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From one hypertension guideline to the next: The 2026 ISH global practice guidelines on hypertension

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During the past three years four major international guidelines on hypertension diagnosis and treatment have been released. They include the one issued by the European Society of Hypertension in 2023, the European Society of Cardiology in 2024 together in the same year with the United Kingdom National Institute for Care and Excellence, and the American Heart Association/American College of Cardiology in 2025 [1–4]. Few days ago a fifth document has been added to the long list, the 2026 Gobal Practice Hypertension Guidelines issued by the International Society of Hypertension (ISH) [5].

We recently had the opportunity to express some concerns about the fact that the high number of hypertension guidelines issued by national and international societies worldwide in the past few years (more than 20), did not help physicians in substantially improving blood pressure control in both european and extra-european countries, which remains by and large unsatisfactory. It should be recognized that the 2026 ISH Global Practice guidelines may represent an exception to the above mentioned criticism.

Indeed, the ISH document has been prepared with general and specific objectives and model of presentation substantially different from those adopted by previous guidelines (Fig. 1). It addresses high blood pressure taking the perspective not only of high-income nations but also of countries around the world, in which the diagnostic approach as well as the therapeutic strategies defined for the disease may pose serious problems of implementation due to the economic burden. The most relevant general difference with other previously published guidelines concerns the fact that the ISH document takes into account the national differences in expertise, economic and medical resources worldwide. This may allow to distinguish among recommendations those that may be defined as “essential“ or “optimal“. Essential recommendations are applicabile to low income countries, while optimal recommendations to countries where economic and medical resources appear to be adequate and/or sufficient to address the high blood pressure matter. In addition, the short format of the text (30 pages compared with more than 100 pages of other guidelines) as well as the artificial intelligence-based instrument for smartphones and computers may simplify the application of the recommendations to the solution of daily clinical problems related to the hypertension diagnostic approach and therapeutic intervention as well.

In addition to the above mentioned “general“ differences, other specific features of the ISH guidelines, compared with other documents, should be worthy of mention (Fig. 1). A first feature concerns the standardization of out-of-office blood pressure measurements. Specifically, 24 h ambulatory blood pressure monitoring retains clinical relevance in confirming elevated blood pressure values assessed at office blood pressure evaluation. On the other hand, home blood pressure measurements, which ISH guidelines define as “standardized“ home blood pressure monitoring, may provide important additional information on blood pressure responses to the antihypertensive non-pharmacological and pharmacological treatment.

Another peculiar feature of the ISH guidelines concerns the blood pressure targets of the therapeutic intervention, with “optimal care“ values amounting to less than 130/80 mmHg and “essential care“ values to less than 140/90 mmHg. As a general rule ISH guidelines maintain orientation towards an intensive blood pressure control, with the

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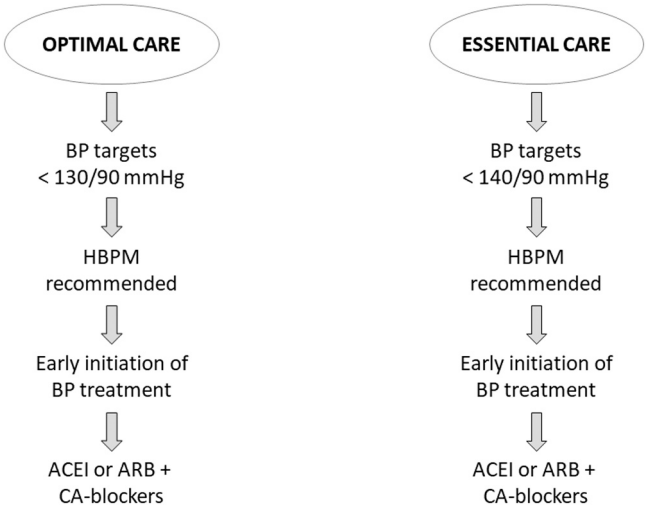


Fig. 1. Scheme illustrating the main elements of novelty of the 2026 International Society of Hypertension (ISH) global practice guidelines. BP: blood pressure; HBPM: home blood pressure monitoring; ACEi: angiotensin concerting enzyme inhibitors; ARB: angiotensin receptor blockers; CA: calcium.

achievement of office blood pressure values close to 120–129/70–79 mmHg, at least in patients aged less than 79 years. To achieve these ambitious targets ISH guidelines strongly recommend combination drug treatment as the preferred initial strategy of the therapeutic intervention in the majority of the hypertensive patients. Preferred two drugs combination is the association in a single pill of a dihydropyridine calcium channel blocker with a drug acting on the renin-angiotensin-aldosterone system, either angiotensin-converting enzyme inhibitor (ACEi) or an angiotensin receptor blocker (ARB). At variance from previous european and extra-european guidelines thiazides are used only as components of triple combination drug treatment. The ISH guidelines emphasize the importance of lifestyle interventions, including dietary salt restriction, regular physical exercise, body weight control, moderation of alcohol intake and cigarette smoking cessation. They also emphasize the therapeutic relevance of the new blood pressure lowering agents, such as aldosterone synthase inhibitors, endothelin receptor antagonists and non-steroidal mineralocorticoid receptor antagonists. Finally, bilateral renal nerves ablation is regarded as a therapeutic intervention for selected patients with true resistant hypertension and a high or very high cardiovascular risk profile. The selection of the approach is based not only on the patient's clinical profile but also on the economic sustainability of the procedure.

Few final words deserve to be added in relation to an important final part of the document devoted to guidelines implementation. This key process is supported by digital technologies but also by simplified therapeutic algorithms, larger use of combination drug treatment as single pill and multidisciplinary care. It is advisable that effective implementation of existing guidelines will allow in the next few years to substantially improve blood pressure control and therefore to reduce cardiovascular risk in hypertensive patients.

Declaration of Competing Interest

none

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