

associated with increased sympathetic nervous activity, raising the possibility that electrical stimulation of the carotid baroreceptor or renal denervation may have a role in the treatment of these patients. However, that remains to be determined.

HYPERTENSIVE EMERGENCIES

Probably due to the widespread availability of antihypertensive therapy, in the United States, there has been a decline in the numbers of patients presenting with hypertensive urgencies and emergencies. Severe asymptomatic hypertension (systolic blood pressure ≥ 180 mmHg or diastolic blood pressure ≥ 120 mmHg) is considered a hypertensive “urgency,” but when accompanied by acute target damage, it is considered a hypertensive “emergency.” Most patients who present with severe hypertension are chronically hypertensive, and there are inherent risks to overly aggressive initial antihypertensive therapy. In hypertensive individuals, the upper and lower limits of autoregulation of cerebral blood flow are shifted to higher levels of arterial pressure, and rapid lowering of blood pressure to below the lower limit of autoregulation may precipitate cerebral ischemia or infarction as a consequence of decreased cerebral blood flow. Renal and coronary blood flows also may decrease with overly aggressive acute therapy. Consequently, the rapidity with which blood pressure should be lowered is dependent on the presence of new or worsening target organ damage and the presence or absence of cardiovascular disease complications. In patients with a hypertensive urgency, except for those with acute aortic dissections or hemorrhagic strokes, blood pressure is generally gradually lowered over 24 h to $\sim 25\%$ of the initial value. **Tables 277-10 and 277-11** list a number of hypertension-related emergencies and recommended therapies.

TABLE 277-10 Preferred Parenteral Drugs for Selected Hypertensive Emergencies