

Appropriate management of hypertension reduces the risk for cardiovascular disease, renal disease, cerebrovascular disease, and death (3–6). However, determining the most appropriate BP targets, particularly for adults aged 60 years or older, has been controversial. Debate about the goal for systolic BP (SBP) among adults treated for hypertension has intensified, especially in light of recent recommendations (7). In addition, when selecting BP targets for adults aged 60 years or older, clinicians need to consider comorbid conditions that could affect treatment choice. Treatments for hypertension include lifestyle modifications, such as weight loss, dietary modification, and increased physical activity, and antihypertensive medications, which commonly include thiazide-type diuretics, angiotensin-converting enzyme inhibitors (ACEIs), angiotensin-receptor blockers (ARBs), calcium-channel blockers, and β -blockers.

GUIDELINE FOCUS AND TARGET POPULATION

The purpose of this American College of Physicians (ACP) and American Academy of Family Physicians (AAFP) joint guideline is to present evidence-based recommendations on the benefits and harms of higher (<150 mm Hg) versus lower ($\leq$ 140 mm Hg) SBP targets for the treatment of hypertension in adults aged 60 years or older. The target audience for this guideline includes all clinicians, and the target patient population includes adults aged 60 years or older with hypertension. These recommendations are based on a background evidence review (8) and systematic review sponsored by the U.S. Department of Veterans Affairs (VA) (9).

METHODS

Systematic Review of the Evidence

The evidence review was conducted by the Portland VA Health Care System Evidence-based Synthesis Program. The summary of methods for the evidence review can be found in the **Appendix** (available at [Annals.org](https://annals.org)). Additional details are included in the accompanying background evidence review (8) and the full evidence report (9).

Grading the Evidence and Developing Recommendations

This guideline was jointly developed by ACP's Clinical Guidelines Committee and representatives from AAFP according to ACP's guideline development process, details of which can be found in the methods paper (10). The committee used the evidence tables in the accompanying systematic review (8) and full report (9) when reporting the evidence and graded the recommendations using the GRADE (Grading of Recommendations Assessment, Development, and Evaluation) method (Table).

Peer Review

The VA evidence review was peer reviewed and posted on the VA Web site for public comments, and

Table. The American College of Physicians' Guideline Grading System*

Quality of Evidence	Strength of Recommendation	
	Benefits Clearly Outweigh Risks and Burden or Risks and Burden Clearly Outweigh Benefits	Benefits Finely Balanced With Risks and Burden
High	Strong	Weak
Moderate	Strong	Weak
Low	Strong	Weak
Insufficient evidence to determine net benefits or risks		

* Adopted from the classification developed by the GRADE (Grading of Recommendations Assessment, Development, and Evaluation) workgroup.

the published review article was peer reviewed through the journal. The guideline had a peer-review process through the journal and was posted online for comments from ACP Regents and Governors, who represent physician members at the national and international level. The guideline was also reviewed by members of AAFP's Commission on Health of the Public and Science.

BENEFITS OF TREATING HIGHER VERSUS LOWER BP TARGETS IN OLDER ADULTS

Across all trials, treating high BP in older adults was beneficial. However, most of the evidence came from studies of patients with moderate or severe hypertension (SBP >160 mm Hg) at baseline and, with treatment, achieved SBP targets greater than 140 mm Hg.

Differing BP Targets

Moderate-quality evidence showed a reduction in all-cause mortality among patients with a baseline SBP of 160 mm Hg or greater who achieved a target SBP of less than 150 mm Hg, although the reductions did not quite reach statistical significance (relative risk [RR], 0.93 [95% CI, 0.85 to 1.00]; absolute risk reduction [ARR], 1.13). High-quality evidence showed reductions in stroke (RR, 0.77 [CI, 0.64 to 0.91]; ARR, 0.92), and cardiac events (RR, 0.83 [CI, 0.71 to 0.96]; ARR, 0.72) (11–21).

In studies with lower SBP targets (<140 mm Hg), low-quality evidence showed no statistically significant reduction in all-cause mortality (RR, 0.93 [CI, 0.75 to 1.14]; ARR, 0.21), cardiac events (RR, 0.91 [CI, 0.77 to 1.04]; ARR, 0.35), or stroke (RR, 0.86 [CI, 0.64 to 1.07]; ARR, 0.19) compared with higher BP targets (11–13, 20, 22, 23). Many of these studies, however, did not achieve the targeted BP, and there was little difference in BP between the intensive treatment and control groups. Therefore, these studies may not have been able to detect differences in clinical outcomes.

A subgroup analysis compared studies that achieved lower SBP targets (<140 mm Hg) with those that achieved higher SBP targets ($\geq$ 140 mm Hg) (11–13,