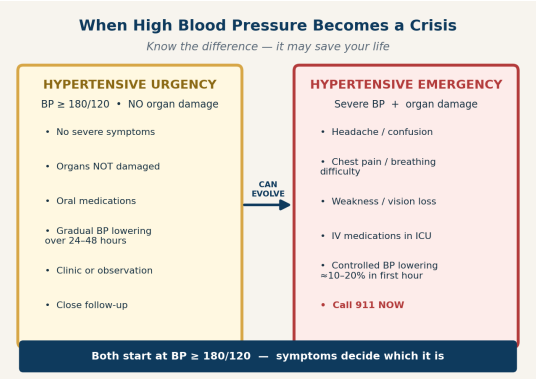
Hypertensive Emergencies

When Very High Blood Pressure Becomes a Medical Emergency

A reading of 180/120 or higher is serious — but it is not always an emergency. This guide explains the difference, what to do, and when to call 911.



Online: https://go.riasalimd.com/htn-emergency-guide

Rias KS Ali, MD FACC

Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

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Names & Terms You Will Hear

Term	Meaning
Hypertensive Crisis	Any time blood pressure reaches 180/120 or higher. It covers both urgency (no organ damage) and emergency (with organ damage).
Hypertensive Emergency	Severe BP with new organ damage — brain, heart, kidneys, aorta, or eyes. Needs IV medicines in a hospital or ICU. Call 911.
Hypertensive Urgency	BP at or above 180/120 with NO organ damage and no severe symptoms. Treated with oral medicines over 24–48 hours. Close follow-up needed.
Target-Organ Damage (TOD)	Harm to a key organ from dangerously high BP. Target organs: brain, heart, kidneys, aorta, and eyes. TOD is what separates emergency from urgency.
Hypertensive Encephalopathy	Brain swelling from very high BP. Signs: confusion, bad headache, vision loss, seizures. BP must be lowered slowly in the ICU.
Aortic Dissection	A tear in the wall of the main artery. Very high BP is the top trigger. Signs: sudden tearing chest or back pain. Needs fast surgery.
Flash Pulmonary Edema	Fluid floods the lungs from a failing heart under extreme BP load. Sudden, severe shortness of breath. Needs IV medicines in the ER or ICU.
Eclampsia / Preeclampsia	A pregnancy complication. Preeclampsia: BP of 140/90 or higher with protein in the urine. Eclampsia: seizures occur. Delivering the baby is the cure.
IV Antihypertensive	BP medicine given through an IV line. Used in emergencies to lower BP in a controlled way. Examples: nicardipine, labetalol, clevidipine, esmolol, nitroprusside.
Controlled BP Lowering	Bringing BP down slowly in an emergency — not all at once. Too-fast a drop cuts blood flow to the brain and kidneys. Goal: 10–20% drop in the first hour; then slowly.

CALL 911 RIGHT NOW if your BP is very high AND you have any of these:

• Severe or sudden headache • Chest pain or pressure
• Sudden shortness of breath • Confusion or trouble speaking
• Weakness or numbness (arm, face, or leg) • Vision loss or change
• Tearing or ripping pain in the chest or back (possible aortic dissection)
• Seizures • Very high BP in pregnancy (headache + swelling)

Do NOT drive yourself. Do NOT wait to see if it gets better.

High BP reading with NO symptoms — what to do:

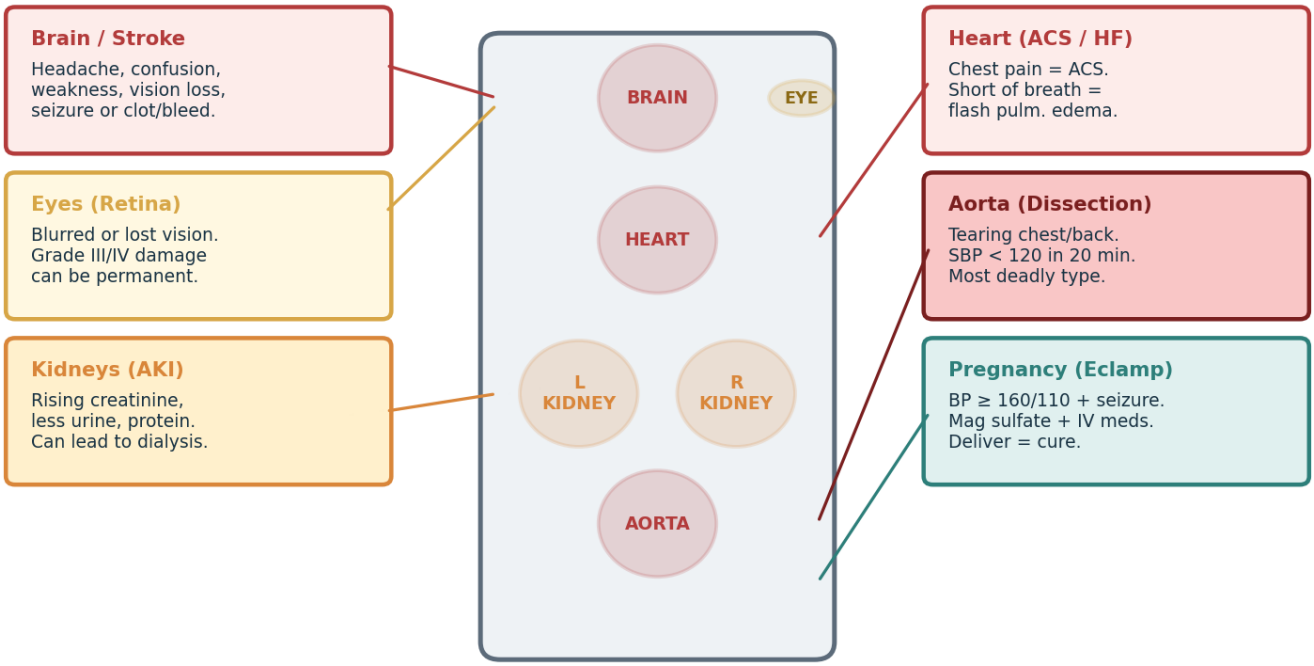
1. Sit quietly for 5 minutes. Re-check your BP.
2. If still high: call our office (727) 943-5200.
3. Do **NOT** take an extra pill on your own to force the number down — this can cause BP to drop too fast and cause fainting or a stroke.
4. If any new symptom develops while you wait: call 911 immediately.

Hypertensive Emergencies?

- **A hypertensive crisis starts at 180/120 mmHg.** At this level, vessel walls face extreme stress. The key question: are organs being damaged right now?
- **Hypertensive URGENCY** means BP is very high but organs are fine. You may feel nothing, or just a mild headache. This is NOT a 911 call. Call our office. Lower BP slowly over 24–48 hours.
- **Hypertensive EMERGENCY** means an organ is being hurt now. Brain, heart, kidneys, aorta, or eyes. This is a 911 emergency. IV medicines in the hospital are needed, not oral pills at home.
- **Symptoms of an emergency:** severe headache or confusion, chest pain, short breath, sudden weakness or numbness, vision changes, tearing back pain, or seizures. Any ONE of these + very high BP = call 911 now.
- **It is not rare.** About 1.7 million ER visits each year in the US involve high BP crises (Janke et al., 2016). Most are caused by skipped medicines.
- **Common triggers:** missed doses, stopping clonidine abruptly, cocaine use, untreated high BP, and secondary causes like kidney disease or sleep apnea.

Hypertensive Emergency: What Organs Are at Risk

These are the target organs — damage here = emergency



Any ONE of these + very high BP = call 911 immediately

Six target organs affected by hypertensive emergency. Brain (stroke, encephalopathy), heart (ACS, flash pulmonary edema), kidneys (acute kidney injury), aorta (dissection), eyes (severe retinopathy), and in pregnancy (eclampsia). Damage to ANY one of these plus very high BP = call 911. Source: ACC/AHA 2017 HTN Guideline.

Urgency vs Emergency: a quick comparison

Feature	Hypertensive URGENCY	Hypertensive EMERGENCY
Blood pressure	180/120 mmHg or higher	Severe elevation
Organ damage?	NO	YES — brain, heart, kidney, aorta, eye
Symptoms	None or mild headache	Chest pain, confusion, weakness, vision loss, shortness of breath
Where treated?	Clinic or observation unit	ER or ICU
Medicines	Oral BP drugs	IV drip — nicardipine, labetalol, etc.

Feature	Hypertensive URGENCY	Hypertensive EMERGENCY
How fast to lower BP?	Gradually over 24–48 hours	10–20% in first hour; then slowly (except dissection: faster)
Call 911?	No — call our office	YES — call 911

Why It Matters

- **Can cause a stroke in minutes.** Very high BP can burst a brain vessel or block one. Both are life-threatening. Every minute without care matters.
- **Aortic dissection can be fatal.** A tear in the main artery wall can bleed fatally without surgery. The clue is sudden tearing chest or back pain.
- **The heart and lungs can fail fast.** Very high BP forces the heart to work too hard. The heart can fail suddenly. Fluid floods the lungs. This is a 911 emergency.
- **Kidneys can fail within hours.** Extreme pressure damages tiny kidney vessels. Injury can start fast and may be lasting.
- **Lowering BP too fast is also harmful.** Dropping BP too quickly cuts blood flow to the brain and kidneys. This is why IV care in the hospital is needed. Not extra pills at home.
- **Most crises can be prevented.** Take your medicines every day. Never stop clonidine abruptly. Call your care team when readings spike. Most ER trips for this are avoidable.

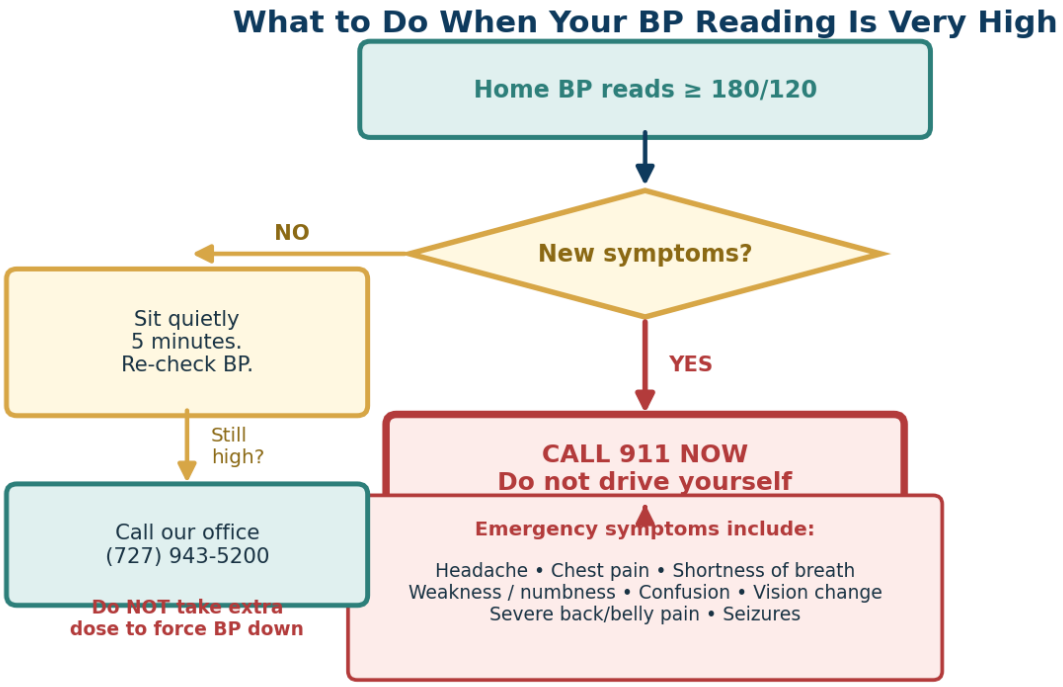
Risk Factors

Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
Non-adherence (skipped doses)	The top cause of hypertensive crisis. Missing even a few doses of BP medicine can cause a rapid rebound spike.
Untreated or undertreated HTN	BP that is chronically high and not well controlled puts patients at continuous risk for crossing the 180/120 threshold.
Stopping clonidine abruptly	Clonidine withdrawal causes a dangerous rebound BP spike within hours. Always taper slowly and call your care team before stopping.
Cocaine or stimulant use	Cocaine, methamphetamine, and many diet pills cause acute catecholamine surges that can spike BP dangerously.
Chronic kidney disease (CKD)	Impaired kidneys retain sodium and fluid, raising BP. CKD both causes and is worsened by hypertensive emergencies.
Primary aldosteronism	Excess aldosterone causes resistant high BP that is more prone to crisis. Common cause of hard-to-treat HTN.
Pregnancy	Pre-existing HTN or new preeclampsia can rapidly escalate to eclampsia. Pregnancy changes which medicines are safe.
Age 40–60 and male sex	Hypertensive emergencies peak in men aged 40–60 with prior uncontrolled HTN. Women face higher risk during pregnancy.
Prior hypertensive crisis	One episode significantly raises the risk of a repeat event. Long-term BP control is critical after the first crisis.

Treatment Options

- **Step 1 — Emergency or urgency?** The ER doctor checks for organ damage. Tests: kidney labs, troponin, ECG, chest X-ray, and brain imaging if there are nerve symptoms. This step decides the treatment.
- **Urgency treatment:** restart or strengthen oral medicines. Lower BP slowly over 24–48 hours. No IV medicines needed. Close follow-up within 1–7 days.
- **Emergency treatment:** hospital, often the ICU. IV medicines lower BP in a controlled way. Goal: 10–20% drop in the first hour. Then slowly over 24–48 hours. Too-fast lowering can cause more harm.
- **IV medicines used:** nicardipine (most common, easy to adjust); labetalol (good for dissection, stroke, pregnancy); clevidipine (very fast-acting); esmolol (slows heart rate); nitroprusside (most powerful, used with care); hydralazine (used in pregnancy).
- **BP targets by condition:**
  Aortic dissection: SBP below 120 in 20 min + slow the heart.
  Ischemic stroke (no tPA): allow up to 220/120 for 24 hours.
  Ischemic stroke (tPA): below 185/110 before tPA is given.
  Brain bleed: SBP below 140–160.
  Eclampsia: below 155/105; magnesium sulfate for seizures.
  Most others: cut 10–20% in first hour; then to 160/100.
- **Treat the cause:** find what set off the crisis. Restart skipped medicines. Address cocaine use. Treat a hidden cause if found. Deliver the baby if eclampsia.
- **After the crisis:** switch from IV to oral medicines. Follow up with a heart specialist within days. Check for organ damage: echo, kidney labs, eye exam. Long-term BP control prevents a repeat event.



Decision flow: when your home BP reads very high. First question: are there new symptoms? Yes = call 911. No = sit, recheck, call our office. Never take extra doses to force the BP down on your own. Source: ACC/AHA 2017 HTN Guideline; AHA Hypertensive Crisis patient page.

Brain Crisis: Encephalopathy and Stroke

- **Brain encephalopathy** means the brain swells from extreme pressure. Signs: severe headache, confusion, vision loss, seizures. This is a 911 emergency.
- The doctor lowers BP slowly in the ICU. The goal is a 20–25% drop in the first hour. Too fast a drop can cause a stroke. The rate matters as much as the target.
- **Ischemic stroke (blocked artery):** if no clot drug (tPA) is used, the team allows BP up to 220/120 for 24 hours. High BP protects the brain border zone. Lowering it fast makes the stroke worse.
- If tPA is given, BP must drop below 185/110 first. It stays below 180/105 during and after. This is strict protocol — no exceptions.
- **Brain bleed (hemorrhagic stroke):** target SBP below 140–160. Faster lowering than ischemic stroke, but still controlled.
- **FAST warning signs for stroke:** Face drooping on one side. Arm weak or numb. Speech slurred or gone. Time — call 911 now.

Heart and Lung Emergencies

- **Flash pulmonary edema** means the heart fails under extreme pressure. Fluid floods the lungs fast. Sudden, severe shortness of breath. This is a 911 call.
- Symptoms come on in minutes: gasping, pink foamy saliva, unable to speak full sentences. Sit upright. Call 911. Do not lie down.
- In the ER: IV nitroglycerin or nitroprusside to open the blood vessels. IV furosemide to remove fluid. High-flow oxygen. Sometimes a BiPAP breathing mask.
- **Heart attack (ACS):** very high BP raises heart oxygen demand. Chest pain in a BP crisis may be a heart attack. The ER checks with ECG and blood tests (troponin).
- For chest pain from a heart attack, labetalol and nitroglycerin are the preferred IV medicines. Nitroprusside is avoided. It can divert blood away from the blocked artery.

Aortic Dissection: Most Time-Critical

- **Aortic dissection** is a tear in the wall of the aorta — the body's main artery. Very high BP is the top trigger. Blood rips into the tear with each beat.
- Classic symptom: sudden, severe tearing or ripping pain. It starts in the chest or back. It may move downward. It can feel like a heart attack but does not ease up.
- This is the fastest-moving emergency. Without surgery, Type A dissection (upper aorta) kills roughly 1–2% of patients per hour.
- **BP target: SBP below 120 within 20 minutes.** Heart rate below 60. IV labetalol or esmolol to slow the rate first. Then add nicardipine if needed.
- Type A (upper aorta) needs urgent cardiac surgery. Type B (lower aorta) is often managed with IV medicines and strict BP control.
- Sudden tearing chest or back pain: call 911 at once. Do not wait. Do not drive yourself.

High BP in Pregnancy: Preeclampsia and Eclampsia

- **Preeclampsia** is new high BP after 20 weeks of pregnancy. BP of 140/90 or higher plus protein in the urine. Severe preeclampsia: BP of 160/110 or higher.
- **Eclampsia** is when seizures occur. It puts both mother and baby at risk. Delivering the baby is the only cure.
- Warning signs in pregnancy: severe headache, vision changes, pain in the right upper belly, sudden face or hand swelling, or BP of 160/110 or higher. Go to Labor and Delivery now.
- In the hospital: IV labetalol or hydralazine for BP. Oral nifedipine is an option. IV magnesium sulfate stops and prevents seizures. Target BP below 155/105.
- Some BP medicines safe in adults harm the baby. ACE inhibitors and ARBs are not safe in pregnancy. Always tell every doctor you are pregnant.
- High BP can return up to 6 weeks after birth. New headache or high BP after delivery needs the same urgent care.

The critical rule: do NOT lower BP too fast.
In most hypertensive emergencies the goal is to reduce BP by 10–20% in the first hour — not all the way to normal. Dropping too fast cuts off blood flow to the brain, heart, and kidneys and can cause a stroke or organ failure. Exception: aortic dissection needs rapid SBP < 120 within 20 minutes plus heart-rate control.

Comfort Measures at Home (No Medication Needed)

These simple steps support healing and ease symptoms. Use them alongside any medication your doctor prescribes.

- Take medicines exactly as prescribed, every day. Set a phone alarm. Use a pill organizer. Missing doses is the most preventable cause of a hypertensive crisis.
- Never stop clonidine abruptly. Even skipping one or two doses can trigger a dangerous rebound BP spike within hours. Always call us before changing or stopping this medicine.
- Check your BP at home. Use a validated upper-arm cuff. Rest 5 minutes first. Check in the morning and evening. Write the readings down and bring the log to every visit.
- Know your numbers. Your personal BP target, your trigger level for calling the office, and what symptoms mean call 911 right now.
- Avoid ibuprofen and naproxen. Use Tylenol (acetaminophen) for pain. NSAIDs raise BP and reduce the effect of your medicines.
- Reduce sodium to under 1,500 mg/day. Cut restaurant meals, canned soups, deli meats, and packaged snacks.
- Limit alcohol to no more than 2 drinks per day. More than this raises BP and blunts medicines.
- Share your full medicine list with every provider. Include every prescription, over-the-counter drug, vitamin, and supplement. Some cause dangerous BP spikes.

Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
IV antihypertensives (hospital treatment)	Require IV access and ICU-level monitoring. Risk of lowering BP too fast (cerebral, renal, coronary hypoperfusion) — this is why hospital care is mandatory, not home treatment. Individual drug side effects: nitroprusside causes cyanide toxicity if used too long; esmolol slows heart rate.	Precise, titratable BP control. Avoids the unpredictability of oral dosing in a crisis. Prevents stroke, kidney failure, aortic rupture, and cardiac failure from uncontrolled BP. IV therapy reduces mortality vs delayed or oral treatment.	No safe oral-only alternative for true hypertensive emergency. Urgency (no organ damage) can use oral options with close follow-up.
Oral medicines for hypertensive urgency	Risk of taking extra doses at home without guidance: may drop BP too fast, causing dizziness, falls, and syncope. Risk of delaying care if an emergency is actually present.	Gradual, safe BP lowering over 24–48 hours. Avoids unnecessary hospitalization. Allows outpatient management with close follow-up.	If any new symptoms appear — especially chest pain, confusion, or shortness of breath — go to the ER.
Magnesium sulfate (eclampsia)	IV magnesium can cause respiratory depression, especially at high doses or in women with kidney disease. Requires IV monitoring. Flushing, warmth are common but self-limited side effects.	Prevents eclamptic seizures and recurring convulsions. Superior to diazepam for seizure prevention in pregnancy. Also mildly lowers BP and protects the baby's brain.	IV labetalol or hydralazine for acute BP control in pregnancy. Delivery of the baby is the definitive cure.

Option	Risks	Benefits	Alternatives
Doing nothing (waiting at home with very high BP + symptoms)	Without treatment, a hypertensive emergency progresses rapidly. Stroke, kidney failure, aortic rupture, or cardiac arrest within hours. Mortality risk without treatment: significant.	Avoids hospital visit and medical interventions short-term.	Call 911. Every minute of delay with active organ damage worsens the outcome.

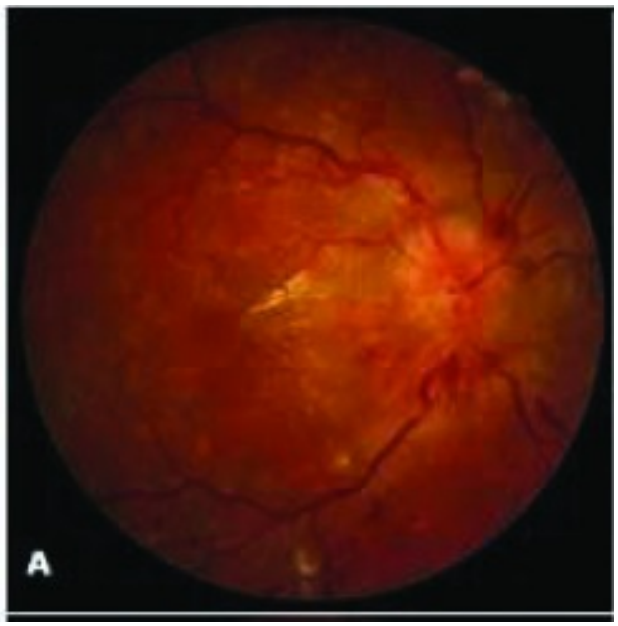
Common Misconceptions

Myth	Reality
"High BP at home is always an emergency — take extra pills to bring it down fast."	A very high BP reading WITHOUT symptoms is usually NOT a crisis. Sit, rest 5 minutes, and re-check. Call our office before taking extra medicine. Dropping BP too fast at home can cause fainting, falls, and even a stroke.
"If I feel fine, the high number cannot be serious."	Hypertensive urgency by definition has no severe symptoms, yet BP at 180/120 still stresses vessels. And early organ damage — like a tiny stroke — can begin before you feel symptoms. A BP this high always needs prompt medical attention.
"An emergency room doctor will just give me a pill and send me home — no need to rush."	For a true hypertensive emergency, the ER or ICU provides continuous BP monitoring and IV drips that cannot be safely replicated at home. Organ damage can become permanent within hours of delay.
"My BP is always high — this is just my normal."	There is no ‘safe’ level of 180/120 in the long run. Chronic severely elevated BP damages arteries and organs over time. Even if you feel fine today, the risk builds. Work with your care team to lower BP to a safe level.
"Hypertensive emergencies only happen to old people."	They peak in adults 40–60 years old, especially men with uncontrolled HTN. Cocaine use can cause hypertensive crisis in young adults. Eclampsia affects pregnant women of any age.
"If the top number is high but the bottom is normal, I am fine."	Either number — systolic or diastolic — can signal a crisis. A top number of 200 alone is dangerous, even if the bottom number looks normal. Your doctor evaluates the whole picture, not one number in isolation.

Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Stroke (Brain Bleed or Blocked Artery)	Burst or blocked brain vessel. Can cause lasting paralysis, speech loss, or death. Most common severe result of a BP emergency.
Brain Swelling (Encephalopathy)	Brain fluids build up under extreme pressure. Confusion, bad headache, vision loss, seizures. Treated slowly in the ICU.
Acute Heart Failure / Wet Lungs	Heart fails under extreme load. Lungs flood with fluid. Sudden, severe shortness of breath. ER/ICU care needed at once.
Heart Attack (ACS)	Extreme BP stress can trigger a clot or block blood to the heart. Chest pain in a BP crisis needs urgent care.
Aortic Dissection	Tear in the main artery wall. Tearing chest or back pain. SBP below 120 in 20 minutes is the goal. Often needs emergency surgery.
Acute Kidney Injury	Extreme pressure damages tiny kidney vessels. Less urine output, rising creatinine. Can lead to dialysis if not treated.
Severe Eye Damage (Retinopathy)	Damaged vessels in the retina. Grade III/IV retinopathy can cause lasting vision loss. Found on an eye exam.
Eclampsia (in Pregnancy)	Seizures in a pregnant woman with high BP. Threatens both mother and baby. Delivery is the only cure.



A real fundus photograph of malignant hypertensive retinopathy — optic disc swelling, flame-shaped hemorrhage, and exudates from extremely high blood pressure. This is target-organ damage in the eye, one of the signs that turns a high reading into a true hypertensive emergency. Source: Mirshahi et al., J Ophthalmic Vis Res 2022 (CC BY 4.0).

Points to Know

If you remember nothing else, remember these key points.

- BP of 180/120 or higher + new symptoms (headache, chest pain, confusion, weakness, vision change, or tearing back pain) = call 911. Do not wait, do not drive yourself.
- BP of 180/120 or higher with NO symptoms = call our office. Rest, re-check, and do NOT take extra medicine on your own to force the number down.
- Urgency = high BP, no organ damage. Treated with oral medicines and close follow-up. Emergency = high BP + organ damage. Treated with IV medicines in the hospital.
- Never stop clonidine abruptly. A sudden stop triggers a dangerous rebound BP spike within hours. Always taper with guidance.
- Aortic dissection is the most time-critical: sudden tearing chest or back pain + very high BP = 911 immediately. Every minute matters.
- Lowering BP too fast is also dangerous. The goal in emergency is a 10–20% reduction in the first hour — not a crash to normal in minutes. This is why IV control in the hospital is essential.
- Non-adherence causes most crises. Take your medicines every day, use a pill organizer, and refill before you run out.
- After any hypertensive crisis, you need close follow-up: cardiology or hypertension specialist, an echocardiogram, kidney labs, and an eye exam to assess organ damage.

When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- **CALL 911 RIGHT NOW** if you have very high BP PLUS any of these symptoms: severe or sudden headache, chest pain or pressure, sudden shortness of breath, weakness or numbness on one side, confusion or trouble speaking, vision loss or change, tearing or ripping sensation in the chest or back, or new seizures. Do not drive yourself to the ER.
- **Go to the ER** if home BP is above 180 systolic or 120 diastolic AND you develop any new symptom while waiting. If you feel completely fine, call our office first.
- **Call our office (727) 943-5200** if home BP is consistently above 180/120 with no symptoms. Do not take an extra dose of your BP medicine without guidance. We will advise on what to take and when.
- **Call us immediately** if you have skipped doses of clonidine or any BP medicine. Do not abruptly restart a high dose — we will guide you on how to safely resume.
- **Call us** if you start any new medicine — including OTC drugs, cold remedies (decongestants), NSAIDs, or stimulants. These can trigger a BP spike within days.
- **Call us** if you are pregnant and your BP is above 140/90 or you have a severe headache, vision changes, right upper belly pain, or swelling in your face or hands. Preeclampsia can progress rapidly.
- **See our companion guides:** Hypertension (htn-guide) · Resistant Hypertension (resistant-htn-guide) · Secondary Hypertension (secondary-htn-guide) · Aortic Aneurysm (aortic-aneurysm-guide)

Office: (727) 943-5200

Companion guides from Dr. Rias Ali:
Hypertension · Resistant Hypertension · Secondary Hypertension · Aortic Aneurysm / Dissection

Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- AHA — Hypertensive Crisis: When to Call 9-1-1 - AHA plain-language guide: urgency vs emergency, symptoms that require 911, and what to expect in the ER.
- Cleveland Clinic — Hypertensive Emergency - Clear overview of symptoms, causes, diagnosis, and treatment for hypertensive emergency.
- Mayo Clinic — Hypertensive Crisis - Mayo Clinic definitions, symptoms list, causes, and when to seek emergency care for severely elevated blood pressure.
- NIH MedlinePlus — Hypertensive Crisis - Federal patient resource with definitions, causes, and management. Spanish-language materials available.
- ACC/AHA 2017 High Blood Pressure Guideline - The current guideline defining BP thresholds, urgency vs emergency, and treatment targets for hypertensive crisis.
- AHA — Home Blood Pressure Monitoring - Step-by-step correct technique for accurate home BP measurement with a validated arm cuff.
- ACOG — Preeclampsia & Eclampsia Patient FAQ - ACOG patient FAQ on hypertension in pregnancy, warning symptoms, and when to call for help.
- AHA Stroke — F.A.S.T. Stroke Warning Signs - Face drooping, Arm weakness, Speech difficulty, Time to call 911. The FAST acronym for recognizing stroke from hypertensive emergency.

Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- ACC/AHA 2017 Hypertension Guideline *[Guideline]*
  Defines hypertensive crisis thresholds; urgency vs emergency classification; BP targets and management approach.
- AHA — Hypertensive Crisis Patient Page *[Patient Page]*
  AHA patient-facing definition of hypertensive urgency vs emergency with 911 call guidance.
- Cleveland Clinic — Hypertensive Emergency *[Patient Page]*
  Plain-language overview of symptoms, causes, treatment, and urgency vs emergency distinction.
- Mayo Clinic — Hypertensive Crisis *[Patient Page]*
  Clinical definitions, symptoms, and when to seek emergency care for severely elevated blood pressure.
- NIH MedlinePlus — Hypertensive Crisis *[Patient Page]*
  Federal resource with definitions, causes, and management; Spanish-language materials available.
- Whelton PK et al. — 2017 ACC/AHA BP Guideline (JACC 2018) *[Trial]*
  Full published guideline: urgency/emergency definitions, target organs, treatment goals including specific BP targets by condition.
- Janke AT et al. — Emergency Department Hypertension Study (Circ 2016) *[Trial]*
  Epidemiology data: ~1.7 million hypertensive emergency ED visits annually in the US.
- Marik PE & Rivera R — Hypertensive Emergencies (Curr Opin Crit Care 2011) *[Review]*
  Clinical review: 10–20% reduction in first hour rule; rate of BP lowering to avoid organ hypoperfusion; specific drug selection for different target organ damage types.
- ACOG Practice Bulletin — Gestational Hypertension and Preeclampsia (2020) *[Guideline]*
  Eclampsia/preeclampsia BP thresholds, magnesium sulfate and IV labetalol/hydralazine use, fetal considerations.
- AHA Stroke Council — BP Management in Acute Stroke (Stroke 2019) *[Guideline]*
  Specific BP thresholds for acute ischemic stroke (permit to 220/120 if no thrombolytics; 185/110 if tPA eligible) and hemorrhagic stroke (SBP <140-160).

About This Guide

Rias KS Ali, MD FACC | Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

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Reviewer note: Reviewed AHA Hypertensive Crisis page, Cleveland Clinic, Mayo Clinic, and ACC/AHA 2017 HTN guideline. This guide adds: the critical urgency-vs-emergency distinction with a visual comparison panel; a target-organ damage body map; a decision-flow chart; specific BP targets per condition (stroke, dissection, eclampsia); IV drug options by scenario; and the 'do not crash the BP' patient safety rule — all absent from standard patient pages.

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