EM Basic- Asymptomatic Hypertension

Asymptomatic HTN- elevated blood pressure with no evidence on end-organ damage

Rule number one- DON’T FREAK OUT!
- Calm down the patient and everyone around them (including the staff)
- Do a good history and physical exams
  - What caused the patient come into the ED?
  - Pt had a headache and happened to check BP?
  - Routine home BP monitoring with high BP with their devil machine?
  - Feeling fine at the pharmacy?
- Do a thorough review of systems
  - Headache
  - Slurred speech, ataxia, limb weakness, facial droop
  - Chest pain, shortness of breath, dyspnea on exertion
  - Blood in the urine

Headache
- Patients will often say BP high and that is giving them a headache
- This has been disproven- it’s the opposite (patient has a headache, this causes rise in BP- same for epistaxis
  - Check for red flags- stroke symptoms? Subarachnoid hemorrhage?
    - Headache that is sudden in onset
    - Headache that is maximal at onset
    - Worst headache of their life

PEARL: Don’t straight up ask “Is this the worst headache of your life?”
Ask patient to compare it to their previous headaches

- Do a thorough physical- focus on the neuro exam
  - Do a full head to toe exam with a neuro exam and walk the pt

At this point- make a decision- is this truly asymptomatic (non-concerning headache doesn’t count as “asymptomatic”)?

If you discover something concerning in your H and P (chest pain, strc symptoms, SAH) then go down that diagnostic pathway

If the patient is truly asymptomatic THEN DO NOT LOWER THE PATIENT’S BLOOD PRESSURE IN THE ED

Rule number two- DO AS LITTLE AS POSSIBLE!

HTN Pathophys- Your brain wants to “see” the same BP all the time- if your systemic BP is high, your brain constricts its blood vessels slowly over time so that the pressure remains the same- if you rapidly drop the patient’s BP, the blood vessels will still be constricted-> decreased bloodflow to the brain -> ischemic stroke

SO DON’T RAPIDLY LOWER BP IN ASYMPTOMATIC HTN!

Testing- not required routinely (to look for end organ damage)

- May consider EKG if strong cardiac history
- Labs only useful if you choose to start oral BP meds

Starting oral BP meds- find out what access the patient has to their PCP

- If the patient has good access to their PCP (can get in within the next few days)- can discharge without starting oral BP meds or talk with PCP to ask what meds they would prefer

- If the patient doesn’t have good PCP access or doesn’t have a PCP- can consider starting oral BP meds from the ED
  - Check a basic metabolic panel- need to know sodium, potasssit and creatinine before starting oral BP meds
**Oral BP med options**

JNC-8 guidelines for initial therapy- Start ACE, ARB, thiazide or calcium channel blocker
Black patients- start thiazide or calcium channel blocker

**-Lisinopril**- 10mg PO daily (don’t use if elevated creatinine)
  - Warn patients about dry cough (can start immediately or years after starting therapy)
  - Also warn about angioedema (lip/airway swelling) and to go to the ED if it happens (very rare reaction)

**-Hydrochlorothiazide (HCTZ)**- 25mg daily (don’t use if patient has a low sodium)- young patients don’t like this med due to frequent urination

JNC-8 guidelines for initial therapy- Start ACE, ARB, thiazide or calcium channel blocker
Black patients- start thiazide or calcium channel blocker

Is there a BP that is just too high to not send home?- In theory, no but once you get to a systolic above 240, likely that you will have something else wrong

Have a conversation with the patient

- Assure the patient that their BP won’t cause them any harm
- Educate the patient that the damage from BP happens over months to years to decades- not hours to days
- Make sure that the patient understands that rapid BP correction can harm them
- Give good return precautions (chest pain, neuro sx, etc.) and a good plan regarding followup

Contact- steve@embasic.org Twitter- @embasic