



KEY TAKEAWAYS FOR CLINICIANS

Optimizing Blood Pressure Care in
Patients With Resistant Hypertension:
2026 ACC Expert Consensus Decision Pathway

The Expert Consensus Decision Pathway (ECDP) provides a practical framework for optimizing blood pressure (BP) care in adults with resistant hypertension by standardizing BP measurement, confirming true resistant hypertension, intensifying treatment, and addressing common barriers to control.

1 Standardize BP measurement.
Ensure accurate and consistent readings to inform diagnosis and management of resistant hypertension. Use validated devices, the correct cuff size, proper patient preparation, repeated measurements, and a consistent protocol across settings. Automated office BP is preferred when feasible.

2 Confirm true resistant hypertension.
Do not diagnose resistant hypertension from office readings alone. Use validated home or 24-hour ambulatory BP monitoring to confirm resistant hypertension, identify white coat effect or masked hypertension, assess nocturnal BP patterns, and guide treatment decisions. Confirm that BP remains above goal despite maximally tolerated use of 3 complementary antihypertensive agents, including a diuretic, or that BP is controlled on 4 or more agents.

3 Rule out pseudoresistance.
Use the RESIST Framework to rule out non-adherence, interfering substances (e.g., OTC medications, herbal supplements), alcohol and sodium intake, and other contributors that raise BP. Address these issues before assuming treatment failure or escalating to fourth-line therapy or device-based treatment.

4 Intensify lifestyle treatment.
Focus on sodium reduction, heart-healthy eating patterns (e.g., DASH or Mediterranean), weight management, physical activity, alcohol reduction, stress management, and potassium optimization. These are active treatment strategies, not background advice.

5 Optimize foundational pharmacotherapy.
Utilize longer-acting agents with more potent BP-lowering effects, simplify dosing, and use single-pill combinations when possible to improve adherence and maintain sustained BP control. Optimize the core 3-drug regimen before adding more medications.

6 Address volume excess.
Optimize diuretic therapy with longer acting thiazide-like diuretics such as chlorthalidone or indapamide. Consider sequential nephron blockade in select patients before moving to other options.

7 Use a mineralocorticoid receptor antagonist as preferred fourth-line therapy.
After optimizing the initial regimen, add spironolactone or eplerenone unless contraindicated or not tolerated. Monitor kidney function and potassium closely and consider screening for primary aldosteronism when clinically appropriate.

8 Screen for secondary causes.
Secondary hypertension is common in patients with true resistant hypertension. Screen for causes such as primary aldosteronism, obstructive sleep apnea, chronic kidney disease, renovascular disease, and endocrine disorders when suspicion is present or BP remains uncontrolled despite optimized therapy.

9 Implement team-based systems of care.
Build workflows that incorporate home BP data, utilize team-based care, and address social determinants of health. Intensify treatment when BP remains uncontrolled rather than documenting it without action.

10 Consider advanced options carefully.
For carefully selected patients with confirmed true resistant hypertension despite optimized therapy, or with intolerance to further medication intensification, specialist referral can help determine whether renal denervation may be appropriate. Remote BP monitoring can support care when it is linked to treatment adjustment, but cuffless BP devices are not sufficiently validated for routine clinical use at this time.

Scan this QR code to access
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figures and clinical nuance.

