Hypertensive Urgency

Definition

- Severe hypertension (SBP >180mmHg and/or DBP >120mmHg)
- Without target organ damage seen in hypertensive emergency (e.g. major neurological changes, hypertensive encephalopathy, cerebral infarction, intracranial haemorrhage, acute LV failure, acute pulmonary oedema, aortic dissection, acute kidney injury, or eclampsia)

Common causes

1. Non-compliance to treatment
2. Inadequate treatment
3. Anxiety
4. Medications exacerbating hypertension e.g. NSAIDs

Basic investigations needed for de novo presentation in an untreated patient

EUC
Early morning cortisol
Plasma renin and aldosterone
Fasting plasma metanephrine and normetanephrine
ECG
Urinalysis

Management principles

- Treatment should begin quickly but the aim is to lower BP over 6-12 hours
- Aim to lower BP over 3-6 hours **using oral therapy** to around 160/100mmHg
- Then adjust usual antihypertensives or start treatment if previously untreated
- Discuss with on-call nephrologist for admission or outpatient renal follow up within a week

Drugs to use

- Prazosin 0.5mg q6h

  Or
- Nifedipine tablets 10mg q6h

If patient is unable to tolerate oral medications, use:

- Intravenous hydralazine 5mg bolus q30min
- If this does not lower blood pressure after 2 doses, consult the on-call nephrologist

References

1. Mancia G, Fagard R, Narkiewicz K, Redon J, Zanchetti A, Bohm M *et al.* 2013 ESH/ESC Guidelines for the management of arterial hypertension: the Task Force for the management of arterial hypertension of the European Society of Hypertension (ESH) and of the European Society of Cardiology (ESC). *J Hypertens* 2013; **31**(7)**:** 1281-1357. e-pub ahead of print 2013/07/03; doi: 10.1097/01.hjh.0000431740.32696.cc