

should be <10 mmHg. A blood pressure differential that exceeds this threshold may be associated with atherosclerotic or inflammatory subclavian artery disease, supraaortic stenosis, aortic coarctation, or aortic dissection. Systolic leg pressures are usually as much as 20 mmHg higher than systolic arm pressures. Greater leg–arm pressure differences are seen in patients with chronic severe AR as well as patients with extensive and calcified lower extremity peripheral arterial disease. The ankle-brachial index (systolic pressure in the dorsalis pedis and/or posterior tibial artery divided by the higher of the two brachial artery pressures) is a powerful predictor of long-term cardiovascular mortality.

The blood pressure measured in an office or hospital setting may not accurately reflect the pressure in other venues. “White coat hypertension” (elevated clinic blood pressure and normal out of clinic blood pressure) is defined by at least three separate clinic-based measurements $>130/80$ mmHg and at least two non-clinic-based measurements $<130/80$ mmHg in the absence of any evidence of target organ damage. Individuals with white coat hypertension may not benefit from drug therapy, although they may be more likely to develop sustained hypertension over time. Masked hypertension (normal or low clinic blood pressure but elevated out of clinic blood pressure) should be suspected when normal or even low blood pressures are recorded in the office in patients with advanced atherosclerotic disease, especially when evidence of target organ damage is present or bruits are audible. Higher systolic blood pressures measured with a 24-h ambulatory blood pressure device are associated with a higher risk of cardiovascular disease and all-cause death independent of blood pressures measured in the outpatient setting.

Orthostatic hypotension is defined by a fall in systolic pressure >20 mmHg or in diastolic pressure >10 mmHg in response to assumption of the upright posture from a supine position within 3 min. There may also be a lack of a compensatory tachycardia, an abnormal response that suggests autonomic insufficiency, as may be seen in patients with diabetes mellitus or Parkinson’s disease. Orthostatic hypotension is a common cause of postural lightheadedness/syncope and should be assessed routinely in