orthostatic Hypotension	
Observation	**Relevance**
systolic Blood Pressure Drop	1.0
diastolic Blood Pressure Drop	1.0

Observation Name	Label	Value	Unit	Relevance
systolic Blood Pressure	elevated	120–139	mmHg	0.2
systolic Blood Pressure	high	>= 140	mmHg	0.5
systolic Blood Pressure Drop		>=20	mmHg	0.3
diastolic Blood Pressure	elevated	70–89	mmHg	0.2
diastolic Blood Pressure	high	>= 90	mmHg	0.5
diastolic Blood Pressure Drop		>=10	mmHg	0.3

This 2024 document updates the 2018 ESC/European Society of Hypertension (ESH) Guidelines on the management of arterial hypertension.[1] While the current document builds on prior guidelines, it also incorporates important updates and new recommendations based on current evidence. For example:

(1) The title has changed from 'Guidelines on the management of arterial hypertension' to 'Guidelines on the management of elevated blood pressure and hypertension'. This is based on evidence that the risk for cardiovascular disease (CVD) attributable to blood pressure (BP) is on a continuous exposure scale, not a binary scale of normotension vs. hypertension.[2,3] Updated evidence also increasingly demonstrates the benefit on CVD outcomes of BP-lowering medications among persons with high CVD risk and BP levels that are elevated but that do not meet traditional thresholds used to define hypertension. The term 'arterial' is removed from the title of the 2024 Guidelines, as arterial hypertension can also occur in the pulmonary arteries, which is not a focus here.

(2) The 2024 Guidelines continue to define hypertension as office systolic BP of ≥140 mmHg or diastolic BP of ≥90 mmHg. However, a new BP category called 'Elevated BP' is introduced. Elevated BP is defined as an office systolic BP of 120–139 mmHg or diastolic BP of 70–89 mmHg.

(3) A major, evidence-based change in the 2024 Guidelines is the recommendation to pursue a target systolic BP of 120–129 mmHg among adults receiving BP-lowering medications. There are several important caveats to this recommendation, including: (i) the requirement that treatment to this BP target is well tolerated by the patient, (ii) the fact that more lenient BP targets can be considered in persons with symptomatic orthostatic hypotension, those aged 85 years or over, or those with moderate-to-severe frailty or limited life expectancy, and (iii) a strong emphasis on out-of-office BP measurement to confirm the systolic BP target of 120–129 mmHg is achieved. For those selected individual cases where a target systolic BP of 120–129 mmHg is not pursued, either due to intolerance or the existence of conditions that favour a more lenient BP target, we recommend targeting a BP that is as low as reasonably achievable. Personalized clinical decision-making and shared decisions with the patient are also emphasized.

(4) Another important change in the 2024 Guidelines compared with earlier versions is the increased focus on evidence related to fatal and non-fatal CVD outcomes rather than surrogate outcomes such as BP lowering alone. Except for lifestyle interventions and low-risk non-pharmacological interventions aimed at implementation or care delivery, the current guidelines require that, for a Class I recommendation to be made for a drug or procedural intervention, the evidence must show benefit on CVD outcomes and not only BP lowering.

(5) The task force comprised of a balanced representation of males and females.

(6) The present guidelines consider sex and gender as an integral component throughout the document, rather than in a separate section at the end. In this document, sex is the biological condition of being female or male from conception, based on genes, and gender is the socio-cultural dimension of being a woman or a man in a given society, based on gender roles, gender norms, gender identity, and gender relations valid in the respective society at a given timepoint.[4,5]

(7) The 2024 Guidelines are written to make them more 'user friendly'. Input from general practitioners (GPs) was obtained in this regard, and one task force member is a GP. Given the ageing population in Europe, there was also a focus on tailoring treatment with respect to frailty and into older age, which is addressed in multiple sections. Moreover, patient input and their lived experiences are considered throughout. We also now include evidence tables in the Supplementary section to provide improved transparency regarding our recommendations. As appropriate, readers who wish to seek additional details and information are referred to the Supplementary data online and to the ESC CardioMed.[6]

(8) The task force recognized that a major challenge in guideline usage is poor implementation. This likely contributes to suboptimal control of hypertension.[7–9] To address this, a dedicated section on implementation is included in the Supplementary data online. Moreover, through a new initiative, we include information from national societies following a survey on guideline implementation completed during the national society peer review of the guidelines document. It is hoped this information may help inform national societies about potential barriers to implementation.

2.1. What is new

These 2024 Guidelines contain a number of new and revised recommendations, which are summarized in *Tables 3* and *4*, respectively.

Table 3 New recommendations

Recommendations	Class[a]	Level[b]
5. Measuring blood pressure		
It is recommended to measure BP using a validated and calibrated device, to enforce the correct measurement technique, and to apply a consistent approach to BP measurement for each patient.	I	B
Out-of-office BP measurement is recommended for diagnostic purposes, particularly because it can detect both white-coat hypertension and masked hypertension. Where out-of-office measurements are not logistically and/or economically feasible, then it is recommended that the diagnosis be confirmed with a repeat office BP measurement using the correct standardized measurement technique.	I	B
Most automated oscillometric monitors have not been validated for BP measurement in AF; BP measurement should be considered using a manual auscultatory method in these circumstances, where possible.	IIa	C
An assessment for orthostatic hypotension (≥20 systolic BP and/or ≥10 diastolic BP mmHg drop at 1 and/or 3 min after standing) should be considered at least at the initial diagnosis of elevated BP or hypertension and thereafter if suggestive symptoms arise. This should be performed after the patient is first lying or sitting for 5 min.	IIa	C