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SYSTEMIC ARTERIAL HYPERTENSION (SAH) IN ELDERLY PATIENTS: CLINICAL PARTICULARITIES AND APPROACH IN PRIMARY HEALTH CARE (PHC)

HIPERTENSÃO ARTERIAL SISTÊMICA (HAS) EM PACIENTES IDOSOS: PARTICULARIDADES CLÍNICAS E ABORDAGEM NA ATENÇÃO PRIMÁRIA À SAÚDE (APS)

HIPERTENSIÓN ARTERIAL SISTÉMICA (HAS) EN PACIENTES MAYORES: PARTICULARIDADES CLÍNICAS Y ABORDAJE EN LA ATENCIÓN PRIMARIA DE SALUD (APS)

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ABSTRACT

This chapter presents a literature review on Systemic Arterial Hypertension (SAH) in older adults and the main challenges related to its management in Primary Health Care (PHC). The review compiles data showing that SAH is highly prevalent among the elderly, especially those with lower income and education levels, reinforcing its importance as a public health issue. In this context, the chapter also discusses the physiological changes associated with aging, such as arterial stiffness, reduced vascular compliance, decreased baroreceptor sensitivity, and declining renal function, all of which contribute to increased blood pressure (BP) and a higher risk of cardiovascular complications. Accordingly, current diagnostic criteria and the necessary care in BP measurement are reviewed, along with the complementary use of assessments such as ABPM and HBPM, which help identify masked hypertension, white-coat hypertension, and common BP fluctuations in this age group. The chapter discusses guideline-recommended targets, lifestyle modifications, and indicated pharmacological treatments, including medications available through the Brazilian Unified Health System (SUS). The review also addresses challenges faced in PHC, such as difficulties in access, resource limitations, team overload, and failures in continuity of care. Additionally, it emphasizes the importance of the bond between health professionals and elderly patients, as a trust-based relationship improves treatment adherence and understanding of health instructions. Therefore, it concludes that adequate hypertension control in older adults depends on a comprehensive approach that considers their clinical, social, and functional conditions and is supported by multiprofessional actions and effective public policies aimed at preventing complications and promoting healthy aging.

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Keywords: Adherence. Primary Health Care. Arterial Hypertension. Elderly. Treatment.

RESUMO
Este capítulo apresenta uma revisão de literatura sobre a Hipertensão Arterial Sistêmica (HAS) em idosos e os principais desafios para seu manejo na Atenção Primária à Saúde (APS). A revisão reúne dados que mostram que a HAS é muito comum em idosos, principalmente entre aqueles com menor renda e escolaridade, o que reforça sua importância como problema de saúde pública. Nesse contexto, também são discutidas as mudanças que ocorrem no organismo com o envelhecimento, como a rigidez arterial, redução da complacência dos vasos, menor sensibilidade dos barorreceptores e o declínio da função renal, que contribuem para o aumento da pressão arterial (PA) e para maior risco de complicações cardiovasculares. Nesse sentido, são revisados os critérios diagnósticos atuais e o cuidado necessário na medida da PA, além do uso complementar de avaliações como MAPA e MRPA, que ajudam a identificar hipertensão mascarada, avental branco e flutuações pressóricas comuns nessa faixa etária. São discutidas as metas recomendadas pelas diretrizes, as mudanças no estilo de vida e os tratamentos farmacológicos indicados, incluindo os medicamentos disponíveis pelo SUS. A revisão, também, aborda dificuldades enfrentadas na APS, como problemas de acesso, limitações de recursos, sobrecarga das equipes e falhas na continuidade do cuidado. Além disso, reforça a importância do vínculo entre profissionais de saúde e pacientes idosos, pois a relação de confiança melhora a adesão ao tratamento e o entendimento das orientações. Diante disso, conclui-se que o controle adequado da hipertensão em idosos depende de uma abordagem completa, que considere suas condições clínicas, sociais e funcionais, e que seja sustentada por ações multiprofissionais e políticas públicas eficazes, visando prevenir complicações e promover um envelhecimento saudável.

Palavras-chave: Adesão. Atenção Primária à Saúde. Hipertensão Arterial. Idoso. Tratamento.

RESUMEN
Este capítulo presenta una revisión de la literatura sobre la Hipertensión Arterial Sistémica (HAS) en personas mayores y los principales desafíos para su manejo en la Atención Primaria de Salud (APS). La revisión reúne datos que muestran que la HAS es muy común en los adultos mayores, especialmente entre aquellos con menor ingreso y escolaridad, lo que refuerza su relevancia como un problema de salud pública. En este contexto, también se discuten los cambios que ocurren en el organismo con el envejecimiento, como la rigidez arterial, la reducción de la complacencia vascular, la menor sensibilidad de los barorreceptores y el deterioro de la función renal, que contribuyen al aumento de la presión arterial (PA) y al mayor riesgo de complicaciones cardiovasculares. En este sentido, se revisan los criterios diagnósticos actuales y los cuidados necesarios en la medición de la PA, además del uso complementario de evaluaciones como MAPA y MRPA, que ayudan a identificar hipertensión enmascarada, de bata blanca y las fluctuaciones tensionales comunes en este grupo etario. Se discuten las metas recomendadas por las guías, los cambios en el estilo de vida y los tratamientos farmacológicos indicados, incluidos los medicamentos disponibles a través del Sistema Único de Salud (SUS). La revisión también aborda las dificultades enfrentadas en la APS, como problemas de acceso, limitaciones de recursos, sobrecarga de los equipos y fallas en la continuidad del cuidado. Además, refuerza la importancia del vínculo entre los profesionales de la salud y los pacientes mayores, ya que la relación de confianza mejora la adherencia al tratamiento y la comprensión de las

orientaciones. Ante esto, se concluye que el control adecuado de la hipertensión en los adultos mayores depende de un abordaje integral que considere sus condiciones clínicas, sociales y funcionales, y que esté sustentado por acciones multiprofesionales y políticas públicas eficaces, con el objetivo de prevenir complicaciones y promover un envejecimiento saludable.

Palabras clave: Adherencia. Atención Primaria de Salud. Hipertensión Arterial. Adulto mayor. Tratamiento.

1 INTRODUCTION

Systemic Arterial Hypertension (SAH), or popularly known as high blood pressure, is a chronic non-communicable disease characterized by a persistent increase in blood pressure levels, with Systolic Blood Pressure (SBP) ≥ 140 mmHg and Diastolic Blood Pressure (DBP) ≥ 90 mmHg. It involves risk factors such as genetics, obesity, sedentary lifestyle, unbalanced diet, alcoholism and advanced age. It can be asymptomatic, and therefore, regularly measuring blood pressure is the most effective way to identify the increased blood pressure. With aging, there is stiffening and loss of compliance of the great arteries and, combined with risk factors, it is common for elderly people to have SAH (BARROSO et al., 2025).

The National Primary Care Policy (PNAB), ordinance No. 2,436, of September 21, 2017, a normative document of the Ministry of Health, organizes the functioning of Primary Health Care (PHC) in Brazil and includes specific guidelines for the care of the elderly, integrating health promotion actions, disease prevention, management of chronic conditions, such as hypertension and diabetes, and comprehensive care in the territory.

This chapter aims to analyze hypertension in the elderly in an integrated way, covering everything from its prevalence at different scales (global, national, state and municipal) to physiological changes related to aging, diagnostic methods, blood pressure goals, non-pharmacological and pharmacological treatments, in addition to the role of PHC and the Family Health Strategy (FHS) in the monitoring and control of the disease.

1.1 EPIDEMIOLOGICAL ASPECTS OF SAH IN THE ELDERLY

According to the World Health Organization (WHO) in 2023, it is estimated that there are 1.28 billion hypertensive people in the age group between 30 and 79 years old. In Brazil, with regard to SAH, according to the Ministry of Health, it is possible to infer that about 60.9% of the elderly have this comorbidity and, regarding the socioeconomic profile, it is characterized by a higher prevalence in low-income people, with less education and living in areas with worse socioeconomic conditions.

In 2017, data from the Global Burden of Disease (GBD) pointed out that the increase in SBP was the main risk factor, being responsible for 10.4 million deaths. The 2019 National Health Survey reported that the prevalence of hypertension was higher among women than men and as for costs, according to the DATASUS Hospitalization System, in 2018 they totaled more than US$523.7 million.

1.2 PHYSIOLOGICAL CHANGES OF AGING AND THEIR RELATIONSHIP TO SAH

According to the 2020 Brazilian Guidelines on Arterial Hypertension, aging is associated with physiological changes that contribute to the increase in the prevalence of arterial hypertension, especially in the isolated systolic form. One of these changes is reduced arterial compliance — the ability of blood vessels to stretch to accommodate the volume of blood ejected by the heart. With age, there is degeneration of elastic fibers, increased collagen deposition, and calcification in the vascular wall, resulting in greater stiffness. This loss of elasticity makes it difficult to dampen the pressure during systole, leading to an increase in systolic blood pressure and pressure pulse (BARROSO ET AL, 2020).

Vascular stiffness, resulting from this reduction in compliance, causes pressure waves to return more rapidly towards the heart, further increasing systolic pressure and cardiac workload. This condition is potentiated by factors such as atherosclerosis, chronic inflammation, and long-standing hypertension, and is associated with a higher risk of cardiovascular events such as stroke, heart failure, and coronary artery disease (BARROSO ET AL, 2020).

Another relevant aspect is the reduction in renal function with advancing age: there is a progressive decrease in glomerular filtration rate, renal blood flow, and sodium excretion capacity, which increases salt sensitivity and favors blood pressure elevation. In addition, the sensitivity of baroreceptors decreases, compromising the rapid regulation of blood pressure and increasing susceptibility to sudden changes, such as orthostatic hypotension (BARROSO ET AL, 2020).

These structural and functional changes — arterial stiffness, less vascular compliance and decline in kidney function — form a set of aging adaptations that, according to the WHO, explain the greater predisposition of the elderly to hypertension and its cardiovascular complications.

1.3 DIAGNOSIS OF HYPERTENSION IN THE ELDERLY

According to guidelines such as the Brazilian Guidelines on Arterial Hypertension (2025), the diagnosis is established when systolic blood pressure (SBP) values are equal to or greater than 140 mmHg and/or diastolic blood pressure (DBP) are equal to or greater than 90 mmHg, obtained in at least two or more consultations, with minimum intervals of one week between them, and in a calm environment, after five minutes of rest (BARROSO et al., 2020).

The measurement should be done with the patient seated, with the arm resting at the height of the heart and using a cuff appropriate to the size of the arm, in PHC the most used method is the measurement with a validated aneroid or digital sphygmomanometer, with a standardized technique. In addition to in-office measurement, methods such as Ambulatory Blood Pressure Monitoring (ABPM) and Home Blood Pressure Monitoring (HBPM) are recommended to confirm the diagnosis and identify cases of white-coat hypertension or masked hypertension (SBC, 2025).

Diagnostic evaluation should include global cardiovascular risk stratification, considering the presence of additional risk factors, such as diabetes mellitus, dyslipidemia, smoking, and family history of early cardiovascular disease. It is also essential to investigate the presence of target organ damage, such as hypertensive retinopathy, left ventricular hypertrophy, and proteinuria (ESC/ESH, 2018). Therefore, the diagnosis of hypertension requires a comprehensive approach, which involves not only the measurement of blood pressure, but also the evaluation of the patient's clinical context, aiming at the prevention of long-term complications, which are frequent, especially in the elderly.

Figure 1

Classification of blood pressure according to in-office measurement from 18 years of age.

BP Rating	SBP (mmHg)		DBP (mmHg)
Normal Phantom Assassin	<120	and	<80
Prehypertension	120-139	and/or	80-89
HA Stage 1	140-159	and/or	90-99
HA Stage 2	160-179	and/or	100-109
HA Stage 3	≥180	and/or	110

DBHA: Brazilian Guideline on Arterial Hypertension; AH: arterial hypertension; BP: blood pressure; DBP: diastolic blood pressure; SBP: systolic blood pressure. "The classification is defined according to BP in the office and by the highest level of BP, systolic or diastolic. " Isolated systolic hypertension , characterized by SBP ≥ 140 mmHg and DBP < 90 mmHg, is classified as Stage 1, 2 or 3, according to SBP values in the indicated intervals. "Diastolic AH , characterized by SBP < 140 mmHg and DBP ≥ 90 mmHg, is classified as Stage 1, 2 or 3, according to DBP values in the indicated intervals.
Source: DBHA (2025).

The diagnosis of SAH in the elderly has particularities resulting from physiological changes of aging, the presence of comorbidities, and greater pressure variability. The prevalence of phenomena such as white-coat hypertension, masked hypertension, and

orthostatic hypotension makes it difficult to interpret the pressure levels obtained in the office. Methods such as ambulatory monitoring (ABPM) and home blood pressure monitoring (HBPM) become fundamental in this context. In addition, factors such as polypharmacy, cognitive deficit, and isolated systolic hypertension require an individualized clinical approach, based on the patient's functional profile and cardiovascular risk (MS, 2013).

1.4 BLOOD PRESSURE TARGETS IN THE ELDERLY

The definition of blood pressure goals in elderly individuals refers to the blood pressure target values established in the treatment of hypertension, with the objective of reducing adverse cardiovascular outcomes, without compromising the clinical safety of the patient. Considering the heterogeneity of the elderly population — which includes from robust individuals to those with frailty and multiple comorbidities — the determination of these goals should be individualized, weighing the potential benefits of strict blood pressure control against the risks of adverse events (ESC/ESH, 2018).

Current guidelines recommend more conservative goals for frail older adults, while pointing to possible benefits of more intensive strategies in functionally independent and clinically stable older adults.

The Brazilian Guideline on Arterial Hypertension (DBHA, 2025), after a systematic review of several randomized controlled clinical trials, published new guidelines, where there is a strong recommendation, that the goal is < 130/80 mmHg for the vast majority of hypertensive older adults.

In addition, according to the Brazilian Society of Cardiology (2025) for frail elderly, very elderly or with conditions that compromise life expectancy, BP should be reduced to the maximum tolerated value.

1.5 NON-PHARMACOLOGICAL TREATMENT OF SAH IN THE ELDERLY

The therapeutic strategy in the elderly should consider: the presence of comorbidities, autonomy, functional status and degree of frailty to plan treatment. No therapeutic intervention should be denied or withdrawn solely on the basis of age (DBHA, 2025).

Lifestyle changes should be encouraged among the elderly, with adherence and satisfactory benefits, as some studies have shown. Moderation in sodium intake (2g/day) and alcohol, in addition to encouraging the DASH diet (emphasizes fruits, vegetables, whole

grains, skim dairy products, and reducing saturated fats) and increasing potassium intake (3.5g/day) (AAFP, 2022).

Regular aerobic physical activity, from light to moderate such as walking, dancing, swimming and light weight training, the ideal is the practice of thirty minutes, five days a week. In addition, weight loss (maintaining a BMI between 22–27 kg/m²) in the elderly are possible goals to be achieved in the elderly and can not only reduce the use of antihypertensive drugs but also improve the profile of other cardiovascular risk factors and the quality of life of patients. Smoking cessation is essential regardless of the clinical picture (SBC, 2025).

Despite the widespread concept that it is very difficult to change very old lifestyle habits, when the approach is made with common sense, creating healthy alternatives, without radicalism, with clarification of the objectives and expected results, it is possible to obtain good adherence, as well as the expected results.

Figure 2

Main interventions that prevent arterial hypertension

Modalidade	Intervenção NF	Dose	Diferença de PAS obtida
Controle do Peso	Peso/gordura corpórea	Alcançar peso ideal. Esperada diminuição de 1mmHg por cada quilo de peso perdido	- 2/3 mmHg
Dieta saudável	Dieta tipo DASH	Dieta rica em frutas, vegetais, grãos e baixo teor de gordura. Redução de gordura saturada e trans	- 3 mmHg
Redução da ingestão de sódio	Sódio na dieta	Ideal < 2 g cu pelo menos redução de 1,0 g/dia	- 2/3 mmHg
Aumento da ingestão de potássio	Potássio na dieta	3,5 a 5,0 g/dia em dieta rica em potássio	- 2 mmHg
Atividade física	Aeróbia	150 min/semana	-5/7 mmHg
	De resistência dinâmica	8 a 10 exercícios para os principais grupos musculares, 1 a 3 séries, 50 a 80% de 1 RM	
	De resistência isométrica	Exercicio de handgrip (preensão de mão) unilateral ou 1 perna, 4 séries, 2 min de contração isométrica, 30% de contração voluntária máximo (CVM), 2-3 min de pausa entre as séries	-4/5 mmHg
Ingestão de álcool	Consumo de álcool	Para quem usa álcool Homens ≤ 2 drinques Mulheres ≤ 1 drinque	-4/5 mmHg

NF: não farmacológica; PAS: pressão arterial sistólica; RM: repetição máxima; mmHg; milimetros de mercúrio. Fonte: Adaptado de Carey et al., 2018.[a]

Source: SBC (2020).

1.6 DRUGS STANDARDIZED BY THE SUS FOR THE TREATMENT OF AH IN THE ELDERLY

The control of systemic arterial hypertension (SAH) in the elderly is a growing challenge in Primary Health Care (PHC) in Brazil, given the high prevalence and impact on cardiovascular complications in this population. To ensure universal access to effective and safe medicines, the Unified Health System (SUS) has developed the National List of Essential Medicines (RENAME) and the Municipal Relations of Medicines (REMUME), which guide the standardized and qualified supply of drugs.

1.7 STANDARDIZED CLASSES AND DRUGS IN RENAME AND REMUME

RENAME 2024 presents the list of essential medicines for the treatment of the most prevalent pathologies in Brazil. Among them, the treatment for SAH has several chronic hypertension drugs, available, mainly in the Basic Component of Pharmaceutical Services (CBAF), being made available mainly in all Basic Family Health Units (USF) and through the Popular Pharmacy Program of Brazil, made available by the Ministry of Health. Among the main drug classes available, we can mention: SUS, the main ones being:

Thiazide diuretics: Hydrochlorothiazide (12.5 mg and 25 mg), considered first-line for isolated systolic hypertension, common in the elderly (BRASIL, 2024).

Angiotensin-converting enzyme (ACE) inhibitors: Captopril (25 mg) and Enalapril Maleate (5 mg, 10 mg, and 20 mg), indicated in comorbidities such as for the treatment of heart failure and chronic kidney disease (BRASIL, 2024).

Angiotensin receptor blockers (ARBs): Losartan Potassium (50 mg), an alternative for patients intolerant to ACE inhibitors (BRASIL, 2024).

Calcium channel blockers (CCB): Amlodipine besylate (5 mg and 10 mg) and nifedipine (10 mg), effective in arterial stiffness, a common characteristic in the elderly (SILVA et al., 2023).

Beta-blockers: Atenolol, Propranolol Hydrochloride, Metoprolol Succinate, and Carvedilol, with specific indications such as for the treatment of heart failure and post-infarction (SBGG-SP, 2023).

Aldosterone antagonists: Spironolactone, used in selected cases such as edema and heart failure (BRASIL, 2024).

The objective of the elaboration of the Municipal List of Essential Medicines (REMUME) is to select pharmaceutical presentations that meet local epidemiological needs, considering the most prevalent pathologies in the population (BRASIL, 2013). Although based on the National List of Essential Medicines (RENAME), REMUME can include drugs that are not nationally standardized, as long as they are justified by the specific demands of the municipality (BRASIL, 2022). Its elaboration is the responsibility of the Pharmacy and Therapeutics Commission (CFT), a multiprofessional body composed of doctors, nurses, pharmacists, dentists and other health professionals, with the function of ensuring technical-scientific criteria in the selection and rational use of medicines (PAHO, 2016).

Practical Considerations for the Use of Pharmacological Treatment in Elderly Patients

The particularities of elderly patients — such as frailty, multiple comorbidities, polypharmacy, greater pressure variability, and increased risk of orthostatic hypotension — make the management of systemic arterial hypertension (SAH) especially complex in Primary Health Care (PHC). Added to the high prevalence of the condition and the frequency of isolated systolic hypertension, these characteristics reinforce the challenge described in the Brazilian Guidelines on Arterial Hypertension 2025. Careful choice, regular monitoring, and continued patient education are essential to ensure adherence and therapeutic efficacy, preventing complications and hospitalizations (OLIVEIRA et al., 2023).

Therapeutic management should be carefully individualized, taking into account global functionality, degree of frailty, cognitive status, renal and hepatic function, as well as the risk of falls and the frequent presence of polypharmacy. As guided by the Brazilian Guidelines on Arterial Hypertension 2025, it is essential to adopt a gradual and prudent approach, starting treatment with low doses and performing slow titration, usually at minimum intervals of two weeks, to reduce adverse effects and improve tolerability. Whenever possible, it is recommended to use fixed-dose combinations, a strategy that reduces the number of pills and favors adherence, especially relevant in polymedicated elderly.

Clinical follow-up should include regular monitoring for orthostatic and postprandial hypotension, conditions that are highly prevalent in this age group and often responsible for falls, syncope, or functional limitation. In addition, it is essential to periodically review all medications in use, avoiding drugs that may precipitate hypotension, sedation, or greater postural instability.

The guidelines establish blood pressure <130/80 mmHg as a general therapeutic goal for most of the elderly, adjusting this goal according to clinical tolerability, especially among the very frail or with reduced life expectancy, in whom the maximum safe value that the patient can bear is prioritized. Finally, health education, the involvement of family members and caregivers, and the integrated performance of the multidisciplinary team are essential components to optimize adherence, reduce risks, and achieve better clinical outcomes.

2 THE ROLE OF USF AND E-MULTI TEAMS

PHC represents the first level of contact of the individual with the health system, being considered the gateway to the SUS, considered essential for promotion. In Brazil, this care is structured through the Basic Health Units and the Family Health Strategy (ESF), which together form the basis of the Unified Health System (SUS). The Basic Health Unit is the

physical and organizational space where most primary care takes place. It works as a gateway to the SUS, offering a variety of services that include medical consultations, monitoring of chronic diseases, vaccination, educational actions and community health programs.

According to the Ministry of Health (BRASIL, 2020), the Basic Health Unit must guarantee accessible, continuous and problem-solving care, promoting comprehensive care and bonding with the population. The FHS, implemented in Brazil since the 1990s, is the main strategy to operationalize PHC. Its differential lies in the organization of care through multiprofessional teams responsible for delimited territories, accompanying families and individuals over time.

This territorialization favors the longitudinality of care, allowing in-depth knowledge of the living conditions, habits and health needs of the assisted population (PAIM et al., 2011). The ESF's e-Multi is composed of doctors, nurses, community health agents, dentists, as well as professionals from other areas such as psychology, social work, physiotherapy and nutrition, according to local demands.

The integrated performance of this team is essential to address the biological, social, and psychological aspects of health, promoting comprehensive care for the individual (SILVA et al., 2019). This integration allows for welcoming, qualified listening, shared treatment planning, and articulation with specialized services. The presence of community agents is essential to strengthen the bond between the team and the community, facilitating access and home monitoring.

Despite the advances, PHC still faces challenges, such as regional inequalities in access, insufficient professionals in certain areas, and structural limitations of the UBS. Valuing multiprofessional teams and continuing education are essential strategies to overcome such difficulties. Strengthening PHC through the UBS, ESF, and multiprofessional teams is crucial to ensure an equitable, efficient, and population-centered health system, promoting sustainable health and reducing the burden at the secondary and tertiary levels (BRASIL, 2020; PAIM et al., 2011).

2.1 CHALLENGES AND PERSPECTIVES FOR THE CONTROL OF SAH IN THE ELDERLY IN PHC

Effective control of SAH is essential for improving quality of life and reducing morbidity and mortality in this population group. Primary Health Care, through the Basic Health Units

and the Family Health Strategy (FHS), plays a crucial role in this process, but faces several challenges that compromise the effectiveness of hypertension management in the elderly. We can subdivide these challenges into:

2.2 STRUCTURAL AND ORGANIZATIONAL BARRIERS

One of the main obstacles to the adequate control of SAH in PHC is the structural barriers that involve the physical infrastructure and resources available in health units. Many studies point out that the absence or insufficiency of adequate equipment for measuring blood pressure, such as calibrated and functional devices, directly impacts the quality of diagnosis and monitoring of the disease (SANTOS et al., 2022).

In addition, the irregularity in the availability of essential medicines, even in the face of the free distribution policy by the SUS, hinders the continuity of treatment (OLIVEIRA et al., 2023). At the organizational level, the overload of multiprofessional teams and the lack of trained professionals for the specific monitoring of hypertensive elderly make it difficult to implement individualized protocols. The fragmentation of care, with little integration between services and levels of care, compromises longitudinal follow-up, which is especially necessary for this population (COSTA et al., 2021).

Another limiting factor is the inefficient scheduling of appointments and the low supply of educational actions, which reduces opportunities for reinforcing self-care and clarifying the importance of therapeutic adherence (MARTINS et al., 2020).

2.3 THE IMPORTANCE OF THE BOND BETWEEN THE PROFESSIONAL AND THE PATIENT

In view of the barriers mentioned, the importance of the bond established between the health professional and the elderly patient is highlighted as a fundamental element for the success of SAH control. Building a relationship of trust and mutual respect favors clear communication, active listening, and patient engagement in treatment-related decisions (LIMA et al., 2019).

This bond, strengthened by continuous monitoring and the integrated performance of the multiprofessional team, allows the professional to better understand the particularities of the social, cultural, and emotional context of the elderly, personalizing care strategies (FERREIRA et al., 2021).

The constant presence of the community health agent (CHA), for example, contributes to the approximation between the team and the community, facilitating home monitoring and support in daily difficulties. The literature reinforces that adherence to treatment and the effectiveness of interventions increase when the patient feels welcomed and valued, with care centered on the person and not just on the disease (RODRIGUES et al., 2022). This includes respecting the autonomy of the elderly and encouraging self-care, which are essential for maintaining positive results in the long term.

3 FINAL THOUGHTS

Systemic Arterial Hypertension in the elderly is a relevant public health problem, given its high prevalence, association with cardiovascular complications and impact on mortality and quality of life. The physiological changes typical of aging, added to modifiable and non-modifiable risk factors, contribute to the increase in incidence and complexity in the management of this clinical condition.

In this context, Primary Health Care plays a strategic role by enabling early diagnosis, longitudinal follow-up, and comprehensive therapeutic interventions, which include non-pharmacological and pharmacological measures. The availability of medications standardized by the Unified Health System, associated with multidisciplinary follow-up, represents a fundamental element for therapeutic adherence and treatment effectiveness.

The need for an integrated and individualized approach is also highlighted, considering not only the clinical and laboratory parameters, but also functional, cognitive, social and cultural aspects of the elderly. This perspective expands the problem-solving capacity of care, favors adherence to the proposed conducts, and contributes to the prevention of treatment-related adverse events, especially in fragile individuals or those with multiple comorbidities.

Although there have been significant advances in the management of hypertension in the elderly, challenges persist related to infrastructure, the organization of services, and the training of teams, which compromise the comprehensiveness and problem-solving capacity of care. The strengthening of PHC, through continuous professional qualification, the expansion of the supply of resources and the appreciation of the bond between the health team and the patient, is essential to overcome these barriers.

It is concluded, therefore, that the control of hypertension in the elderly requires an integrated approach, supported by effective public policies and evidence-based clinical

practices, in order to reduce cardiovascular morbidity and mortality and promote healthy and functional aging.

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