What Have We Learned – Day 2

30th Annual Conference on Hypertension
Diabetes, and Dyslipidemia

Hyatt Regency Hotel
Savannah, Georgia
June 3-5, 2026

CONTINUING EDUCATION COMPANY

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Day 2-Hypertension
Dr Basile spoke on "What's New in Outpatient Hypertension: Clinical Pearls from the New Hypertension Guideline":

- Accurate blood pressure measurement is foundational; automated oscillometric BP devices in the office are now preferred over routine auscultatory measurement in adults.
- Home blood pressure monitoring is superior to office BP alone for predicting cardiovascular outcomes and should routinely confirm hypertension diagnoses and rule out white coat and masked HTN.
- Validated upper-arm home BP devices are preferred; wrist and especially finger devices frequently overestimate BP.
- The 2025 hypertension guideline reinforces a BP target < 130/80 mmHg and encourages a systolic BP < 120 mmHg in higher-risk patients, if it can be done safely.
- Lifestyle modification remains predominantly a Class I therapy for all patients with elevated BP or hypertension regardless of CV risk.

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Day 2-Hypertension

Dr Basile spoke on "What's New in Outpatient Hypertension: Clinical Pearls from the New Hypertension Guideline":

- New lifestyle areas include alcohol abstention/reduction, weight reduction, stress reduction strategies through Transcendental Meditation, and dietary Na+ restriction and potassium supplementation.
- The PREVENT risk estimator replaces and is more accurate than the older PCE 2013 paradigm by integrating broader and more recent cardiovascular, kidney, metabolic, and social-risk variables.
- Initial antihypertensive therapy should prioritize thiazide-type diuretics, ACEi or ARB therapy, and long-acting dihydropyridine CCBs.
- Initial Single-pill combination therapy is now strongly encouraged, especially for stage 2 hypertension—to improve adherence and lessen the time it takes to control BP.
- Aggressive long-term BP control may reduce dementia risk and cognitive decline, emphasizing the importance of earlier treatment.

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Day 2-Focus on HYPERTENSION

Dr Hundemer spoke on "MRAs (Steroidal and Non-Steroidal) and Aldosterone Synthase Inhibitors in Hypertension and Renal Disease

- Aldosterone excess contributes substantially to cardiovascular fibrosis, CKD progression, resistant hypertension, and persistent cardio-renal risk despite ACEi/ARB therapy.
- Aldosterone breakthrough commonly occurs during chronic RAAS blockade, leaving patients with persistent mineralocorticoid receptor activation over time.
- Spironolactone remains highly effective for resistant hypertension and proteinuria reduction, but endocrine adverse effects and hyperkalemia limit its use in CKD.
- Eplerenone provides fewer anti-androgen adverse effects than spironolactone but is less potent, more expensive, and requires twice-daily dosing.
- Finerenone demonstrated meaningful cardiovascular and renal protection in diabetic CKD in FIDELIO-DKD and FIGARO-DKD, despite only a modest 2-3 mm Hg BP reduction.

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Day 2-Focus on HYPERTENSION

Dr Hundemer spoke on "MRAs (Steroidal and Non-Steroidal) and Aldosterone Synthase Inhibitors in Hypertension and Renal Disease

- Finerenone should be considered one of the core evidence-based therapies for patients with diabetes, CKD, and albuminuria alongside ACEi/ARB, SGLT2i, and GLP-1RA therapy.
- Finerenone lowered CKD progression and CV events with or w/o the SGLT2 inhibitor empagliflozin as seen in the FIDELITY sub-group analysis of the FIDELIO and FIGARO trials.
- Finerenone also benefited all those with clinical heart failure and an EF $\geq$ 40% as seen in the FINEARTS-HF trial.
- Hyperkalemia occurs with both steroidal and non-steroidal MRAs, but discontinuation rates in major trials remain relatively low with appropriate monitoring.
- Cost, compliance, and side effects will determine the use of Finerenone over other steroidal MRAs in the future.

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Day 2-Focus on HYPERTENSION

Dr Hundemer spoke on "MRAs (Steroidal and Non-Steroidal) and Aldosterone Synthase Inhibitors in Hypertension and Renal Disease

- Aldosterone synthase inhibitors (ASIs) target CYP11B2 and may eventually provide an alternative approach by suppressing aldosterone production directly.
- Second-generation ASIs such as baxdrostat and lorundrostat in clinical trials significantly reduced systolic BP in uncontrolled or resistant hypertension without causing adrenal insufficiency.
- Vicadrostat, a 3rd ASI in clinical trials, appears promising in CKD because of its albuminuric reduction when combined with an ACEi or ARB and SGLT2 inhibition.

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Day 2-Focus on HYPERTENSION

Dr Hundemer spoke on "MRAs (Steroidal and Non-Steroidal) and Aldosterone Synthase Inhibitors in Hypertension and Renal Disease

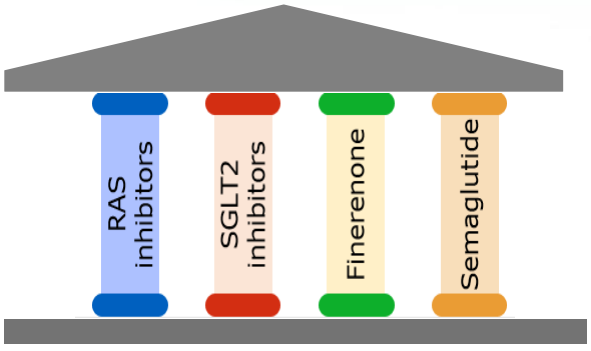
A Pillared Approach to Treat CKD in Diabetes

RAS inhibitors

- Decrease efferent arteriole tone
- Decrease hyperfiltration
- Decrease endothelial dysfunction
- Decrease cardiac remodeling

SGLT2 inhibitors

- Increase afferent artieriole tone
- Improve tubuloglomerular feedback
- Decrease hyperfiltration
- Decrease proteinuria
- Decrease oxidative stress
- Increase anti-inflammatory and anti-fibrotic effects



Finerenone

- Decreases inflammation
- Decreases fibrosis
- Decreases endothelial dysfunction
- Decreases tissue remodeling
- Decreases proteinuria

Semaglutide

- Decrease weight
- Decrease dyslipidemia
- Decrease oxidative stress
- Decrease endothelial dysfunction

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Day 2-Focus on HYPERTENSION

Dr Egan spoke on "Hypertension in Older Women: Illuminating a Bright Spot"

- Systolic BP and pulse pressure rise more sharply with aging in women than men, especially after 75 years of age.
- Older women frequently have lower hypertension control rates despite taking a similar number of antihypertensive medications as men.
- Shorter stature and greater salt sensitivity may partly explain higher systolic BP and pulse pressure in older women.
- Older women are often volume- and sodium-sensitive; calcium channel blockers and thiazide-type diuretics may be particularly effective to control their BP.
- Beta-blockers should generally be reserved for compelling indications or as a 5th line drug in resistant hypertension rather than routine first-line use in older women.

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Day 2-Focus on HYPERTENSION
Dr Egan spoke on "Hypertension in Older Women: Illuminating a Bright Spot"

- Excellent long-term BP control earlier in life may reduce the excessive age-related rise in systolic and pulse pressure seen in older woman.
- Lifestyle measures remain critically important: sodium restriction, weight management, physical activity, DASH/Mediterranean eating patterns, and potassium optimization.
- Prompt escalation to 3- or 4-drug regimens is often necessary in older women with resistant or persistent systolic hypertension.
- Attention to lipid management and statin therapy is important, as women remain undertreated for cardiovascular risk reduction.
- Aggressive but individualized systolic BP lowering in older women can substantially reduce stroke, heart failure, and cardiovascular risk.

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Day 2-Focus on HYPERTENSION
Dr Hundemer spoke on "Rethinking Primary Aldosteronism"

- Primary aldosteronism (PA) is far more common than previously recognized and exists along a continuum from subclinical disease to overt resistant hypertension.
- Less than 1% of patients with PA are ever diagnosed despite major risks for stroke, atrial fibrillation, CKD, heart failure, and cardiovascular mortality.
- PA should be strongly considered in resistant hypertension, hypokalemia, early-onset hypertension, adrenal nodules, and unexplained cardiovascular disease.
- Subclinical PA may be present in many patients with mild hypertension—or even normal BP—and still confer increased cardiovascular and kidney risk.
- Traditional screening algorithms using the aldosterone-renin ratio (ARR) have important limitations and may miss many patients with PA.

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Day 2-Focus on HYPERTENSION
Dr Hundemer spoke on "Rethinking Primary Aldosteronism"

- Newer guidelines increasingly support simplified screening approaches and reduced reliance on cumbersome confirmatory testing.
- Adrenal vein sampling remains valuable but has important limitations including invasiveness, technical complexity, and limited availability.
- For medically treated PA, successful mineralocorticoid receptor antagonist therapy should ideally produce a rise in renin as a marker of adequate blockade.
- Spironolactone and eplerenone remain foundational therapies in PA, but careful potassium and renal monitoring are essential.
- Aldosterone Synthase Inhibitors (ASI's) may offer additional clinical benefits in the treatment of hyperaldosteronism.
- Earlier recognition and targeted treatment of PA may substantially reduce long-term cardiovascular and renal morbidity.

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Day 2-Focus on HYPERTENSION
Dr Egan spoke on "Reframing Goal BP to Align Patients and Providers on the Target"

- Therapeutic inertia remains one of the greatest barriers to hypertension control; medication intensification still occurs too infrequently in uncontrolled patients.
- Achieving BP control on ≥ 80% of visits generally requires a mean systolic BP below 130 mmHg across an entire patient population.
- Single-pill combination (SPC) therapy improves adherence, BP control, and cardiovascular outcomes while reducing pill burden.
- Adding a second antihypertensive agent at standard dose lowers BP substantially more than simply doubling the dose of an existing medication.
- Accurate BP measurement is essential—common technique errors can falsely elevate systolic BP by 5–40 mmHg.

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Day 2-Focus on HYPERTENSION
Dr Egan spoke on "Reframing Goal BP to Align Patients and Providers on the Target"

- Home BP monitoring and automated office BP measurement should be incorporated whenever possible to improve diagnostic accuracy and treatment confidence.
- The MAP framework—Measure accurately, Act rapidly, Partner with patients—provides a practical systems-based approach to improving hypertension outcomes.
- Monthly follow-up after uncontrolled BP readings improves treatment intensification and shortens time to BP control.
- Team-based care involving pharmacists, nurses, and care coordinators has been shown to significantly improve BP reduction and adherence.
- Consistent BP control preserves heart, brain, and kidney health and reduces long-term risks of stroke, heart failure, dementia, and CKD.

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Excessive Alcohol Consumption and Hypertension: Clinical Implications of Current Research

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- Alcohol biomarkers can also be used to screen those hypertensive patients whose self-reports are suspect. In an investigation of hypertensive patients in eight primary care clinics, Fleming and Mundt found Carbohydrate Deficient Transferrin (CDT) to be especially useful in screening the blood of these patients for heavy drinking.
- **Monitoring Treatment and Recovery**: **CDT** can be used to track abstinence or relapse in patients undergoing treatment for alcohol use disorder. Levels typically normalize within 2–4 weeks after stopping alcohol, and rise again within days if drinking resumes.

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