

|                                | ACC/AHA<br>(2017) | KDIGO<br>(2012) | ESH/ESC<br>(2013) | KHA-CARI<br>(2016)**                | HT Canada<br>(2017)                     |
|--------------------------------|-------------------|-----------------|-------------------|-------------------------------------|---|
| CKD<br>No DM<br>No proteinuria | 130/80            | 140/90          | 140/90            | 140/90<br>120 if<br>tolerated       | 140/90<br>sBP < 120 if<br>high CV risk* |
| CKD<br>No DM<br>Proteinuria    | 130/80            | 130/80          | 140/90            | 140/90<br>120 if<br>tolerated       | 140/90<br>sBP < 120 if<br>high CV risk* |
| CKD<br>DM<br>No proteinuria    | 130/80            | 140/90          | 140/90            | 140/90<br>120 if stroke<br>priority | 130/80                                  |
| CKD<br>DM<br>Proteinuria       | 130/80            | 130/80          | 140/90            | 140/90<br>120 if stroke<br>priority | 130/80                                  |
| Renal transplant               | 130/80            | 130/80          | 140/90            | No separate<br>recommendation       | 140/90<br>sBP < 120 if<br>high CV risk* |
| Elderly                        | 130/80            | Individualize   | 140/90            | Aim towards<br>120 if<br>tolerated  | 140/90<br>sBP < 120 if<br>high CV risk* |

**Notes:**

Proteinuria = 30 mg/day for KDIGO; > 300 mg/day for ACC/AHA

\*See details at [guidelines.hypertension.ca](http://guidelines.hypertension.ca) for definitions/cautionary statements

\*\* The KHA-CARI guidelines specify different strengths and levels of evidence for 140 (usually strong and level 1) vs for 120 (strong to moderate, level 2)