Appendix 1. Treatment strategy for arterial hypertension in patients with chronic kidney disease (ESH, 2023)*

Recommendations and representations	Evidence	
	Class	Level
BP should be monitored at all stages of CKD because it is the second most important risk factor for the development of terminal CKD.	I	A
Non-dipping or elevated nocturnal BP is common in patients with CKD. It should be controlled via 24-h or home BP monitoring.	I	B
In both diabetic and non-diabetic patients with CKD and AH, antihypertensive therapy slows the decline in renal function and the risk of developing cardiovascular complications.	I	A
Most patients with CKD, regardless of stage, require antihypertensive therapy if SBP is >140 mmHg and DBP is >90 mmHg.	I	C
In most patients with CKD, the goal is to reduce the office (clinical) BP to <140 mmHg and DBP to <90 mm Hg.	I	A
In most patients with CKD (young, with Al/Cr >300 mg/g, and with high risk of CVD), office BP should be lowered to 130/80 mm Hg if well tolerated.	II	B
In patients undergoing renal transplantation, the office (clinical) BP should be lowered to <130/80 mm Hg.	II	B

BP, blood pressure; CKD, chronic kidney disease; AH, arterial hypertension; SBP, systolic BP; DBP, diastolic BP; CVD,

* Mancia G, Kreutz R, Brunström M, et al. 2023 ESH Guidelines for the management of arterial hypertension. *J Hypertens.* 2023;41(12):1874–2071. doi: 10.1097/HJH.0000000000003480