Annals of
Clinical Case Studies and Medical Images

Family Medicine ACCSMI-1004 Opinion

Re-Evaluating Hypertension Beyond Numerical Diagnostic Thresholds: A Novel Risk and Symptom-Based Approach in Primary Care

Murat KILIC[1] and Mehmet Akif BUYUKBESE[2]*

[1]Family Medicine Resident, Department of Family Medicine, Gaziantep University Faculty of Medicine, Gaziantep, Türkiye

[2]School of Medicine, Department of Internal Medicine, Gaziantep Islam Science and Technology University, Gaziantep, Türkiye

***Corresponding Author:** Mehmet Akif BUYUKBESE, School of of Medicine, Department of Internal Medicine, Gaziantep Islam Science and Technology University, Gaziantep, Türkiye; **Tel:** +90532-5456670; **Email:** akif_buyukbese@yahoo.com*

Received Date : *06 April,, 2026*
Accepted Date : *27 April,, 2026*
Published Date : *30 April, 2026*

Citation: *Murat KILIC, Mehmet Akif BUYUKBESE. Re-Evaluating Hypertension Beyond Numerical Diagnostic Thresholds: A Novel Risk and Symptom-Based Approach in Primary Care. Ann Clin Case Stud Med Images. 2026; 1(1): 1004*

Opinion

Hypertension is one of the leading modifiable causes of cardiovascular morbidity and mortality worldwide. Although it has traditionally been defined as a "*silent disease*," this concept may underestimate the early clinical manifestations of blood pressure dysregulation, particularly in primary care settings where patients are followed longitudinally [1]. In daily practice, family physicians frequently encounter individuals presenting with nonspecific complaints such as headache, fatigue, palpitations, or dizziness, often accompanied by a positive family history and accumulating metabolic risk factors. These presentations are often regarded as benign or transient, and early-stage hypertension may therefore be missed. This is a primary care-centered perspective that describes hypertension as a multifactorial and gradually progressive process shaped by genetic susceptibility, environmental exposure, metabolic burden, and subtle clinical warning signs. Rather than restricting detection to elevated office blood pressure values, early recognition should also take into account family clustering, individual risk stratification, and symptom-oriented clinical assessment. In this context, nonspecific symptoms may reflect early physiological dysregulation preceding overt hypertension, especially in high-risk individuals. This perspective challenges the traditional view of hypertension as a silent condition and supports a shift toward earlier, proactive detection strategies in primary care.

Hypertension remains a major global health challenge, affecting more than 1.4 billion people worldwide (1). Conventional diagnostic approaches rely heavily on numerical blood pressure thresholds, which may delay recognition until vascular changes have already developed. However, hypertension is increasingly understood as a progressive and multifactorial condition that evolves over time through the interaction of genetic (2), environmental, and metabolic factors. Primary care offers a unique opportunity for early identification because of continuous patient follow-up. Hypertension should therefore be reconsidered not as a condition that appears abruptly at a threshold, but as a gradual and dynamic process.

In conclusion; hypertension does not begin when blood pressure crosses a diagnostic threshold; it begins much earlier, within a continuum of genetic predisposition [2], metabolic burden, and subtle clinical signals. A primary care-centered, genetics-informed [2], and symptom-aware approach [3,4] may significantly improve early detection and prevention strategies and transform family physicians into proactive risk managers.

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