

EM Basic- Asymptomatic Hypertension

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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, stroke 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- consider starting oral BP meds from the ED

-Check a basic metabolic panel- need to know sodium, potassium 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

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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's, etc.) and a good plan regarding followup

Contact- steve@embasic.org

Twitter- @embasic