2 Select Comparison of 2025 AHA/ACC/Multisociety and 2024 ESC High Blood Pressure Guidelines

	ESC Guideline[3]		AHA/ACC/Multisociety Guideline[1]	
	COR*	ESC Recommendations	COR*	AHA/ACC/Multisociety Recommendations
Overarching BP treatment goal (Top Take-Home Message 1)	1	It is recommended that in hypertensive patients with confirmed BP ≥140/90 mm Hg, irrespective of CVD risk, lifestyle measures and pharmacological BP-lowering treatment are initiated promptly to reduce CVD risk.	1	In all adults with hypertension, initiation of medications to lower BP is recommended when average SBP is ≥140 mm Hg to reduce the risk of cardiovascular events and total mortality.
			1	In all adults with hypertension, initiation of medications to lower BP is recommended when average DBP is ≥90 mm Hg to reduce the risk of cardiovascular events and total mortality.
	1	To reduce CVD risk, it is recommended that treated systolic BP values in most adults be targeted to 120-129 mm Hg, provided the treatment is well tolerated.	1	In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of cardiovascular events and total mortality.
		No corresponding recommendation	1	In adults with hypertension and clinical CVD, initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of cardiovascular events and total mortality.
	1	BP-lowering drug treatment is recommended for people with pre-diabetes or obesity when confirmed office BP is ≥140/90 mm Hg or when office BP is 130-139/80-89 mm Hg and the patient is at predicted 10-y risk of CVD ≥10% or with high-risk conditions, despite a maximum of 3 mo of lifestyle therapy.	1	In adults with hypertension without clinical CVD but with diabetes or CKD or at increased short-term CVD risk (ie, estimated 10-y CVD risk ≥7.5% based on PREVENT†), initiation of medications to lower BP is recommended when average SBP is ≥130 mm Hg to reduce the risk of CVD events and total mortality.
			1	In adults with hypertension without clinical CVD but with diabetes or CKD or at increased 10-y CVD risk (ie, ≥7.5% based on PREVENT†), initiation of medications to lower BP is recommended when average DBP is ≥80 mm Hg to reduce the risk of CVD events and total mortality.
Lifestyle changes to prevent and treat elevated BP (Top Take-Home Message 5)	1	It is recommended to aim for stable and healthy BMI (eg, 20-25 kg/m^2) and waist circumference values (eg, <94 cm in men and <80 cm in women) to reduce BP and CVD risk.	1	In adults who have overweight or obesity, weight loss is recommended with a goal of at least 5% of body weight reduction to prevent or treat elevated BP and hypertension.
	1	Adopting a healthy and balanced diet, such as the Mediterranean or DASH diets, is recommended to help reduce BP and CVD risk.	1	In adults with or without hypertension, a heart-healthy eating pattern, such as the DASH eating plan, is recommended to prevent or treat elevated BP and hypertension.
	1	Restriction of sodium to approximately 2 g/d is recommended where possible in all adults with elevated BP and hypertension (this is equivalent to about 5 g of salt [sodium chloride] per day or about a teaspoon or less).	1	In adults with or without hypertension, reduction of dietary sodium intake‡ is recommended to <2,300 mg/d, moving toward an ideal limit of <1,500 mg/d to prevent or treat elevated BP and hypertension.
	2a	In patients with hypertension without moderate to advanced CKD and with high daily sodium intake, an increase of potassium intake by 0.5-1.0 g/d—for example, through sodium substitution with potassium enriched salt (comprising 75% sodium chloride and 25% potassium chloride) or through diets rich in fruits and vegetables—should be considered.	2a	In adults with or without hypertension, potassium-based salt substitutes§ can be useful to prevent or treat elevated BP and hypertension, particularly for patients in whom salt intake is related mostly to food preparation or flavoring at home, except in the presence of CKD or use of drugs that reduce potassium excretion where monitoring of serum potassium levels is indicated.‖
			1	In adults with elevated BP or hypertension, moderate potassium supplementation¶, ideally from dietary sources, is recommended to prevent or treat elevated BP and hypertension, except in the presence of CKD or use of drugs that reduce potassium excretion where monitoring of serum potassium levels is indicated.‖
	1	Men and women are recommended to drink less alcohol than the upper limit, which is about 100 g/wk of pure alcohol. How this translates into number of drinks depends on portion size (the standards of which differ per country), but most drinks contain 8-14 g of alcohol per drink. Preferably, it is recommended to avoid alcohol to achieve the best health outcomes.	1	Adults with or without hypertension who currently consume alcohol should be advised to pursue a recommended goal of abstinence, or at least to reduce alcohol intake to ≤1 drink/d for women and ≤2 drinks/d for men to prevent or treat elevated BP and hypertension.#
	1	Moderate intensity aerobic exercise of ≥150 min/wk (≥30 min, 5-7 d/wk) or alternatively 75 min of vigorous intensity aerobic exercise per wk over 3 d are recommended and should be complemented with low- or moderate-intensity dynamic or isometric resistance training (2-3 times/wk) to reduce BP and CVD risk.	1	In adults with or without hypertension, increasing physical activity, through a structured exercise program that includes aerobic exercise and/or resistance training, is recommended to prevent or treat elevated BP and hypertension.
		No corresponding recommendation	2b	In adults with or without hypertension, stress reduction through transcendental meditation may be reasonable to prevent or treat elevated BP and hypertension, as an adjunct to lifestyle or medication interventions.
		No corresponding recommendation	2b	In adults with or without hypertension, other forms of stress management, such as breathing control techniques or yoga, may be reasonable to prevent or treat elevated BP and hypertension, as an adjunct to lifestyle or medication interventions.

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TABLE 2 Continued

	ESC Guideline[3]		AHA/ACC/Multisociety Guideline[1]	
	COR*	ESC Recommendations	COR*	AHA/ACC/Multisociety Recommendations
Initial 3- to 6-mo trial of lifestyle modification before medication (Top Take-Home Message 7)	1	In adults with elevated BP and sufficiently high CVD risk, after 3 mo of lifestyle intervention, BP lowering with pharmacological treatment is recommended for those with confirmed BP ≥130/ 80 mm Hg to reduce CVD risk.	1	In adults with hypertension without clinical CVD and with estimated 10-y CVD risk <7.5% based on PREVENT†, initiation of medications to lower BP is recommended if average SBP remains ≥130 mm Hg after a 3- to 6-mo trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.
			1	In adults with hypertension without clinical CVD and with estimated 10-y CVD risk <7.5% based on PREVENT†, initiation of medications to lower BP is recommended if average DBP ≥80 mm Hg after a 3- to 6-mo trial of lifestyle intervention to prevent target organ damage and mitigate further rise in BP.

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†Increased short-term or 10-y risk is defined as a 10-y predicted risk for CVD events of ≥7.5% based on PREVENT (Predicting Risk of cardiovascular disease EVENTs).
‡Dietary sodium reduction may be contraindicated in patients with severe, symptomatic orthostatic hypotension.
§This recommendation refers to potassium-based salt substitutes, which typically contain 25% to 30% potassium chloride, 65% to 75% sodium chloride, and 0% to 10% flavoring agents. Products that refer to themselves as "salt substitutes" that do not contain potassium chloride as a substitute for sodium chloride have unknown effects on BP.
‖Drugs that reduce potassium excretion include: potassium-sparing diuretics (eg, amiloride, triamterene), mineralocorticoid receptor antagonists (eg, spironolactone, eplerenone, finerenone), angiotensin-converting enzyme inhibitors (eg, captopril, enalapril, lisinopril, benazepril, and others), angiotensin receptor blockers (eg, losartan, valsartan, candesartan, telmisartan, and others), and some immunosuppressive agents (eg, cyclosporine, tacrolimus).
¶Moderate potassium supplementation is <80 mmol/d (<80 mEq/d).
#One standard drink (12-14 g alcohol) is equivalent to 12 oz of beer (5% alcohol by volume), 5 oz of wine (12% alcohol by volume), or 1.5 oz of distilled spirits (40% alcohol by volume).

ACC = American College of Cardiology; AHA = American Heart Association; BMI = body mass index; BP = blood pressure; CKD = chronic kidney disease; COR = Class of Recommendation; CVD = cardiovascular disease; DASH = Dietary Approaches to Stop Hypertension; DBP = diastolic blood pressure; ESC = European Society of Cardiology; SBP = systolic blood pressure; PREVENT = Predicting Risk of Cardiovascular Disease EVENTs.

JACC ILLUSTRATION

Central Illustration: Lifestyle Before Medication For Patients at Low Risk With Stage 1 High Blood Pressure

The AHA/ACC/Multisociety HBP Guideline emphasizes the need for primary prevention, which plays an important role in managing early stages of hypertension. The 2025 HBP Guideline-at-a-Glance **Central Illustration** highlights the importance of implementing lifestyle modifications such as adopting a healthier diet and increasing physical activity to prevent progression and reduce long term CVD. In adults with an average blood pressure 130-139/80-89 mm Hg and low CVD risk, medication is recommended after 3 to 6 months of lifestyle modification if blood pressure is not at goal. The illustration focuses on Top Take-Home Message 7.

COMPARISON OF PREVIOUS AHA/ACC GUIDELINES

The AHA/ACC/Multisociety HBP Guideline[1] updates content previously covered in the 2017 High Blood Pressure Guideline.[2] **Table 1** outlines recommendations on HBP treatment goals, lifestyle changes, and initial 3- to 6-month lifestyle modification before medication initiation between the 2017 and 2025 versions of the guideline. The comparison focuses on Top Take-Home Messages 1, 5, and 7.

For further details, refer to the corresponding sections of the AHA/ACC/Multisociety HBP Guideline[1]:

- Section 5.1. "Lifestyle and Psychosocial Approaches"
- Section 5.2.2. "BP Treatment Threshold and the Use of CVD Risk Estimation to Guide Drug Treatment of Hypertension"

AHA/ACC/MULTISOCIETY HBP GUIDELINE COMPARISON TO ESC HBP GUIDELINE

In 2024, the ESC published a guideline on the diagnosis and management of elevated blood pressure and hypertension (2024 ESC HBP Guideline).[3] **Table 2** compares the recommendations related to HBP as a risk factor for CVD, lifestyle changes, and initial 3- to 6-month lifestyle modification before medication initiation between the 2025 AHA/ACC/Multisociety HBP Guideline and the 2024 ESC HBP Guideline. The comparison focuses on Top Take-Home Messages 1, 5, and 7.

For further details, refer to the corresponding sections of the 2024 ESC HBP Guideline[3]:

- Section 8.2.5. "Smoking"
- Section 8.4. "Selecting Patients for Pharmacological Blood Pressure-Lowering Treatment"
- Section 8.5.3. "Personalizing Treatment Strategies"
- Section 9.6.3. "Managing Blood Pressure in Diabetes"

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