



Key highlights of the Japanese Society of Hypertension Guidelines for the management of elevated blood pressure and hypertension 2025 (JSH2025)

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Abstract

Japan has long maintained a robust national health system with universal health coverage and accessible antihypertensive therapy. Nevertheless, population-level blood pressure (BP) control remains suboptimal. To address this public health challenge, the Japanese Society of Hypertension published the Guidelines for the Management of Elevated Blood Pressure and Hypertension 2025 (JSH2025), integrating evidence-based recommendations and practical approaches to improve hypertension care. JSH2025 introduces a dual-format structure comprising clinical question sections developed through systematic reviews and consensus-based narrative chapters. The key updates include universal BP targets of <130/80 mmHg across populations, promotion of home BP monitoring, stratified cardiovascular risk assessment, expanded guidance on digital health and behavioral interventions, and condition-specific management strategies for older adults, women, and cancer survivors. We outline the major updates and innovations in JSH2025 and show their clinical and public health implications.

Keywords Clinical practice · Elevated blood pressure · Hypertension · Guidelines · Japanese Society of Hypertension

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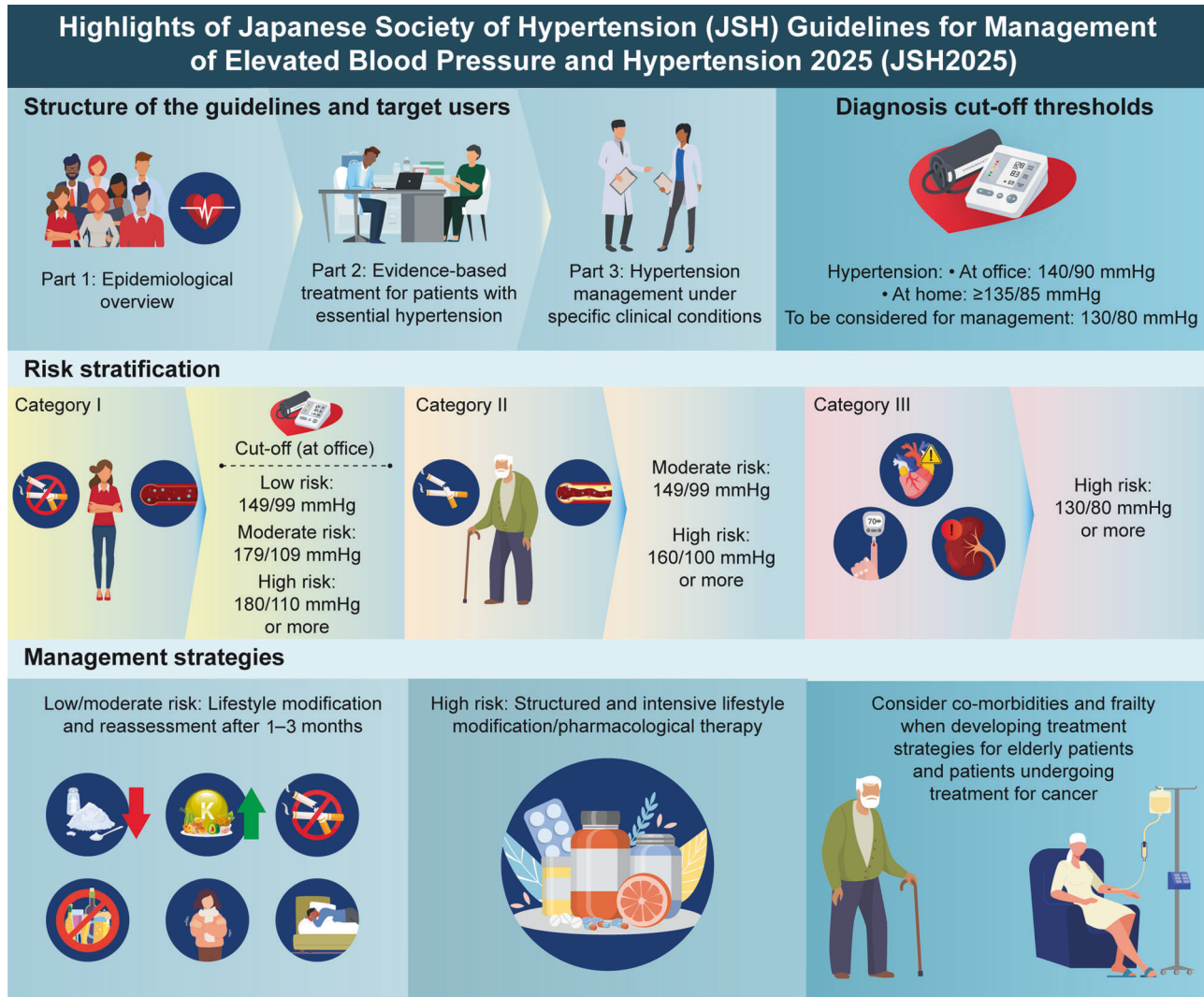
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Graphical Opinion



Introduction

Japan has established a well-structured national health system facilitating routine health screening and the prevention of lifestyle-related diseases. In addition, universal health coverage ensures broad access to antihypertensive medications at a low cost. Despite such favorable conditions, Japan ranks among the lowest among the high-income countries in terms of population-level blood pressure (BP) control [1]. To address this gap in real-world BP management, the Japanese Society of Hypertension released its Guidelines for the Management of Elevated Blood Pressure and Hypertension 2025 (JSH2025) on August 29, 2025 [2]. The new guidelines incorporate several novel approaches aimed at improving hypertension management in clinical practice. In line with

its mission to summarize the best available evidence on all aspects of elevated BP and hypertension management, the JSH2025 Task Force Committee developed a comprehensive evidence-based guideline [2]. This paper provides an overview of the key components and innovations presented by JSH2025.

Development framework, methodology, and structure

JSH2025 is structured in two distinct formats: a “Clinical Question (CQ)”-based format and a textbook-style descriptive format. In the CQ-based section, 19 CQs were addressed through systematic reviews (SRs) and meta-analyses, which served as the basis for developing

Table 1 Structure of JSH2025 guidelines

Part	Focus	Key content	Intended users
Part 1	General population and communities; epidemiological overview and population-based approach	Epidemiological overview; population-based strategies	General public and public health professionals
Part 2	Evidence-based standard treatments for essential hypertension; systematic reviews and meta-analyses	CQ-based recommendations; published/in-press results in Hypertension Research	Primary care physicians and collaborating healthcare providers
Part 3	Management of hypertension in specific clinical conditions requiring specialist care	Specialist-driven care for specific clinical scenarios	Hypertension specialists

Translated and adapted from ref. [2]

CQ clinical question

evidence-based recommendation statements. The SR teams systematically identified and reviewed the relevant studies, evaluated the quality of each article based on the outcomes and study design, and synthesized the findings into a comprehensive body of evidence. This evidence was critically appraised and integrated into the recommendation development process. Both the anticipated benefits and potential harms were considered, and the strength and direction of each recommendation were determined accordingly. A modified Delphi method consisting of three rounds of online voting was used to reach an expert consensus, and the level of agreement for each CQ was documented within the guidelines.

For 11 clinical topics in which the evidence was insufficient to support a formal SR, but which were still deemed important for everyday clinical practice, consensus-based responses were developed as “Questions (Qs)” and presented in the textbook-style sections. In addition, for other relevant topics not covered by CQs or Qs, narrative descriptions were created based on a comprehensive review of the existing medical literature. The draft guidelines underwent an internal review by the JSH2025 Task Force Committee, followed by an external review by affiliated academic societies and a public comment process [2]. The feedback from these reviews was incorporated into the final version of the manuscript.

The guidelines are organized into three distinct parts to provide guidance for their intended users and facilitate practical application (Table 1). Part 1 addresses the general population and communities, providing an epidemiological overview and outlining a population-based approach. Part 2 focuses on evidence-based standard treatment for patients with essential hypertension. The CQs were examined through systematic reviews and meta-analyses, with the results published in *Hypertension Research* (some articles currently in press). This section is intended for primary care physicians and other healthcare professionals involved in the management of hypertension. Part 3 addresses the management of hypertension in specific clinical conditions that typically require specialist care.

Classification and diagnostic criteria

The classification of BP remains consistent with the 2019 guidelines (JSH2019) [3]. Hypertension is defined as an office BP of $\geq 140/90$ mmHg, and elevated BP as a value of 130–139/80–89 mmHg (Table 2) [2]. However, the updated JSH2025 guidelines explicitly state that individuals with BP $\geq 130/80$ mmHg should be considered for appropriate management [2].

Table 2 Classification of blood pressure in adults

Classification	Office blood pressure (mmHg)			Home blood pressure (mmHg)		
	SBP		DBP	SBP		DBP
Normal blood pressure	<120	and	<80	<115	and	<75
High normal blood pressure	120–129	and	<80	115–124	and	<75
Elevated blood pressure	130–139	and/or	80–89	125–134	and/or	75–84
Grade I hypertension	140–159	and/or	90–99	135–144	and/or	85–89
Grade II hypertension	160–179	and/or	100–109	145–159	and/or	90–99
Grade III hypertension	≥180	and/or	≥110	≥160	and/or	≥100
(Isolated) systolic hypertension	≥140	and	<90	≥135	and	<85

Translated and adapted from ref. [2]

DBP diastolic blood pressure, *SBP* systolic blood pressure

Emphasis on home blood pressure monitoring

JSH2025 continues to prioritize home BP monitoring (HBPM) as a central component of hypertension diagnosis and management. This approach is supported by recent systematic reviews demonstrating that HBPM yields a greater antihypertensive effect than management based on office BP [4, 5]. The diagnostic thresholds for home BP remain unchanged: hypertension is defined as a value of ≥135/85 mmHg and elevated BP as 125–134/75–84 mmHg.

Cardiovascular risk stratification

Consistent with JSH2019, JSH2025 continues to base the cardiovascular risk assessment on data derived from Japanese populations. Category I includes individuals with no prognostic factors other than elevated BP (e.g., sex (woman), aged <65 years, without diabetes mellitus, dyslipidemia, smoking, atrial fibrillation, proteinuria-positive chronic kidney disease [CKD], or cardiovascular disease). Category II includes sex (man), aged ≥65 year, dyslipidemia and/or smoking, but without cardiovascular disease, atrial fibrillation, diabetes, or proteinuria-positive CKD. Category III includes individuals with a history of cardiovascular disease, atrial fibrillation, diabetes mellitus, proteinuria-positive CKD, or three or more Category II risk factors. Each risk category is further stratified into low, moderate, or high risk based on office BP levels (Table 3) [2].

Treatment initiation and assessment

Initial clinical evaluation and management should include confirmation of sustained BP elevation, exclusion of secondary hypertension, assessment of cardiovascular risk and organ damage, education on lifestyle modification,

and determination of pharmacological therapy. These steps can be performed sequentially or concurrently based on the clinical need. At the initial visit, a comprehensive hypertension management plan should be established (Fig. 1) [2].

Blood pressure treatment targets

The systematic reviews and meta-analyses conducted for JSH2025 support a target office BP of <130/80 mmHg in adults with hypertension [6], prior stroke [7], diabetes mellitus [8], and individuals aged ≥75 years [9]. In patients with heart failure with preserved ejection fraction (HFpEF), targeting a systolic BP <130 mmHg was associated with a significant reduction in hospitalizations compared to higher targets [10]. In those with CKD, this target showed a trend toward reduced all-cause mortality [11]. However, intensive systolic BP lowering, particularly to values <120 mmHg, was associated with an increased risk of adverse events, including symptomatic hypotension and acute kidney injury [6]. Notably, no serious adverse events specific to older adults or those with comorbidities were reported, and findings were generally consistent across subgroups and studies [7–11].

Based on this body of evidence, JSH2025 recommends a treatment target of BP <130/80 mmHg, irrespective of age or comorbid conditions (Table 4) [2]. Regarding the target level for home BP, a value of <125/75 mmHg is recommended in Japan, based on the findings of the HOMED-BP and HONEST studies [2]. Nonetheless, BP reduction should be approached cautiously, with careful monitoring for potential adverse effects, such as symptomatic or orthostatic hypotension, acute kidney injury, and electrolyte disturbances (e.g., hyperkalemia). For individuals with elevated BP (130–139/80–89 mmHg) who are at a low to moderate cardiovascular risk and without target organ damage or diabetes, intensified lifestyle modification may be considered as an initial approach, taking into account clinical context and cost-effectiveness [2].

Table 3 Stratification of the risk of cardiovascular diseases based on office blood pressure

Classification of blood pressure risk category	Elevated blood pressure 130–139/80–89 mmHg	Grade I hypertension 140–149/90–99 mmHg	Grade II hypertension 160–179/ 100–109 mmHg	Grade III hypertension ≥180/≥110 mmHg
Category I No prognostic factor	Low risk	Low risk	Moderate risk	High risk
Category II At least one risk factor of age (≥65 years), sex (man), dyslipidemia and smoking	Moderate risk	Moderate risk	High risk	High risk
Category III At least one risk factor of cardiovascular diseases, atrial fibrillation, diabetes mellitus and CKD with proteinuria, or 3 or more risk factors of Category II	High risk	High risk	High risk	High risk

CKD chronic kidney disease

Translated and adapted from ref. [2]

Lifestyle interventions

Lifestyle modifications are essential both before and after the initiation of antihypertensive therapy. The core approach is consistent with the JSH2019 recommendations (Table 5) [2]. However, JSH2025 introduces new evidence supporting the utility of urinary sodium-to-potassium (Na/K) ratio measurements to encourage potassium intake, as well as the inclusion of resistance training as a strategy for BP management [2]. Reduction in sodium intake to <6 g/day is observed to effectively lower BP. Both individual-level and population-level interventions implemented in communities, workplaces, schools, and households have demonstrated significant benefits [12]. An increased consumption of potassium-rich foods, including vegetables, fruits, and low-fat dairy products, is also recommended. A systematic review reported that dietary counseling and clinical care incorporating Na/K ratio monitoring devices are effective in reducing both systolic BP and sodium intake [13]. The JSH Working Group has proposed a urinary Na/K ratio target of <2 as an optimal threshold for BP control [14]. Regular aerobic and resistance exercise have been shown to be equally effective in lowering BP, and both are strongly recommended [15]. In addition to dietary and exercise intervention, comprehensive lifestyle modifications include appropriate weight management, moderation of alcohol consumption, smoking cessation, stress reduction, adequate sleep, and the avoidance of cold exposure and constipation [2].

Antihypertensive drug therapy

The major antihypertensive agents with a proven efficacy in preventing cardiovascular events include long-acting dihydropyridine calcium channel blockers (CCBs), angiotensin receptor blockers (ARBs), angiotensin-converting enzyme (ACE) inhibitors, low-dose thiazide diuretics, and β -blockers (including $\alpha\beta$ -blockers). These agents are classified as Group G1 drugs in the JSH2025 guidelines (Table 6) [2]. Each drug class has compelling indications, contraindications, and clinical considerations that should be carefully evaluated when selecting appropriate therapy.

Based on the JSH2025 systematic review and meta-analysis, the previous preferential recommendation for renin-angiotensin system inhibitors in patients with diabetes mellitus without proteinuria or microalbuminuria has been removed [16]. Among the Group G1 agents, CCBs, ARBs, and ACE inhibitors are generally well-tolerated and widely prescribed in clinical practice in Japan; thus, they are categorized as Group G1a in the treatment algorithm. In contrast, the use of low-dose thiazide diuretics (including

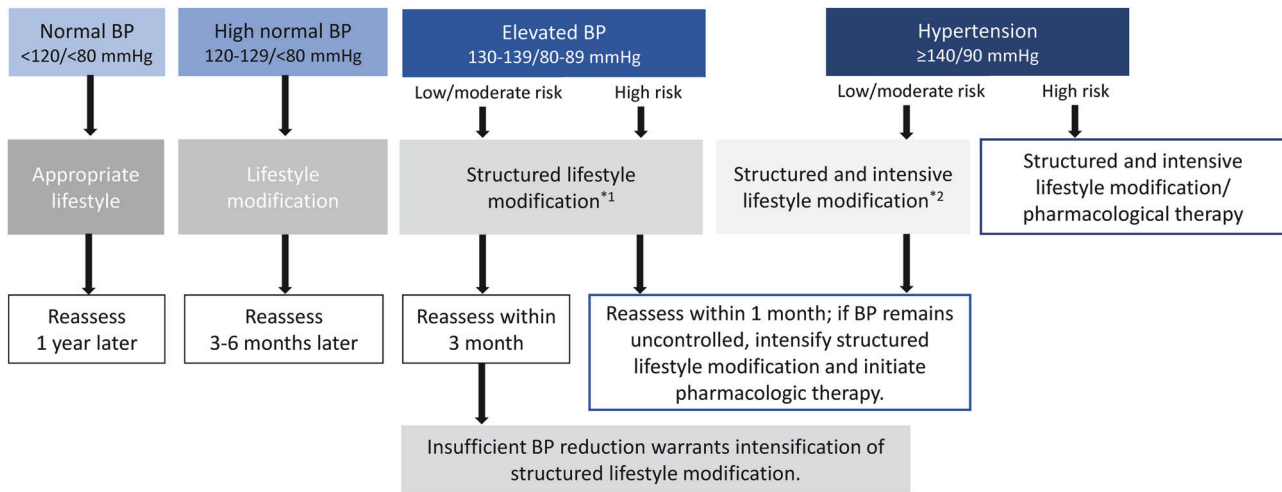


Fig. 1 Initial planning of hypertension management according to the blood pressure level. If a patient presents following a referral for BP elevation through routine or specific health checkup, confirm persistent elevation and proceed according to the flowchart. *¹: Structured lifestyle modification involves shared decision-making to establish

treatment goals (e.g., blood pressure targets) and implement comprehensive lifestyle-based management accordingly. *²: If hypertension has been previously diagnosed and lifestyle modification advised, pharmacologic therapy may be initiated at the first visit. BP blood pressure. Translated and adapted from ref. [2]

Table 4 Target blood pressure levels

Office blood pressure <130/80 mmHg	Home blood pressure <125/75 mmHg
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For individuals with elevated blood pressure (office blood pressure 130–139/80–89 mmHg) who are at low to moderate cardiovascular risk—such as those without a history of cardiovascular disease or diabetes mellitus—an intensification of lifestyle modifications is recommended as the primary approach.

When initiating or intensifying antihypertensive therapy, careful attention should be paid to the potential occurrence of adverse events, including symptomatic hypotension (e.g., dizziness, lightheadedness, presyncope, fatigue, or syncope), orthostatic hypotension, acute kidney injury, and electrolyte disturbances such as hyperkalemia.

Translated and adapted from ref. [2]

Table 5 Lifestyle modification strategies

Lifestyle modification	Recommendation
Sodium (Na) restriction	Daily salt intake should be <6 g.
Active intake of potassium (K)	Encourage the consumption of potassium-rich foods, such as vegetables, fruits, and low-fat dairy products, to reduce the sodium/potassium (Na/K) ratio. Also, increase the intake of calcium, magnesium, dietary fiber, and unsaturated fatty acids.
Maintaining a healthy weight	Maintain a BMI of less than 25 (weight [kg] / height ² [m ²]).
Exercise therapy	Engage in moderate-intensity aerobic exercise for at least 30 min daily. Low-intensity resistance exercises is also effective
Alcohol moderation	Limit ethanol intake to <20–30 mL/day for men and 10–20 mL/day for women.
Smoking cessation	Avoid smoking, including the use of heated tobacco products.
Other recommendations	Avoid exposure to cold indoors and outdoors, ensure adequate sleep, prevent constipation, and manage stress.

Digital and combined lifestyle interventions: The combined improvement of multiple lifestyle factors, supported by smartphone applications and digital technologies, is more effective

Potassium restriction in kidney disease: In patients with kidney disease requiring potassium restriction, an active intake of vegetables and fruits is not recommended

Fruit intake in diabetes mellitus and obesity: In patients with diabetes or obesity, fruit consumption may be recommended; however, the quantity should be personalized based on individual guidance

Translated and adapted from ref. [2]

BMI body mass index

Table 6 Classification of antihypertensive drug classes used in stepwise combination therapy

Group	Antihypertensive drugs	Details
G1	<ul style="list-style-type: none"> a <ul style="list-style-type: none"> • Long-acting dihydropyridine calcium channel blockers (CCBs) • Renin-angiotensin system inhibitors (ARBs, ACE inhibitors) b <ul style="list-style-type: none"> • Low-dose thiazide diuretics^b • β-blockers (e.g., bisoprolol, carvedilol) 	<ul style="list-style-type: none"> • Major antihypertensive drugs • Select from Treatment STEP 1^a based on the clinical condition • Evidence supporting prevention of cerebrovascular and cardiovascular events in hypertension
G2	<ul style="list-style-type: none"> • Angiotensin receptor neprilysin inhibitors (ARNI) • Mineralocorticoid receptor antagonists (MRAs) 	<ul style="list-style-type: none"> • Select from Treatment Step 2 or Step 3^a based on the clinical condition • No evidence for preventing cerebrovascular and cardiovascular events in hypertension
G3	<ul style="list-style-type: none"> • α-blockers • Hydralazine • Central sympatholytics, etc. 	<ul style="list-style-type: none"> • Currently underutilized in conditions where they should be prescribed in Japan, active administration is recommended • Used in treatment-resistant hypertension or specific clinical conditions

Translated and adapted from ref. [2]

ARBs angiotensin II receptor blockers, ARNI angiotensin receptor-neprilysin inhibitor, ACE angiotensin-converting enzyme, CCBs calcium channel blockers, MR mineralocorticoid receptor

^aRefer to Fig. 2 for treatment steps

^bEquivalent doses of thiazide diuretics: trichlormethiazide 0.5–1 mg, hydrochlorothiazide 6.25–12.5 mg, indapamide 0.5–1 mg

thiazide-like agents) and β -blockers remains relatively limited despite their established efficacy in Japan; these are designated as Group G1b (Table 6) [2].

An early initiation of antihypertensive therapy is recommended to achieve target BP. If adequate BP control is not achieved, treatment should be escalated per the STEP strategy, while ensuring that patients understand the rationale for therapy intensification and that tolerability is continuously assessed to avoid adverse events. In the STEP strategy, STEP 1 involves initiating monotherapy using a Group G1 agent; however, for patients with Stage II or III hypertension, or high-risk Stage I hypertension, it may be appropriate to initiate treatment from STEP 2. In principal, STEP 2 involves the combination of two Group G1 agents, and Group G2 agents may also be used when clinically appropriate (Fig. 2, Table 6) [2]. If BP remains uncontrolled, treatment should be advanced to STEP 3, triple combination therapy with Group G1 and G2 agents. In cases of persistent uncontrolled hypertension, a comprehensive reassessment of medication adherence, lifestyle modifications, and treatment regimens is essential. Referral to a hypertension specialist should be considered when appropriate [2].

Behavioral and digital health interventions

In addition to theoretical recommendations, JSH2025 synthesizes the best available evidence on behavior-based interventions—such as team-based approaches [17] and digital device-based strategies [13, 18, 19]—that support individuals and patients in improving BP control [2]. In recent years, digital technologies such as smartphone applications, short message services (SMS), and web-based platforms have been increasingly employed for BP management in adults. Systematic reviews and meta-analyses conducted for the development of JSH2025 evaluated the effectiveness of digital health interventions in BP control. The findings indicated that smartphone-based interventions significantly reduced the systolic BP for up to 3 months in normotensive individuals and up to 6 months in patients with hypertension [18]. Moreover, the integration of digital tools, such as smartphone apps and SMS into routine care in combination with in-person consultations, was associated with further reductions in BP levels [19]. In addition, digital devices capable of measuring the urinary Na/K ratio or urinary sodium concentration have shown benefit in lowering both systolic BP and dietary sodium intake by supporting self-monitoring, dietary counseling, and clinical management [13]. However, further evidence is warranted to establish the long-term effectiveness and sustainability of these digital interventions [2, 5, 13, 18, 19].

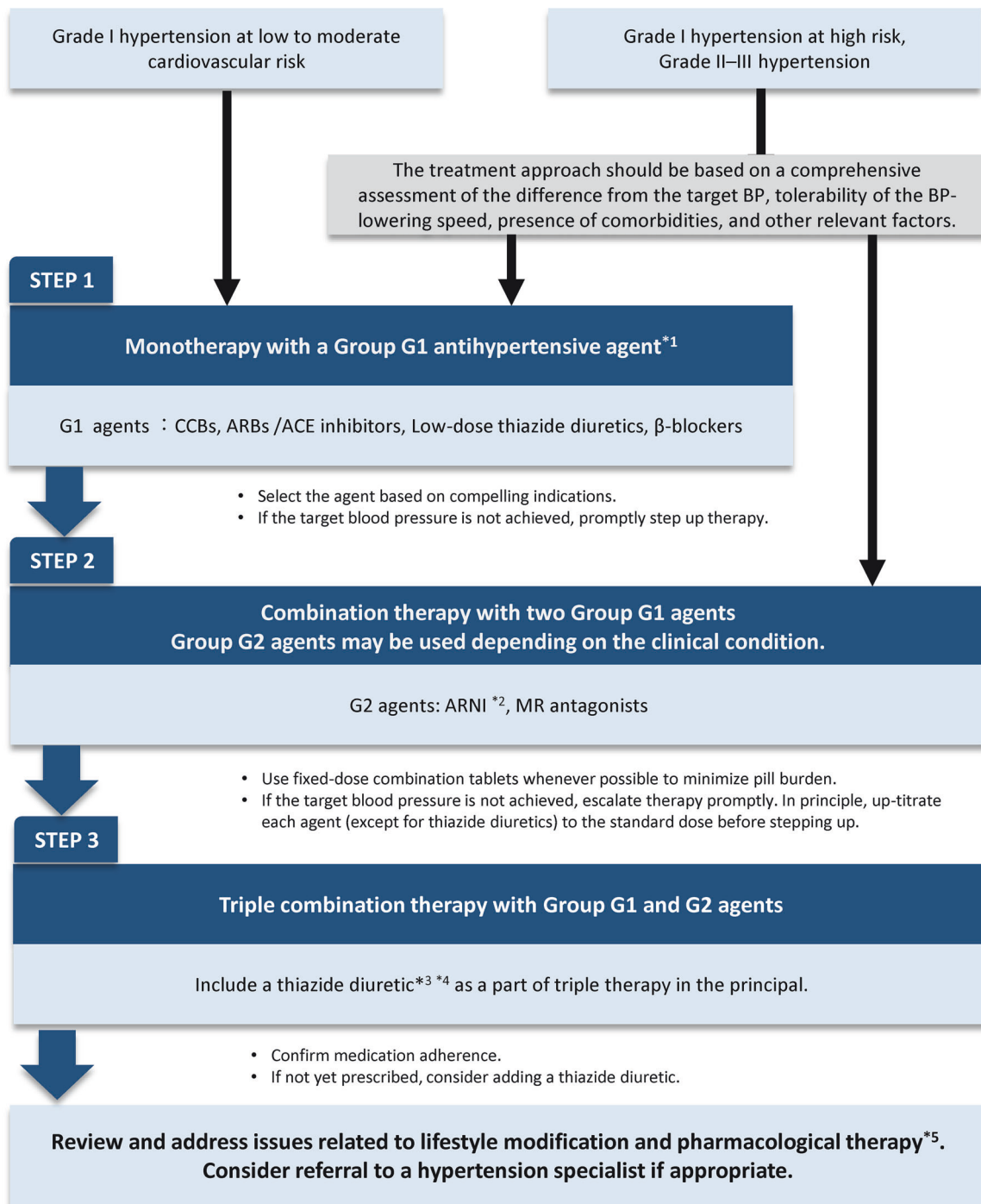


Fig. 2 Stepwise antihypertensive therapy for hypertension: strategies for achieving target blood pressure. ^{*1}: For patients aged ≥ 75 years or with impaired renal function (CKD stage 4 or $eGFR < 30 \text{ mL/min/1.73 m}^2$), treatment should generally be initiated at half the standard dose of monotherapy. ^{*2}: ARNI should not be used concomitantly with ACE inhibitors. A washout period of at least 36 h is required when switching from an ACE inhibitor to an ARNI. According to the product label, ARNI should not be used as the initial drug for antihypertensive therapy in principle. ^{*3}: Loop diuretics are preferred in patients with $eGFR < 30 \text{ mL/}$

min/1.73 m^2 . ^{*4}: ARNI and MR antagonists may be used as alternatives given their natriuretic effects. ^{*5}: Evaluate and address factors affecting lifestyle modifications and medication adherence, such as adverse effects or polypharmacy. ARB angiotensin II receptor blocker, ARNI angiotensin receptor–neprilysin inhibitor, ACE angiotensin-converting enzyme, BP blood pressure, CKD chronic kidney disease, $eGFR$ estimated glomerular filtration rate, MR mineralocorticoid receptor. Translated and adapted from ref. [2]

Table 7 Categories for blood pressure management based on health and functional status in older adults aged ≥ 75 years^a

	Category 1 Preserved ADLs; able to attend outpatient visits independently.	Category 2 Reduced instrumental ADLs; assistance needed for outpatient visits.	Category 3 Reduced basic ADLs; unable to attend outpatient visits.	Category 4 end-of-life stage
General health status	Fit to frail	Frail to needing care	Needing care	End-of-life
Instrumental ADL ^b	Maintained	Reduced	Severely reduced	
Basic ADL ^c		Maintained to reduced	Reduced	Severely reduced
Blood pressure targets	<130/80 mmHg	Target systolic BP < 140 mmHg; however, a more intensive target of <130 mmHg may be considered based on individual comorbidities and clinical context.	Target systolic BP < 150 mmHg; further lowering should be considered on an individual basis depending on comorbidities, but reduction to <120 mmHg should be avoided.	Individualized decision (with a reference range of systolic BP between 140 and 160 mmHg).
Other approaches	Management strategy similar to that for non-elderly individuals.	Consider tapering antihypertensive medication when systolic BP falls below 120 mmHg.		Consider stepwise dose reduction or withdrawal of antihypertensive agents; initiation of treatment is not recommended in previously untreated individuals.

Translated and adapted from ref. [2]

ADL activities of daily living, BP blood pressure

^aThe recommendations in this table also apply to older adults aged 65–74 years with declining health and functional status

^bInstrumental ADLs, which require greater complexity and effort—such as shopping, meal preparation, medication management, financial management, and use of public transportation—are assessed using tools such as the Lawton scale

^cBasic ADLs, including mobility, stair climbing, bathing, toileting, eating, dressing, and continence, are assessed using tools such as the Barthel Index

“10 Facts About Hypertension” — For the Japanese Public

A wide range of information about hypertension is available to the public, but not all of it is scientifically accurate. To address this issue, the Guideline Committee of the Japanese Society of Hypertension has compiled ten evidence-based facts derived from the latest guideline recommendations. Based on these facts, the guideline establishes a target blood pressure of <math><130/80\text{ mmHg}</math>.

1. Hypertension is a major risk factor for cardiovascular disease, kidney disease, and dementia.
2. In Japan, approximately 170,000 deaths each year are attributable to hypertension-related conditions.

Blood Pressure Control Status Among 43 Million Japanese Adults with Hypertension (2017)

Treated and well-controlled: 27%	Treated but poorly controlled: 29%	Unaware of hypertension or aware but untreated: 44%
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3. Among major developed countries and regions, Japan ranks among the lowest in blood pressure control.
4. Lowering systolic blood pressure by 10 mmHg reduces the risk of cardiovascular disease by approximately 20%.
5. In individuals with hypertension, reducing blood pressure to <math><130/80\text{ mmHg}</math> lowers the risk of cardiovascular events regardless of age.
6. Lifestyle modifications—such as sodium reduction, regular physical activity, weight management, and moderation of alcohol intake—effectively lower blood pressure.
7. Japanese adults consume approximately 10 g of salt per day, among the highest levels globally. For individuals with hypertension, intake should be reduced to <math><6\text{ g/day}</math>.
8. To achieve target blood pressure, most patients with hypertension require two or more antihypertensive medications.
9. Antihypertensive medications are generally affordable, safe, and effective; in most cases, their benefits far outweigh the risks of adverse effects.
10. Home blood pressure monitoring is widespread in Japan and plays a vital role in both the diagnosis and management of hypertension.

Fig. 3 “10 Facts About Hypertension” sheet. Translated and adapted from ref. [2]

Hypertension in women: a life-course approach

A life-course approach is essential for the prevention and management of cardiovascular risk in women. JSH2025 offers specific recommendations for the management of hypertension across key life stages in women, including the preconception period, pregnancy, and menopause. Preconception care should be provided to all individuals of reproductive age, regardless of pregnancy intention, to support both physical health and reproductive well-being. Hypertensive disorders during pregnancy are classified as high-risk conditions and require appropriate clinical management. Although the optimal target for pre-pregnancy blood pressure remains uncertain [20], achieving an adequate control of hypertension and comorbid conditions prior to conception is strongly recommended. Similar management strategies are advised during the interconception period, with the goal of improving the maternal and perinatal outcomes in subsequent pregnancies [2].

Hypertension in older adults

With the increasing number of healthy older individuals and the growing body of evidence on hypertension management in the elderly, it is now considered inappropriate to categorize older adults solely based on chronological age. JSH2025 shifts from age-based to condition-based treatment recommendations, minimizing the references to the term “elderly” and instead focusing on individual characteristics associated with aging [2]. For patients with hypertension aged ≥ 75 years who are functionally robust and tolerate treatment well, a systolic BP target of < 130 mmHg is recommended [9]. Particular attention is given to frailty, need for long-term care, and end-of-life considerations, where individualized treatment approaches are essential (Table 7) [2]. In cases of physical or cognitive decline, treatment should be carefully individualized to the patient’s condition. A systematic review and meta-analysis conducted for JSH2025 demonstrated that intensive BP reduction in elderly patients (≥ 75 years) was beneficial, regardless of their frailty status [9]. In individuals with functional impairment or dementia, BP management should be individualized with special attention to fall risk and medication adherence [2].

Onco-hypertension

With the growing number of cancer survivors, the management of hypertension in this population—commonly referred to as “onco-hypertension”—has become an

increasingly important clinical concern. Hypertension is a prevalent comorbidity among patients with cancer, often occurring alongside cardiovascular toxicities, which can significantly affect patient health and treatment outcomes. The JSH2025 guidelines explicitly address this issue by incorporating perspectives on onco-hypertension. The bidirectional relationship between cancer and hypertension is mediated by shared risk factors such as aging, obesity, smoking, and diabetes. In addition, cancer therapies—including anti-angiogenic agents, Bruton’s tyrosine kinase inhibitors, platinum-based chemotherapies, and radiation—can induce hypertension via endothelial dysfunction and renal toxicity. Effective BP control is essential to reduce the risk of cardiovascular events and to ensure the uninterrupted continuation of cancer treatment. Antihypertensive management in cancer patients should follow current recommendations for high-risk hypertension (Table 6, Fig. 2) [2], with careful consideration of frailty, nutritional status, and potential drug–drug interactions [2].

Public education: “10 Facts for Hypertension”

In response to the growing public narratives questioning the necessity and effectiveness of antihypertensive therapy, a supplementary section entitled “10 Facts About Hypertension” has been developed (Fig. 3). This section aims to provide scientifically accurate, evidence-based information to the general public [2]. It is specifically designed to enhance the public understanding of hypertension, its associated health risks, and the critical role of antihypertensive treatment in mitigating these risks—particularly in the Japanese population. By presenting well-established facts in a clear and accessible format, this section aims to counteract misinformation and promote informed decision-making regarding BP management. Ultimately, the objective is to empower individuals to take proactive steps toward managing their health by equipping them with the knowledge necessary to understand the importance of consistent and appropriate management of elevated BP and hypertension.

Conclusion

Despite these favorable healthcare resources, an estimated 4.5 million individuals in Japan remain untreated despite being aware of their condition, and ~ 12.5 million have poorly controlled hypertension despite receiving treatment [2]. Therefore, efforts to reduce the number of individuals with inadequately controlled BP are urgently required. The Japanese Society of Hypertension and its Guidelines Committee

hope that the implementation of JSH2025 will lead to substantial improvements in hypertension management in Japan. Furthermore, the evidence and recommendations outlined in the guidelines are expected to make a meaningful contribution to the advancement of hypertension care globally.

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Compliance with ethical standards

Conflict of interest The Task Force Committee for the JSH2025 was established in accordance with the Guidance on Eligibility Criteria for Participation in Clinical Practice Guideline Development 2023 issued by the Japan Medical Association. The committee members were selected based on the Conflict of Interest (COI) Management Policy for JSH2025. Declarations of COI for all committee members over the past 3 fiscal years (2022–2024) have been disclosed and are publicly available on the website of the Japanese Society of Hypertension. https://www.jpns.jp/data/jsh2025/jsh2025_coi.pdf

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