

Comprehensive Clinical Reference: 2025 AHA/ACC Hypertension Guidelines for Pharmacists

This document provides evidence-based recommendations from the 2025 AHA/ACC/AAPA/ABC/ACPM/AGS/APhA/ASH/ASPC/NMA/PCNA Guideline for the Management of High Blood Pressure in Adults, specifically tailored for pharmacists practicing in acute care, ambulatory care, and hospital settings. The updated guidelines include significant terminology changes, treatment thresholds, and clinical approaches that will impact pharmaceutical care across various practice settings.

Major Terminology Update: From Hypertensive Urgency to Severe Hypertension

New 2025 Definition

Blood pressure **>180/120 mm Hg** without acute target organ damage. This replaces the previously used term "hypertensive urgency."

Rationale for Change

The term "hypertensive urgency" contributed to inappropriate emergency department utilization and unnecessary administration of intravenous antihypertensive medications, potentially causing harm.

Evidence-Based Approach

The new terminology promotes oral medication initiation and outpatient follow-up, reducing inappropriate acute interventions in emergency settings.

Clinical Impact for Pharmacists

This terminology shift represents a significant paradigm change in how asymptomatic elevated blood pressure is managed. Pharmacists play a crucial role in implementing this new approach by:

- Advocating for appropriate oral medication initiation rather than IV therapy
- Educating healthcare team members about the potential risks of rapid blood pressure reduction
- Developing protocols that emphasize outpatient follow-up for patients with severe hypertension
- Reviewing medication orders to prevent inappropriate use of IV antihypertensives
- Promoting patient safety through gradual blood pressure control strategies

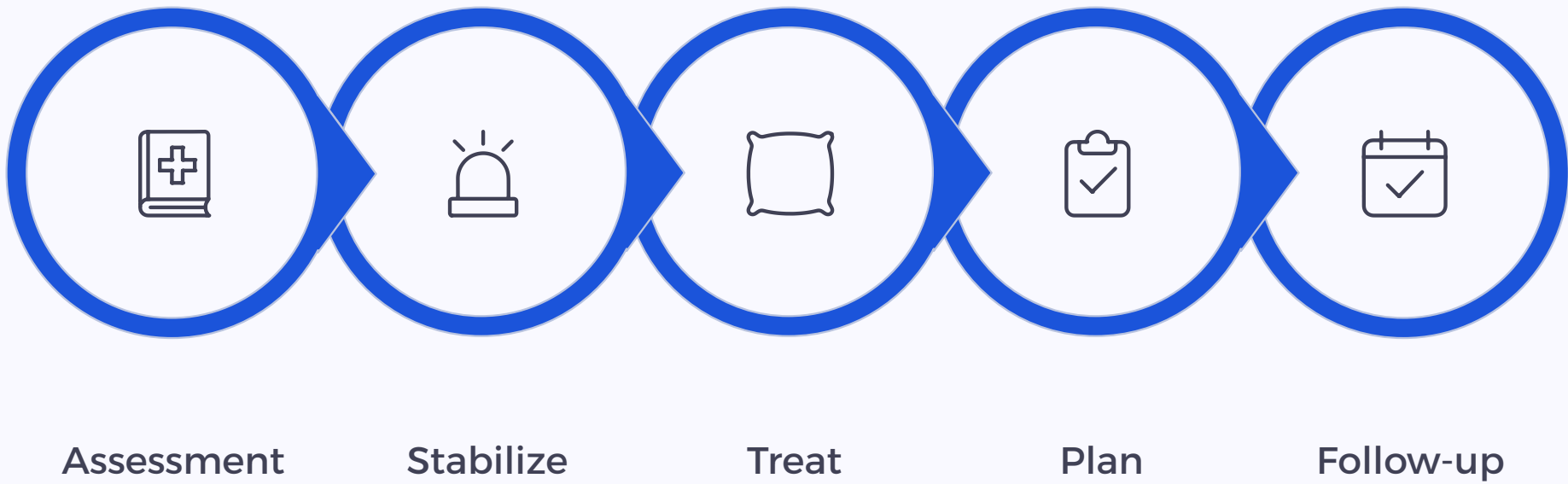
The 2025 guidelines emphasize that patients with severe hypertension without target organ damage are best managed with oral medications and close follow-up rather than emergency interventions. This approach reduces healthcare utilization costs while improving patient outcomes through safer blood pressure management strategies.

Severe Hypertension Management in Hospital Settings

2025 Recommendation Update (Section 6.2)

Class IIa (Moderate), Level of Evidence B-NR: Avoid intermittent intravenous or immediate-release sublingual antihypertensive medications in hospitalized patients with severe hypertension without evidence of acute target organ damage.

Multiple studies demonstrate no clinical benefit and potential harm from acute blood pressure reduction in asymptomatic patients. Precipitous blood pressure lowering can lead to cerebral, coronary, or renal hypoperfusion, resulting in iatrogenic injury. This recommendation aims to prevent common prescribing patterns where PRN IV hydralazine or metoprolol orders are written for asymptomatic elevated blood pressure.



Clinical Application for Pharmacists

Consider the following clinical scenario: A 68-year-old hospitalized patient with blood pressure 185/115 mm Hg, no acute symptoms, normal cardiac biomarkers, no evidence of acute kidney injury, normal neurological examination, and stable clinical status.

Pharmacist Recommendation

Immediate Action: "Recommend against PRN hydralazine or metoprolol orders. Document blood pressure readings and patient's asymptomatic status."

Assessment	Medication Approach	Follow-up Plan
Monitor blood pressure every 4-6 hours	Initiate or optimize oral antihypertensive therapy only if persistently elevated	Arrange cardiology or primary care follow-up within 7 days of discharge
Document absence of target organ damage	Consider amlodipine 5 mg daily or lisinopril 10 mg daily for sustained elevation	Provide comprehensive medication counseling

This evidence-based approach prevents the common but potentially harmful practice of administering PRN IV antihypertensives for asymptomatic blood pressure elevations in hospitalized patients. By advocating for this approach, pharmacists can significantly improve patient safety while ensuring appropriate blood pressure management.

Acute Intracerebral Hemorrhage (ICH) Management

2025 Blood Pressure Targets (Section 5.3.9.1)

The management of blood pressure in intracerebral hemorrhage represents a critical balance between reducing hematoma expansion risk while maintaining adequate cerebral perfusion. Based on evidence from the INTERACT2 and ATACH-II trials, the 2025 guidelines provide specific blood pressure targets based on presentation severity:

For SBP 150–220 mm Hg:

- Lower systolic blood pressure to **130–140 mm Hg** within the first 7 days post-ICH
- Discontinue antihypertensive medications if SBP falls below **130 mm Hg**
- Use controlled, gradual reduction to prevent cerebral hypoperfusion

For SBP >220 mm Hg:

- Use continuous intravenous infusion therapy
- Avoid bolus medications to prevent blood pressure variability
- Implement more aggressive titration protocols with close monitoring



Intracerebral hemorrhage requires precise blood pressure management to prevent hematoma expansion while maintaining cerebral perfusion.

Clinical Scenarios for Pharmacists



Scenario A: Moderate ICH

Patient: 72-year-old ICU patient with spontaneous intracerebral hemorrhage (basal ganglia), Glasgow Coma Scale 14, systolic blood pressure 165 mm Hg, currently receiving lisinopril 20 mg daily and amlodipine 10 mg daily via nasogastric tube.

Pharmacist Recommendation: "Recommend initiating nicardipine IV infusion starting at 5 mg/hour, targeting systolic blood pressure 130–140 mm Hg."

- Temporarily discontinue oral lisinopril and amlodipine
- Titrate nicardipine by 2.5 mg/hour every 15 minutes until target achieved
- Monitor blood pressure continuously with arterial line
- Restart oral agents when patient stable and neurologically improving



Scenario B: Severe ICH

Patient: 59-year-old emergency department patient with acute intracerebral hemorrhage, systolic blood pressure 230 mm Hg, altered mental status, and evidence of increased intracranial pressure on CT imaging.

Pharmacist Recommendation: "Recommend clevidipine IV infusion starting at 1–2 mg/hour with aggressive titration protocol."

- Avoid hydralazine or labetalol boluses due to unpredictable response
- Titrate clevidipine by 1–2 mg/hour every 5–10 minutes
- Target gradual reduction: 10–15% in first hour, then to 130–140 mm Hg over 24 hours
- Coordinate with neurosurgery for potential surgical intervention

The evidence supporting these recommendations demonstrates that controlled blood pressure reduction improves functional outcomes and reduces hematoma expansion risk. However, excessive reduction below 130 mm Hg may compromise cerebral perfusion and worsen neurological outcomes. Pharmacists must carefully monitor both blood pressure parameters and neurological status to optimize therapy.

Acute Ischemic Stroke Blood Pressure Management

⊗ 2025 Critical Update (Section 5.3.9.2)

Class III (Harm), Level of Evidence B-R: Avoid lowering systolic blood pressure below 140 mm Hg within 24 - 72 hours post-reperfusion therapy as this may worsen neurological outcomes.

The updated guidelines represent a significant shift in post-reperfusion blood pressure management based on emerging evidence from the DAWN and DEFUSE-3 trials. These studies demonstrate that aggressive blood pressure reduction post-thrombectomy can compromise collateral circulation and penumbral tissue recovery. Maintenance of adequate cerebral perfusion pressure is critical during the acute recovery phase to support neurological recovery and prevent secondary injury.



Clinical Scenario for Pharmacists

Patient Presentation: 66-year-old ICU patient status post-successful mechanical thrombectomy for large vessel occlusion 8 hours ago. Current systolic blood pressure 145 mm Hg, NIHSS improved from 18 to 6, patient neurologically stable. Home medications include metoprolol 50 mg twice daily and losartan 100 mg daily.

Pharmacist Recommendation

Critical Decision: "Recommend holding all antihypertensive medications. Maintain systolic blood pressure between 140 - 180 mm Hg for optimal cerebral perfusion."

Monitoring Protocol

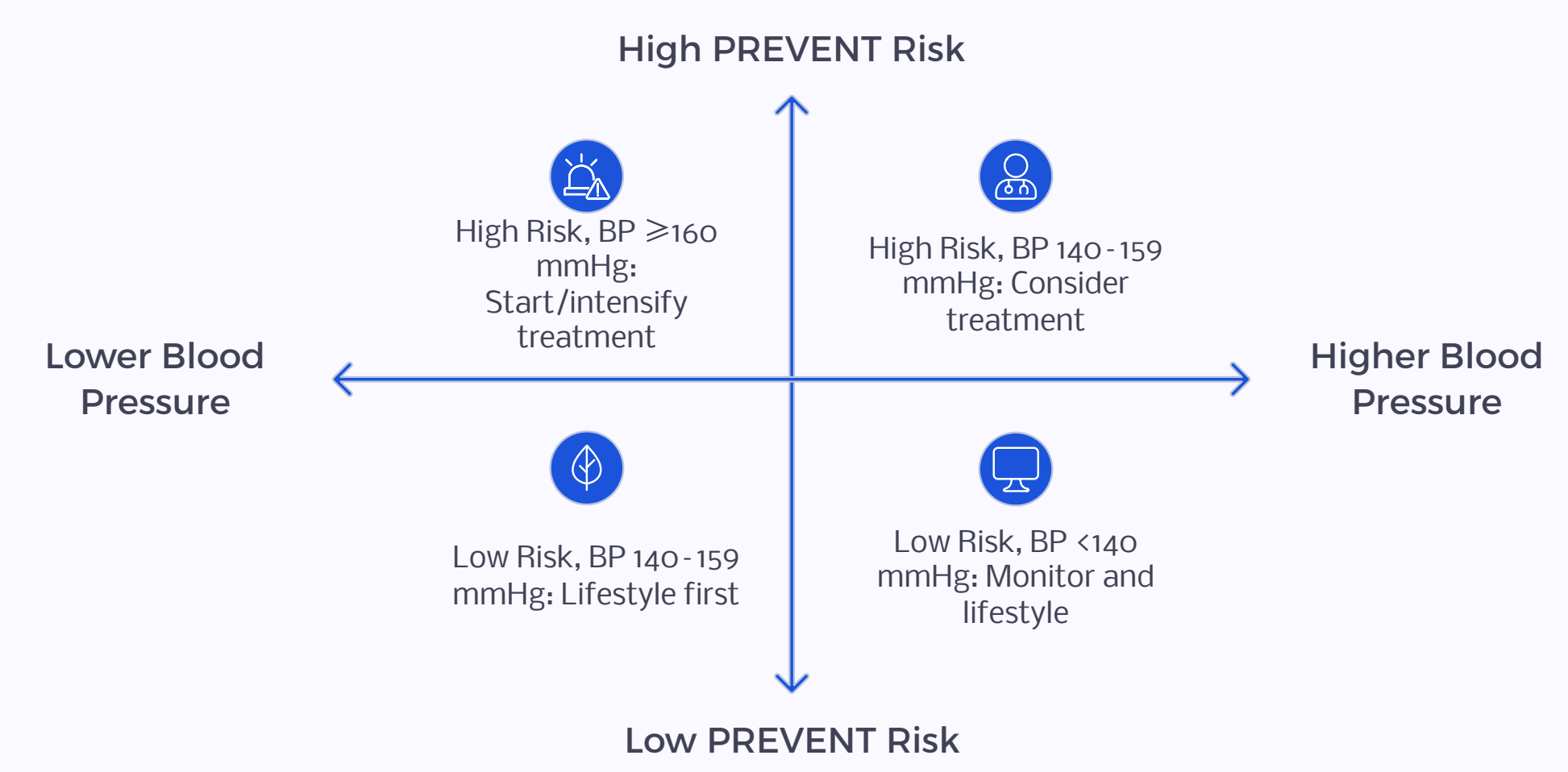
Timeframe	Actions
0-24 hours	<ul style="list-style-type: none">- Hold metoprolol and losartan- Monitor blood pressure every 2 hours with neuro checks- Maintain SBP 140-180 mm Hg- Intervene only if SBP >180 mm Hg persistently
24-72 hours	<ul style="list-style-type: none">- Continue to withhold routine antihypertensives- Consider nicardipine IV if intervention required (start 5 mg/hour)- Monitor for neurological deterioration- Assess for reperfusion injury or hemorrhagic transformation
>72 hours	<ul style="list-style-type: none">- Resume home medications if neurologically stable- Titrate gradually to avoid precipitous drops- Transition to standard secondary prevention targets- Consider neurology consult for medication adjustments

This approach reflects the current understanding that cerebral autoregulation is impaired following ischemic stroke, particularly after reperfusion therapy. Maintaining adequate perfusion pressure during this critical period supports tissue recovery and may improve long-term neurological outcomes. Pharmacists play a crucial role in preventing inappropriate blood pressure lowering during this vulnerable period.


Blood Pressure Treatment Thresholds Using PREVENT Risk Assessment

2025 Major Update (Section 5.2.2)

A significant advancement in the 2025 guidelines is the integration of the PREVENT (Predicting Risk of cardiovascular disease EVENTS) risk assessment tool, which provides more inclusive and contemporary cardiovascular risk prediction compared to the 2013 ACC/AHA Pooled Cohort Equations. The PREVENT model includes kidney disease, social determinants of health, and updated population demographics, providing more accurate risk stratification for diverse patient populations.




Treatment Approaches Based on Risk Stratification



High-Risk Patients (Immediate Treatment)

Initiate antihypertensive therapy at **SBP ≥ 130 mm Hg or DBP ≥ 80 mm Hg** if ANY of:

- Established clinical cardiovascular disease
- Type 1 or Type 2 diabetes mellitus
- Chronic kidney disease (eGFR < 60 or albuminuria)
- PREVENT 10-year risk $\geq 7.5\%$



Lower-Risk Patients (Lifestyle-First)

For patients with **SBP 130-139 mm Hg or DBP 80-89 mm Hg** and PREVENT risk $< 7.5\%$:

- Begin with 3-6 months of structured lifestyle intervention
- DASH diet, sodium restriction, physical activity, weight management
- Initiate pharmacotherapy only if BP remains elevated after lifestyle modifications

Clinical Scenarios for Pharmacists

High-Risk Patient

Patient: 58-year-old male with type 2 diabetes (HbA1c 7.2%), microalbuminuria (ACR 45 mg/g), blood pressure 132/82 mm Hg (confirmed on multiple visits), currently on metformin 1000 mg twice daily and atorvastatin 40 mg daily. No prior antihypertensive therapy.

Recommendation: "Based on 2025 guidelines, this patient meets criteria for immediate antihypertensive therapy due to diabetes and microalbuminuria."

Optimal Selection: Initiate lisinopril 10 mg daily (ACE inhibitor preferred for diabetes with albuminuria) with target blood pressure $< 130/80$ mm Hg.

Lower-Risk Patient

Patient: 45-year-old female with no comorbidities, blood pressure 135/85 mm Hg (average of multiple readings), PREVENT 10-year risk 4.2%. She has completed 6 months of DASH diet adherence and regular aerobic exercise (150 minutes/week). Current blood pressure remains 134/84 mm Hg.

Recommendation: "Despite excellent lifestyle modifications, blood pressure remains elevated. Per 2025 guidelines, pharmacotherapy is now indicated."

First-Line Therapy: Initiate chlorthalidone 12.5 mg daily (preferred thiazide-like diuretic) with target blood pressure $< 130/80$ mm Hg.

The integration of the PREVENT risk calculator allows for more personalized treatment decisions, particularly for patients with borderline blood pressure elevations. Pharmacists should familiarize themselves with this tool (available at [Tools.acc.org/PREVENT](https://tools.acc.org/PREVENT)) to provide evidence-based recommendations for hypertension management.

Severe Hypertension in Outpatient Settings

Emergency Department Approach to Asymptomatic Severe Hypertension

2025 Paradigm Shift

Class I (Strong), Level of Evidence B-NR: For patients presenting to the emergency department with severe hypertension (**>180/120 mm Hg**) without acute target organ damage, initiate oral antihypertensive therapy and arrange outpatient follow-up rather than administering intravenous medications.

Multiple studies, including the OPTIMIST and TARGET-BP trials, demonstrate that gradual blood pressure reduction over 24-48 hours results in better outcomes than acute reduction. Rapid blood pressure lowering in asymptomatic patients can precipitate stroke, myocardial infarction, or acute kidney injury. This evidence has led to a fundamental shift in how these patients are managed in emergency settings.

Emergency Department Scenario

Patient Presentation: 52-year-old male presents to emergency department with blood pressure 190/110 mm Hg, no acute symptoms (no chest pain, shortness of breath, neurological deficits, or visual changes), normal electrocardiogram, normal chest X-ray, basic metabolic panel within normal limits, and normal urinalysis. Patient reports missing his blood pressure medications for "a few weeks."

Pharmacist Recommendation

Emergency Department Management: "This patient meets criteria for severe hypertension without acute target organ damage. Intravenous antihypertensives are not indicated and may cause harm."

Immediate Assessment

Confirm absence of target organ damage through physical examination, laboratory studies, and appropriate imaging. Differentiate between asymptomatic severe hypertension and hypertensive emergency.

Medication Initiation

Initiate amlodipine 5 mg daily immediately (long-acting, well-tolerated) or lisinopril 10 mg daily if no contraindications. Provide 72-hour medication supply and prescription for continued therapy.

Follow-up Planning

Arrange primary care or cardiology follow-up within 72 hours. Educate on medication adherence importance and lifestyle modifications. Provide return precautions for symptoms of target organ damage.

This approach emphasizes that severe hypertension without evidence of acute end-organ damage is best managed in the outpatient setting with oral medications, close follow-up, and patient education. By implementing these guidelines, pharmacists can help reduce unnecessary hospital admissions, prevent adverse events from aggressive blood pressure lowering, and promote cost-effective care.

Severe Hypertension in Pregnancy

2025 Timing Update (Section 5.5)

Critical Treatment Window

Class I (Strong), Level of Evidence B-R: Treat severe hypertension in pregnancy (**SBP ≥ 160 mm Hg or DBP ≥ 110 mm Hg**) within 30-60 minutes to prevent maternal stroke while avoiding fetal compromise.

Severe hypertension in pregnancy represents a medical emergency requiring prompt but controlled intervention. Delays in treatment increase risk of maternal stroke, placental abruption, and HELLP syndrome, while excessive blood pressure reduction can compromise uteroplacental perfusion. The 2025 guidelines emphasize the critical 30-60 minute treatment window to optimize both maternal and fetal outcomes.

Labor and Delivery Scenario

Patient Presentation: 32-year-old gravida 2, para 1 at 37 weeks gestation presents to triage with blood pressure 165/112 mm Hg (confirmed on repeat), mild headache, no visual disturbances, 1+ proteinuria, normal reflexes, and reactive fetal heart rate tracing.

Pharmacist Recommendation

Immediate Intervention: "Recommend immediate antihypertensive therapy within 30 minutes of confirmed severe hypertension."

First-Line: Oral Nifedipine

Immediate-release

nifedipine 10 mg, may repeat in 30 minutes if SBP remains ≥ 160 or DBP ≥ 110 mm Hg

Note: Administer orally, not sublingually (risk of precipitous hypotension)

Alternative: IV Labetalol

Labetalol 20 mg IV bolus, may repeat with 40 mg in 10 minutes, then 80 mg every 10 minutes (maximum 220 mg)

Contraindicated in asthma, heart block, or heart failure

Second Alternative: IV Hydralazine

Hydralazine 5-10 mg IV, may repeat 5-10 mg every 20-30 minutes (maximum 20 mg)

Associated with more maternal hypotension than labetalol

Blood Pressure Targets and Monitoring

- Target: Reduce blood pressure by 10-15% or to **140-150/90-100 mm Hg**
- Avoid reducing mean arterial pressure by more than 25% in first 1-2 hours
- Monitor blood pressure every 10 minutes during acute treatment
- Continuous fetal monitoring during treatment
- Assess for signs of preeclampsia progression (headache, visual changes, epigastric pain)

Pharmacists play a critical role in ensuring timely and appropriate management of severe hypertension in pregnancy by having protocols in place, educating staff on proper medication selection and dosing, and monitoring for both maternal and fetal effects of therapy.

Chronic Hypertension in Pregnancy

2025 Treatment Thresholds

The 2025 guidelines recommend treating chronic hypertension in pregnancy when **SBP 140–159 mm Hg or DBP 90–109 mm Hg** to target **<140/90 mm Hg** for optimal maternal and fetal outcomes. This recommendation is based on the CHAP trial, which demonstrated improved maternal and fetal outcomes with tighter blood pressure control during pregnancy.

Benefits of Treatment

- Reduced risk of preeclampsia development
- Lower rates of preterm birth
- Decreased risk of placental abruption
- Reduced maternal cardiovascular complications
- Improved fetal growth parameters






Regular blood pressure monitoring and medication management are essential components of prenatal care for women with chronic hypertension.

Prenatal Care Scenario

Patient Presentation: 29-year-old gravida 1 at 12 weeks gestation with blood pressure 145/95 mm Hg (average of multiple readings), normal urinalysis, no proteinuria, and normal basic metabolic panel. She has a history of mild hypertension but discontinued lisinopril when pregnancy was confirmed.

Pharmacist Recommendation

Pregnancy-Safe Antihypertensive Selection: "Initiate pregnancy-safe antihypertensive therapy to prevent progression to severe hypertension and reduce preeclampsia risk."

		
Initial Assessment Confirm chronic hypertension diagnosis Evaluate for target organ damage Screen for secondary causes if indicated	Medication Selection First-Line: Labetalol 100 mg twice daily (may titrate to 200–400 mg twice daily) Alternative: Methyldopa 250 mg twice daily (may increase to 500 mg twice daily) Third-Line: Extended-release nifedipine 30 mg daily if beta-blockers contraindicated	Monitoring Plan Monitor blood pressure weekly initially, then every 2 weeks when stable Coordinate care with high-risk obstetrics Assess for preeclampsia at each visit

Special Considerations

When managing chronic hypertension in pregnancy, pharmacists should be aware of several important considerations:

- Home blood pressure monitoring is recommended to guide therapy adjustments
- Medication doses may need to be increased during the second and third trimesters due to physiological changes
- Target blood pressure should not be excessively low to maintain adequate uteroplacental perfusion
- Patients should be monitored for fetal growth restriction, especially with beta-blocker therapy
- Low-dose aspirin (81 mg daily) starting at 12 weeks is recommended for preeclampsia prevention

By following these evidence-based guidelines, pharmacists can help optimize outcomes for both mother and baby when managing chronic hypertension during pregnancy.

2025 Expanded Contraindicated Medications List in Pregnancy

Critical Safety Update

Renin-Angiotensin System Inhibitors

- All ACE inhibitors (lisinopril, enalapril, ramipril, etc.)
- All ARBs (losartan, valsartan, olmesartan, etc.)
- Direct renin inhibitors (aliskiren)

Risks: Oligohydramnios, fetal growth restriction, renal tubular dysplasia, anuria, renal failure, skull hypoplasia, and fetal death

Beta-Blockers

- Atenolol (specifically contraindicated)

Risks: Greater risk of fetal growth restriction compared to other beta-blockers, placental hypoperfusion, and bradycardia

Note: Other beta-blockers like labetalol and metoprolol are considered safe

Mineralocorticoid Receptor Antagonists

- Spironolactone
- Eplerenone

Risks: Antiandrogenic effects on male fetus, potential feminization, and electrolyte disturbances

Other Agents

- Sodium nitroprusside

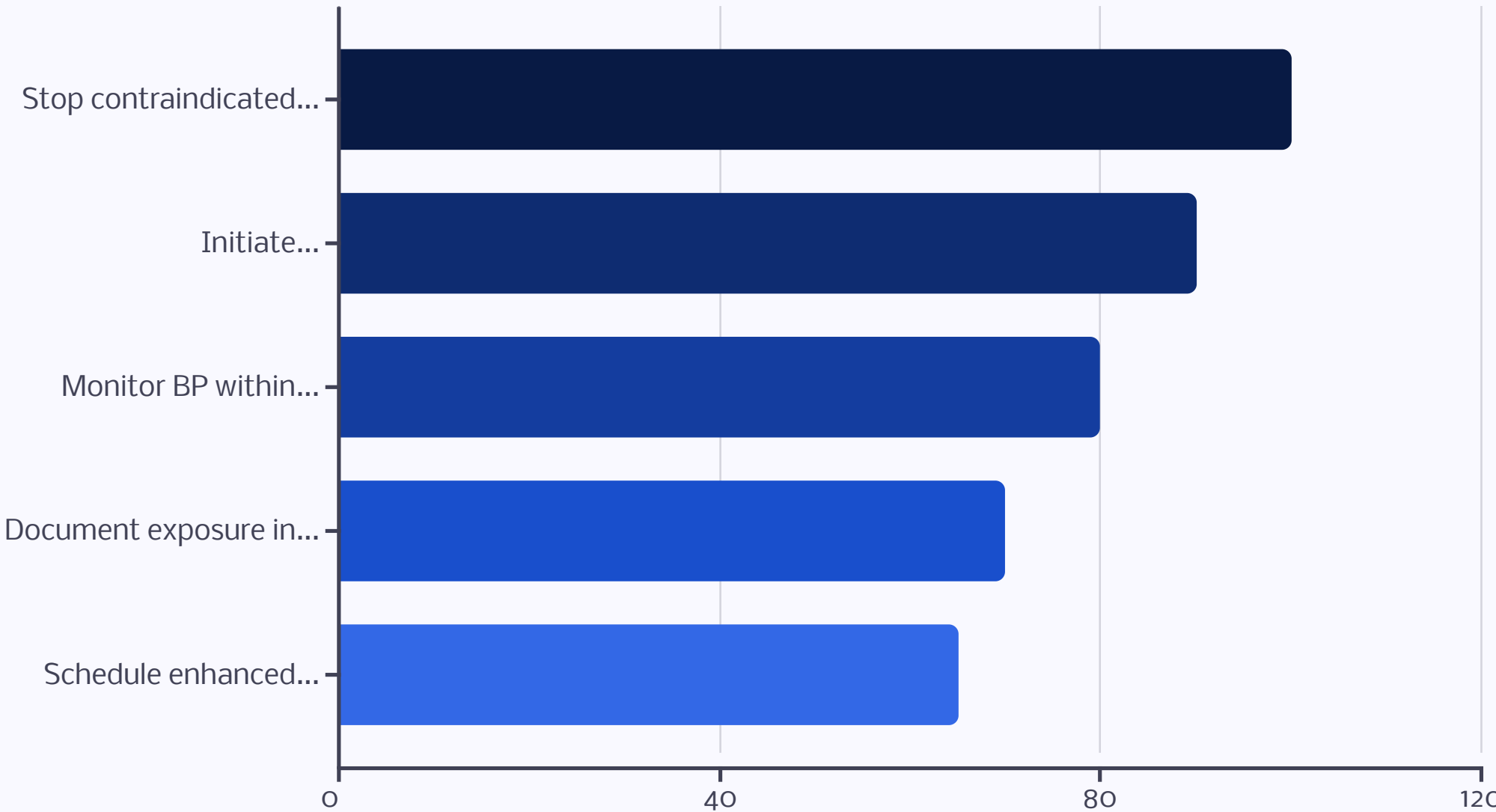
Risks: Potential for cyanide toxicity with prolonged use, fetal cyanide poisoning

Medication Reconciliation Scenario

Patient Presentation: 26-year-old female at 8 weeks gestation (confirmed by ultrasound) currently taking losartan 100 mg daily and spironolactone 25 mg daily for hypertension. Blood pressure today is 142/88 mm Hg. Patient was unaware of pregnancy until 2 weeks ago and has continued all medications.

Urgent Pharmacist Intervention

Immediate Actions Required: "Discontinue losartan and spironolactone immediately due to significant teratogenic risk."



Comprehensive Management Plan

- Stop:** Losartan and spironolactone today
- Initiate:** Labetalol 100 mg twice daily immediately
- Monitor:** Blood pressure in 48-72 hours, adjust labetalol as needed
- Document:** Medication changes in prenatal record and notify obstetrics team
- Counsel:** Patient on importance of pregnancy-safe medications
- Follow-up:** Enhanced fetal monitoring due to early ACE inhibitor exposure

Early recognition and immediate discontinuation of contraindicated medications is critical to minimize fetal risk. Pharmacists play a vital role in medication safety during pregnancy by screening for contraindicated medications, recommending appropriate alternatives, and educating patients and providers about medication risks in pregnancy.

Preeclampsia Prevention

✔ 2025 Aspirin Recommendation

Class I (Strong), Level of Evidence A: Recommend low-dose aspirin (81 mg daily) starting at 12 weeks gestation for pregnant patients with chronic hypertension to reduce preeclampsia risk.

Low-dose aspirin has been shown to reduce the risk of preeclampsia by approximately 25% in high-risk patients. The 2025 guidelines strengthen this recommendation based on multiple randomized controlled trials and meta-analyses demonstrating significant benefits for maternal and fetal outcomes.

Mechanism of Action

Low-dose aspirin prevents preeclampsia through several mechanisms:

- Inhibition of thromboxane A₂ synthesis while preserving prostacyclin production
- Improved placental perfusion through reduced platelet aggregation
- Modulation of inflammatory pathways involved in preeclampsia pathogenesis
- Promotion of deeper placentation and improved trophoblast invasion
- Reduction of oxidative stress at the maternal-fetal interface

Preconception Counseling Scenario

Patient Presentation: 33-year-old female with chronic hypertension well-controlled on amlodipine 5 mg daily, planning pregnancy within the next 6 months. She has no other cardiovascular risk factors and normal kidney function.

Preconception Pharmacist Counseling

Pregnancy Planning Recommendations:

Current Medication Assessment:

- Amlodipine is safe to continue during pregnancy
- Consider switching to labetalol if planning pregnancy soon (more pregnancy experience)

Aspirin Prophylaxis Plan:

- Start low-dose aspirin 81 mg daily at 12 weeks gestation
- Continue aspirin through 36 weeks gestation unless contraindicated
- Take in the evening for optimal chronotherapeutic effect



Preconception counseling allows pharmacists to optimize medication regimens before pregnancy and plan for appropriate therapy during pregnancy.

Monitoring and Discontinuation

When implementing aspirin therapy for preeclampsia prevention, pharmacists should provide the following guidance:



Timing Considerations

Initiate at 12 weeks gestation (after completion of organogenesis) and continue until 36 weeks gestation to minimize bleeding risk during delivery.



Administration Instructions

Take aspirin with food to minimize gastrointestinal effects. Evening dosing may provide better outcomes based on chronotherapeutic principles.



Monitoring Parameters

No specific laboratory monitoring is required for low-dose aspirin. Monitor for signs of preeclampsia at each prenatal visit regardless of aspirin use.



Discontinuation Timing

Stop aspirin at 36 weeks gestation to minimize bleeding risk during delivery. Earlier discontinuation may be warranted for planned cesarean delivery or bleeding complications.

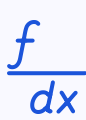
Aspirin prophylaxis represents a safe, cost-effective intervention that significantly reduces preeclampsia risk in high-risk populations. Pharmacists should proactively identify candidates for aspirin prophylaxis and provide evidence-based recommendations for implementation.

Quick Reference Summary for Pharmacists


2025 Hypertension Guideline Implementation Tool

Clinical Setting	BP Values/Criteria	Key Pharmacist Recommendation	Preferred Medications
ED Severe HTN (Asymptomatic)	190/110 mm Hg No organ damage	Start oral therapy, avoid IV medications, arrange 72-hour follow-up	Amlodipine 5 mg daily Lisinopril 10 mg daily
High-Risk Outpatient (Diabetes/CKD)	132/82 mm Hg PREVENT ≥7.5%	Immediate therapy initiation, target <130/80 mm Hg	Lisinopril 10 mg daily (ACEi preferred for DM)
Lower-Risk Outpatient	135/85 mm Hg Failed lifestyle (6 months)	Initiate first-line therapy after lifestyle trial	Chlorthalidone 12.5 mg daily Amlodipine 5 mg daily
ICH Management	SBP 165 mm Hg (150-220 range)	IV infusion to 130-140 mm Hg, hold oral meds temporarily	Nicardipine IV 5 mg/hour (titrate by 2.5 mg/hour q15min)
ICH Emergency	SBP 230 mm Hg (>220 range)	Aggressive IV therapy, avoid BP variability	Clevidipine IV 1-2 mg/hour (titrate q5-10min)
Post-Stroke (Thrombectomy)	SBP 145 mm Hg Within 24-72 hours	Maintain 140-180 mm Hg, hold antihypertensives	Hold all BP meds Nicardipine IV if SBP > 180
Pregnancy Severe HTN	165/112 mm Hg Treat within 30-60 min	Immediate oral or IV therapy, avoid sublingual nifedipine	Nifedipine IR 10 mg PO Labetalol 20 mg IV
Pregnancy Chronic HTN	145/95 mm Hg 12 weeks gestation	Pregnancy-safe antihypertensive, target <140/90	Labetalol 100 mg BID Methyldopa 250 mg BID
Pregnancy Planning	Chronic HTN Risk factors present	Start aspirin at 12 weeks, ensure pregnancy-safe medications	Aspirin 81 mg daily Continue safe antihypertensives
Hospital Severe HTN	185/115 mm Hg No organ damage	Avoid PRN IV medications, monitor and optimize oral therapy	Avoid hydralazine PRN Optimize oral regimen


Key 2025 Guideline Resources



PREVENT Risk Calculator
Access the PREVENT risk assessment tool at [Tools.acc.org/PREVENT](https://tools.acc.org/PREVENT) to guide treatment decisions based on comprehensive cardiovascular risk evaluation.



Mobile Applications
Download the ACC/AHA Guideline Mobile Applications for point-of-care access to treatment algorithms, medication recommendations, and clinical decision support.



Clinical Practice Guidelines
Access the full 2025 AHA/ACC High Blood Pressure Guideline and implementation tools through the AHA/ACC Clinical Practice Guidelines Portal.

Implementation Strategies for Pharmacists

- Update clinical protocols and order sets to reflect new terminology and treatment recommendations
- Train pharmacy and medical staff on terminology changes and evidence-based approaches
- Revise patient education materials to incorporate new guideline language
- Implement PREVENT risk assessment in medication therapy management services
- Document guideline-concordant care decisions in clinical notes and interventions
- Develop screening protocols to identify high-risk patients requiring immediate treatment
- Create pregnancy-specific medication safety protocols and screening tools

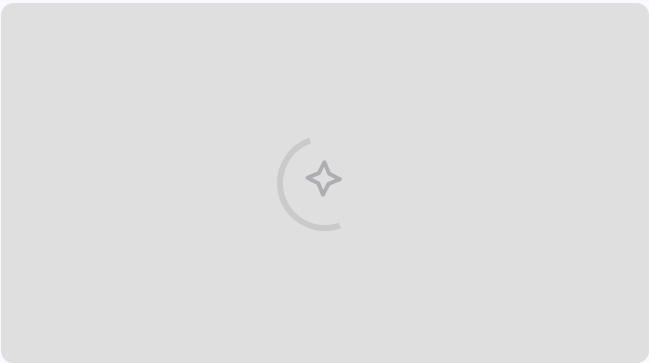
This quick reference guide provides a concise summary of the most clinically relevant aspects of the 2025 hypertension guidelines for pharmacists across practice settings. For comprehensive guidance, refer to the complete published guidelines.

Conclusion: Implementing the 2025 Hypertension Guidelines in Pharmacy Practice

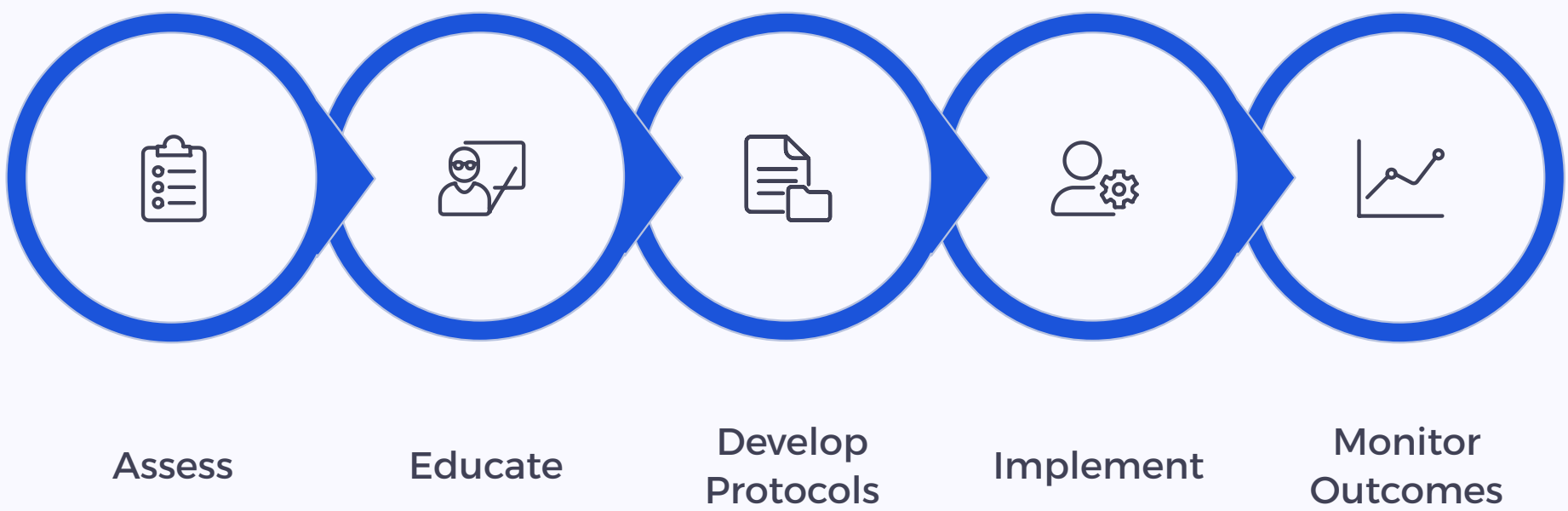
The 2025 AHA/ACC Hypertension Guidelines represent a significant evolution in the approach to hypertension management across various clinical settings. Key changes including the shift from "hypertensive urgency" to "severe hypertension," the integration of the PREVENT risk calculator, and specialized recommendations for neurological emergencies and pregnancy will substantially impact pharmaceutical care.

Pharmacists are uniquely positioned to lead implementation of these evidence-based recommendations through:

- Developing and updating institutional protocols and order sets
- Educating healthcare providers on appropriate medication selection
- Preventing inappropriate use of IV antihypertensives in asymptomatic patients
- Ensuring pregnancy-safe medication selection and aspirin prophylaxis
- Applying risk-stratified treatment approaches using the PREVENT calculator
- Monitoring for guideline adherence through medication use evaluations



Pharmacists serve as key clinical leaders in implementing hypertension guidelines across healthcare settings.



Key Practice-Changing Updates

30-60

Minute Window

Critical timeframe for treating severe hypertension in pregnancy to prevent maternal stroke while avoiding fetal compromise

7.5%

PREVENT Risk Threshold

10-year cardiovascular risk level at which immediate antihypertensive therapy is recommended for patients with BP \geq 130/80 mm Hg

140

SBP Threshold

Minimum systolic blood pressure (mm Hg) to maintain for 24-72 hours post-reperfusion therapy in acute ischemic stroke

The 2025 guidelines emphasize a more personalized, risk-based approach to hypertension management while prioritizing patient safety in specialized populations. By incorporating these recommendations into daily practice, pharmacists can significantly improve patient outcomes, reduce adverse events from inappropriate interventions, and optimize medication therapy across the continuum of care.

This comprehensive clinical reference should be used in conjunction with clinical judgment and the complete published guidelines to provide evidence-based pharmaceutical care for patients with hypertension in all clinical settings.