

The Importance of a Constitutional Approach in Hypertension

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Abstract: Hypertension is a common chronic disorder and a major risk factor for stroke, ischemic heart disease, heart failure, chronic kidney disease, and premature death. Although blood-pressure guidelines provide standardized diagnostic and treatment targets, effective management cannot rely on a uniform plan for every patient. A constitutional approach considers the individual's age, sex, body composition, family history, lifestyle, dietary pattern, psychological state, comorbidities, kidney function, drug tolerance, socioeconomic circumstances, and treatment preferences. Current hypertension guidance supports individualized blood-pressure targets, riskbased treatment, accurate repeated measurements, lifestyle modification, shared decision-making, and patient-specific drug selection. This article discusses why constitutional assessment is important in hypertension and how it can improve safety, adherence, and long-term cardiovascular outcomes.^{[1][3]}

Keywords: Hypertension, Constitutional Approach, Individualized Treatment, Personalized Medicine, Lifestyle Modification, Cardiovascular Risk, Patient-Centered Care.

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I. INTRODUCTION

Hypertension is defined as persistently elevated arterial blood pressure. It is often called a “silent” condition because many individuals have no symptoms until target-organ damage or a cardiovascular event occurs. The condition is influenced by multiple interacting factors, including genetic susceptibility, excess body weight, high sodium intake, physical inactivity, alcohol consumption, stress, aging, diabetes, renal disease, and environmental conditions.

A constitutional approach means evaluating the patient as a whole rather than treating only the numerical blood-pressure reading. It does not replace evidencebased guidelines; instead, it applies those guidelines according to the patient's clinical characteristics and circumstances. The 2025 American Heart Association/American College of Cardiology guideline emphasizes clinical judgment, shared decision-making, repeated blood-pressure measurements, and monitoring for treatment-related adverse effects.^[1]

➤ Meaning of the Constitutional Approach

The term “constitution” refers to the patient's overall biological, physical, psychological, and social characteristics. In hypertension care, it may include:

- Age and sex.
- Body mass index, waist circumference, and body composition.

- Family history of hypertension and premature cardiovascular disease.
- Dietary habits, particularly sodium and potassium intake.
- Level of physical activity.
- Sleep quality and possible obstructive sleep apnea.
- Tobacco, alcohol, and stimulant use.
- Emotional stress and mental-health conditions.
- Diabetes, kidney disease, dyslipidemia, and cardiovascular disease.
- Pregnancy status and reproductive health.
- Frailty, cognitive function, and functional capacity in older adults.
- Financial circumstances, health literacy, access to medicines, and social support.
- Previous response to antihypertensive medication and history of adverse effects.

This assessment helps clinicians distinguish between patients who may benefit from lifestyle intervention alone and those who require prompt pharmacological treatment.

➤ Why it is Important Accurate diagnosis

A single elevated reading does not always establish persistent hypertension. Blood pressure varies with stress, pain, recent exercise, caffeine, tobacco use, posture, and measurement technique. Contemporary guidance recommends basing treatment decisions on an average of at least two readings obtained at two or more visits, rather than on one isolated measurement^[1]

A constitutional approach also considers white-coat hypertension, in which clinic readings are high but out-of-office readings are normal, and masked hypertension, in which clinic readings appear normal but home or ambulatory readings are elevated. Home blood-pressure monitoring or ambulatory monitoring can therefore improve diagnostic accuracy.

➤ *Assessment of Total Cardiovascular Risk*

Blood pressure should not be considered in isolation. Two patients with the same reading may have very different risks because of differences in age, kidney function, diabetes, lipid levels, smoking status, or previous cardiovascular disease.

Recent risk-based approaches use several variables, including blood pressure, cholesterol, body mass index, kidney function, diabetes, smoking, and other comorbidities. This allows treatment intensity to reflect the patient's overall probability of cardiovascular events rather than relying only on a blood-pressure category.^[2]

➤ *Individualized Treatment Targets*

A single blood-pressure target may not be suitable for every patient. A younger patient with multiple cardiovascular risk factors may tolerate intensive treatment, while a frail older adult may be more vulnerable to dizziness, falls, kidney injury, or inadequate blood flow to vital organs.

Guidance supports individualized targets based on cardiovascular risk, comorbidities, frailty, cognition, functional status, quality of life, and patient preference. The aim is to reduce cardiovascular risk while avoiding excessive treatment and preventable adverse effects.^[3]

➤ *Selection of Appropriate Medication*

Common first-line antihypertensive classes include thiazide-type diuretics, longacting dihydropyridine calcium-channel blockers, angiotensin-converting enzyme inhibitors, and angiotensin-receptor blockers. However, the best choice depends on the patient's constitution and associated diseases.^[2]

➤ *Patient Characteristic Treatment Considerations*

Chronic kidney disease An ACE inhibitor or ARB may be particularly useful, or albuminuria with monitoring of kidney function and potassium.

Treatment should account for kidney status, Diabetes cardiovascular risk, and other diabetic complications.

Pregnancy or pregnancy Some antihypertensive medicines are contraindicated planning and require specialist guidance.

Begin cautiously when appropriate and monitor for Older age or frailty orthostatic hypotension, falls, and functional decline.

Peripheral edema or Medication selection should consider adverse-effect tachycardia profiles and coexisting cardiovascular disease.

Poor adherence or Simplified dosing and single-pill combinations may complex regimen improve persistence.

Electrolyte or kidney Diuretics and renin–angiotensin-system drugs require abnormalities laboratory monitoring.

Medication decisions should be made by a qualified clinician. Patients should not start, stop, or change antihypertensive medicines without medical advice.

➤ *Constitutional Lifestyle Management*

Lifestyle treatment is central to hypertension management, but recommendations should be realistic and adapted to the patient's circumstances.

➤ *Dietary Pattern*

A DASH-style dietary pattern emphasizes vegetables, fruits, legumes, whole grains, low-fat dairy products, nuts, and reduced intake of processed foods. Current guidance recommends reducing sodium below 2,300 mg per day, with an ideal goal near 1,500 mg per day for many patients when practical.^[4]

Dietary advice should consider culture, affordability, food availability, kidney function, diabetes, and patient preferences. For example, simply advising a patient to “avoid salt” may be less effective than identifying major sources of sodium such as packaged foods, pickles, sauces, instant meals, and restaurant meals.

➤ *Weight Management*

Excess adiposity is associated with insulin resistance, sleep apnea, inflammation, and increased sympathetic activity. Even moderate weight reduction can contribute to improved blood-pressure control. Weight-loss goals should be gradual, measurable, and compatible with the patient's nutritional needs and physical capacity.

➤ *Physical Activity*

Exercise should be selected according to age, mobility, musculoskeletal health, cardiovascular status, and personal preference. Walking, cycling, swimming, resistance exercise, and supervised activity may all be appropriate. A previously inactive person may benefit from beginning with short, regular sessions rather than adopting an unrealistic intensive program.

➤ *Sleep and Stress*

Poor sleep, obstructive sleep apnea, chronic stress, anxiety, and depression may worsen blood-pressure control and reduce adherence. Constitutional assessment should therefore include sleep quality, snoring, daytime somnolence, emotional health, and occupational or family stressors.

➤ *Alcohol, Tobacco, and Stimulants*

Smoking cessation is essential for reducing cardiovascular risk, even when its effect on the blood-

pressure number is modest. Alcohol intake should be limited, and excessive caffeine, illicit stimulants, and certain over-the-counter medicines should be reviewed when blood pressure is difficult to control.

➤ *Role of Patient Participation*

The constitutional approach requires shared decision-making. Patients are more likely to follow a treatment plan when they understand:

- Why treatment is necessary.
- What benefits and adverse effects to expect.
- How frequently blood pressure should be measured.
- When laboratory tests are required.
- Which lifestyle changes are most important for them.
- How treatment will be adjusted over time.

Adherence is not simply a matter of patient behavior. It may be affected by medication cost, complicated dosing schedules, side effects, transport difficulties, limited health literacy, and lack of access to follow-up care. Recognizing these barriers allows clinicians to design more sustainable treatment plans.

➤ *Relevance to Integrative and Traditional Concepts*

In some systems of traditional or complementary medicine, “constitution” may refer to categories such as body type, temperament, or constitutional pattern. Such concepts may help clinicians explore diet, stress, sleep, and symptom patterns, but they should not replace validated blood-pressure measurement, cardiovascular-risk assessment, or proven medical treatment.

The strongest clinical basis for a constitutional approach is therefore individualized, evidence-based care. Traditional practices should be evaluated for safety, possible interactions, and supporting evidence. They should be used only as complementary measures and not as substitutes for prescribed antihypertensive treatment.

II. CHALLENGES AND LIMITATIONS

A constitutional approach has several limitations. First, constitutional assessment may become subjective if it is not based on clear clinical criteria. Second, individualized care requires time, accurate records, laboratory testing, and regular follow-up. Third, treatment decisions may be influenced by unequal access to healthcare and medicines. Finally, personalized care must not lead to undertreatment of patients who have a high cardiovascular risk.

The most appropriate model combines standardized evidence-based protocols with individualized clinical judgment. This provides consistency while allowing treatment to be adapted safely.

III. CONCLUSION

A constitutional approach is important in hypertension because patients differ substantially in cardiovascular risk, comorbidities, treatment response, lifestyle, tolerance, and

personal goals. Accurate repeated measurement, comprehensive risk assessment, individualized targets, suitable medication selection, realistic lifestyle planning, and shared decision-making can improve blood-pressure control and reduce complications.

Constitutional care should not mean abandoning clinical guidelines. It should mean applying them intelligently to the individual patient. In this way, hypertension management becomes safer, more acceptable, and more effective over the long term.

REFERENCES

- [1]. American Heart Association/American College of Cardiology. *2025 Guideline for the Prevention, Detection, Evaluation and Management of High Blood Pressure in Adults*.
- [2]. American Heart Association/American College of Cardiology. *2025 Hypertension Guideline and risk-based treatment recommendations*.
- [3]. Agency for Care Effectiveness, Singapore. *Hypertension: Tailoring the Management Plan to Optimise Blood Pressure Control*.
- [4]. Review of the 2025 AHA/ACC Hypertension Guideline. *The 2025 AHA/ACC Hypertension Guidelines*.
- [5]. European Society of Cardiology. *2024 ESC Guidelines for the Management of Elevated Blood Pressure and Hypertension*.