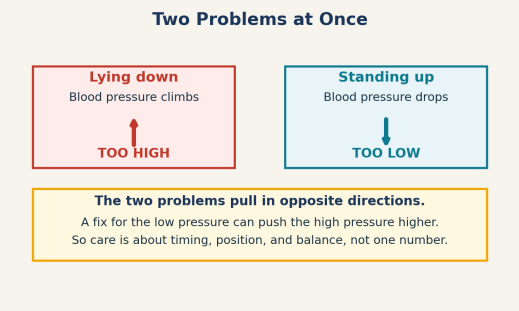
Understanding Supine Hypertension with Orthostatic Hypotension

When blood pressure drops too low standing AND climbs too high lying down

A hard, two-sided problem of the body's automatic controls — managed with timing, position, and balance, never one number.



Online: https://go.riasalimd.com/supine-htn-oh-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

Last Updated: August 2026

Names & Terms You Will Hear

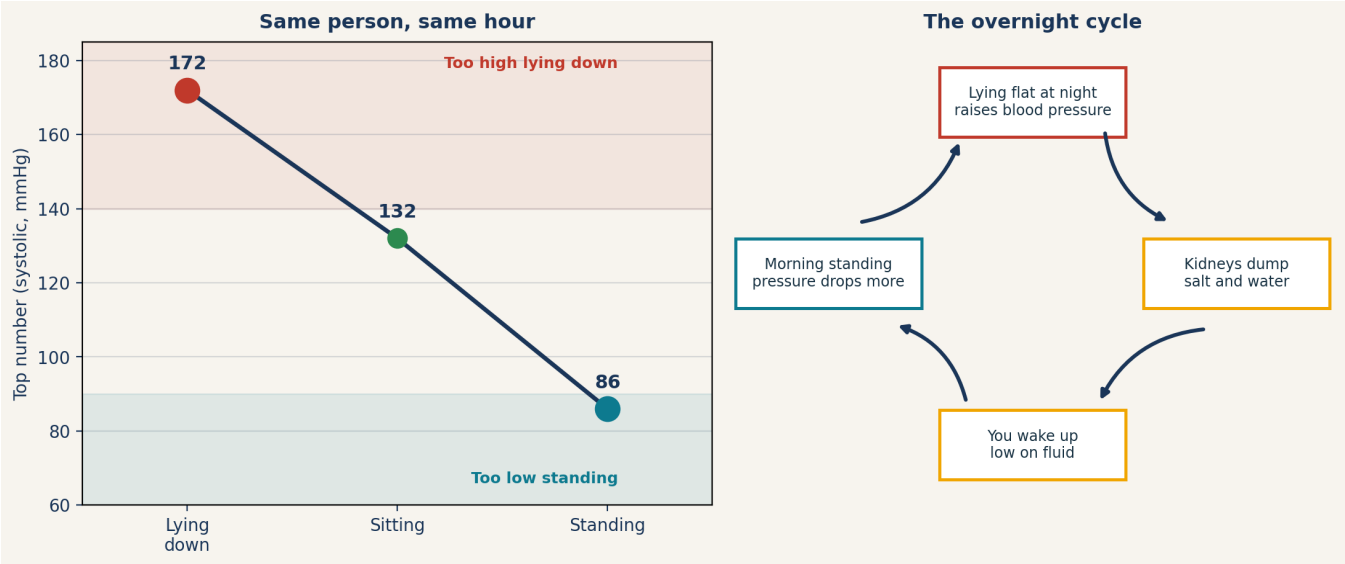
Term	Meaning
Orthostatic hypotension (OH)	Blood pressure that falls too much when you stand. To meet the medical mark, the top number drops 20 points or more, or the bottom number drops 10 points or more, within 3 minutes of standing. It causes dizziness, near-fainting, and falls.
Supine hypertension	High blood pressure when you lie down. 'Supine' means lying on your back. Doctors often mark it as a top number of 140 or higher, or a bottom number of 90 or higher, after resting flat for at least 5 minutes.
Neurogenic orthostatic hypotension (nOH)	The most common cause of this two-sided problem. The nerves that steady blood pressure are damaged. It is seen in Parkinson disease, multiple system atrophy, pure autonomic failure, and nerve damage from diabetes or amyloid.
Autonomic failure	The automatic nervous system runs blood pressure, heart rate, and digestion without you thinking about it. In autonomic failure, this system is damaged, so blood pressure swings with body position.
Baroreflex	Your body's built-in blood pressure thermostat. Sensors in your neck and chest tell the brain to tighten vessels and speed the heart when you stand. When this reflex is broken, pressure is not defended.
Pressure natriuresis	When blood pressure is high, the kidneys flush out extra salt and water. Lying flat at night raises pressure, so the kidneys dump fluid overnight. You wake up dry, and standing pressure drops even more.
Pressor	A medicine or step that raises blood pressure, such as midodrine or a fast drink of water. Pressors help standing-up lows but can worsen lying-down highs, so timing matters.

This is one of the hardest blood pressure problems to manage — partner closely with your doctor.

Because the two problems pull in opposite directions, there is no safe way to self-adjust. **Do not start, stop, or change any medicine, dose, timing, or blood pressure target on your own.** Keep a home blood pressure log in different positions and bring it to every visit. Ask whether an autonomic specialist should join your care.

What Is Supine Hypertension with Orthostatic Hypotension?

- Some people have two opposite blood pressure problems at the same time. Standing up, the pressure drops too low. Lying down, it climbs too high. This guide is about managing both at once.
- The usual cause is autonomic failure. The automatic nerves that keep blood pressure steady are damaged. This happens in Parkinson disease, multiple system atrophy, pure autonomic failure, and nerve damage from diabetes or amyloid.
- When you stand, gravity pulls blood into your legs. A healthy body tightens vessels and speeds the heart within seconds. With the thermostat broken, this does not happen, so standing pressure falls.
- When you lie down, the same broken system cannot buffer pressure. Leftover vessel tone, made jumpy by the nerve damage, drives the pressure up. So lying flat pushes it too high.
- This is hard to treat because the two problems pull in opposite directions. A step that raises standing pressure can push lying-down pressure higher. A step that lowers lying-down pressure can drop standing pressure more.
- The goal is not a perfect number. The goal is to keep you safe on your feet without too much harm from the high pressure at night. That balance is set by your doctor for you.



Left: in the same person within the same hour, blood pressure can be too high lying down, normal sitting, and too low standing. Right: lying flat at night raises pressure, the kidneys flush out salt and water, and you wake up dry — so morning standing pressure drops even more. Numbers are examples only; yours will differ.

1. The Paradox and the Vicious Cycle

- The body has a built-in blood pressure thermostat called the baroreflex. Sensors in your neck and chest tell the brain to tighten vessels and speed the heart the instant you stand.
- In autonomic failure, this thermostat is broken. When you stand, blood pools in your legs and the pressure is not defended, so it falls. This causes the dizziness and the falls.
- When you lie down, the same broken system cannot smooth pressure out. Leftover vessel tone, made jumpy by the nerve damage, drives the pressure up. So lying flat pushes it too high.
- Here is the trap that makes mornings worst: high pressure overnight tells the kidneys to flush out salt and water. You lose fluid while you sleep and wake up dry.
- Being dry means even less blood to defend standing pressure, so the morning drop is the deepest of the day — right when you get out of bed. Raising the head of the bed helps break this loop.

Why It Matters

- The low side causes dizziness, near-fainting, and falls. A fall can mean a broken hip, a head injury, or the loss of living on your own. This is the most urgent daily risk.
- The high side, over months and years, can quietly harm the heart, brain, and kidneys. High pressure at night is linked to thicker heart muscle and to small strokes.
- The overnight cycle makes mornings worst. Lying flat raises pressure, so the kidneys flush out fluid all night. You wake up dry, and your standing pressure is at its lowest just as you get out of bed.
- Because the two problems fight each other, there is no single pill that fixes both. Your plan must use timing and body position, not just medicine. This takes teamwork between you and your care team.
- Many people also carry other heart and nerve conditions. When heart failure is added, the balance gets even harder. That is why this guide stresses partnering with your doctor and, often, an autonomic specialist.

How to check at home — readings in more than one position

When	How	What it tells your doctor
After lying 5 to 10 minutes	Measure while still lying down	How high the lying-down (supine) pressure runs
After sitting up	Measure seated, feet down	A middle reference point
1 minute after standing	Measure standing, hold the chair	The early standing drop
3 minutes after standing	Measure standing again	Whether the pressure recovers or stays low

2. What Blood Pressure Do We Treat To — Standing or Lying?

- This is the key question, and the answer surprises most people: your doctor treats mainly to your STANDING pressure and your symptoms, not to the lying-down or sitting number.
- The goal is enough standing pressure to function and to prevent faints and falls — often a standing top number that keeps you symptom-free, which may be well below a textbook 'normal.' Your doctor sets your line.
- At the same time, doctors usually TOLERATE some high pressure lying down to keep you safe on your feet. They step in mainly when the lying-down pressure is severe. Your doctor sets that threshold for you.
- That is why a single clinic reading cannot guide this. You check at home in more than one position — lying, sitting, and standing at 1 and 3 minutes — and keep a log.
- Your doctor reads that log to balance the two sides and to time your steps and medicines. The targets are personal and may change over time. Never chase a number on your own.

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
Parkinson disease and related disorders	These attack the nerves that run blood pressure. Up to half of people with Parkinson disease and most with multiple system atrophy develop this two-sided problem over time.
Pure autonomic failure	A condition where the autonomic nerves slowly fail on their own, without the movement problems of Parkinson disease. Wide swings in blood pressure with body position are the hallmark.
Diabetes with nerve damage	Long-standing diabetes can damage the autonomic nerves. This is a common, often missed, cause of standing lows with lying-down highs.
Amyloid and other nerve diseases	Amyloid deposits and some inherited nerve diseases harm the same blood pressure nerves and can cause severe, hard-to-treat swings.
Older age	The blood pressure thermostat gets less sharp with age, and many older adults also take pills that lower pressure. Both make the swings worse.
Certain medicines	Water pills, prostate pills like tamsulosin, nitrates, erection pills like sildenafil, some mood drugs, and alcohol all lower standing pressure and can unmask or worsen the problem.

Treatment Options

- Lifestyle and body position come first for BOTH problems. They are the foundation. Medicine is added on top only when these are not enough, and always by your doctor.
- For the low side, the steps raise standing pressure: slow staged standing, leg-crossing and muscle squeezing, an abdominal binder or waist-high compression, salt and fluids if your doctor allows, a fast water drink before activity, and small low-carb meals.
- For the high side, the single most important step is to sleep with the head of the bed raised 6 to 12 inches. Never lie fully flat. Recline instead, even for daytime rest. A small bedtime snack can help.
- Daytime BP-raising medicines, when your doctor prescribes them, are taken early so the effect is gone by bedtime. Midodrine and droxidopa are the two approved options. The last dose is well before you lie down.
- For severe high pressure at night, a specialist may prescribe a short-acting medicine at bedtime, chosen so its effect is gone by morning. This is fine-tuned to you and is not something to start or change on your own.
- The whole plan is checked with home blood pressure readings taken in more than one position. Your doctor uses that log to set your personal targets and to adjust timing. Never chase a number on your own.

Medicine map: which way each one pushes, and its label status

Medicine / step	Standing lows	Lying-down highs	Label status
Midodrine (daytime)	Raises (helps)	Can worsen if late	FDA-approved for symptomatic OH
Droxidopa / Northera (daytime)	Raises (helps)	Can worsen	FDA-approved for neurogenic OH
Pyridostigmine	Raises (mild help)	Tends not to worsen	Off-label
Fludrocortisone	Raises (volume)	Worsens; caution in heart failure	Off-label
Abdominal binder / compression	Raises (helps)	No worsening	Device / non-drug

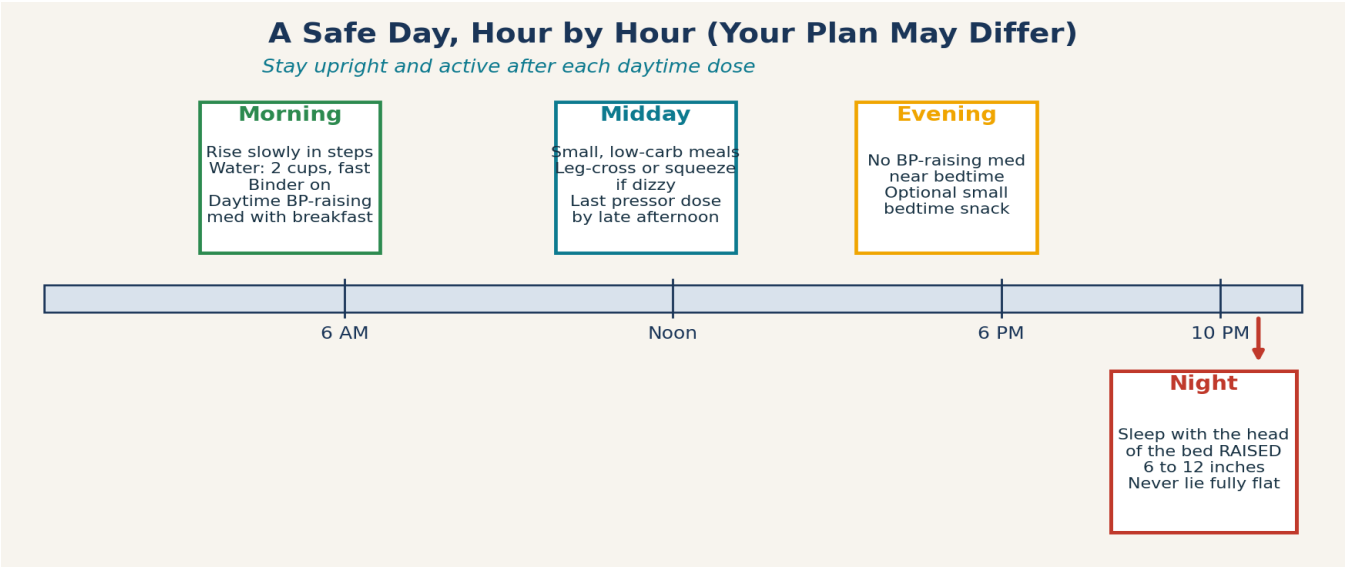
Medicine / step	Standing lows	Lying-down highs	Label status
Nighttime short-acting BP-lowering med	Can lower next-morning standing	Lowers (helps)	Off-label, specialist-directed
Avoid / review: tamsulosin, water pills, nitrates, sildenafil, alcohol	Lowers (harmful)	Varies	Review with your doctor

Off-label medicine note. Midodrine is FDA-approved for symptomatic orthostatic hypotension, and droxidopa (Northera) is FDA-approved for neurogenic orthostatic hypotension. Several other steps in this guide — fludrocortisone, pyridostigmine, octreotide, and any bedtime medicine used to lower lying-down pressure — are **off-label**, meaning they are used based on specialist experience rather than a label for this exact use. Your doctor weighs the benefits and risks and supervises them closely.

Comfort Measures at Home (No Medication Needed)

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

- Stand up in stages. Sit on the edge of the bed for 30 to 60 seconds, then stand, then pause before you walk.
- Before you get up or before activity, drink about 2 cups of cool water quickly. In people with autonomic failure this can raise blood pressure for 1 to 2 hours.
- Use counter-pressure moves when you feel dizzy: cross your legs and squeeze, clench your buttocks and calves, rise on your toes, or tense your fists and arms.
- Wear an abdominal binder, waist-high compression, or both during the day. A binder is often more helpful than stockings because it stops blood from pooling in the belly.
- Raise the head of your bed 6 to 12 inches, or sleep with your upper body propped up. Do not lie flat, even for a nap. Recline instead.
- Eat small, frequent, low-carb meals so blood does not pool in the gut after eating. Limit alcohol, hot showers, and standing in the heat, which all lower pressure.
- If your doctor allows it, add salt and fluids by day. Do not add large amounts of salt on your own if you have heart failure or kidney disease.



An example of how positions, water, meals, and prescribed medicines are spread across the day so that BP-raising steps work while you are upright and wear off before you lie down — and the head of the bed stays raised at night. Your own plan and timing are set by your doctor.

Risks, Benefits, and Alternatives

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

Option	Risks	Benefits	Alternatives
Lifestyle and body position first (slow stands, binder, water, head-of-bed up)	Compression can feel hot. Salt and fluids can worsen lying-down highs and are limited if you have heart failure. Sleeping flat by habit is hard to change.	Helps both problems with no drug. Head-of-bed-up lowers nighttime pressure and eases the morning dizziness. Trials show a binder can work as well as a pressor pill.	You could add a daytime pressor sooner. Your doctor decides based on how disabling the dizziness is and how high the night pressure runs.
Daytime pressor medicine (midodrine or droxidopa), prescribed and timed	Both can raise lying-down pressure if taken too late in the day. Midodrine can cause goosebumps and scalp tingling; droxidopa can cause headache. Dosing is daytime only.	Raises standing pressure so you can function and fall less. Midodrine is FDA-approved for symptomatic OH; droxidopa is FDA-approved for neurogenic OH.	An abdominal binder and a water bolus can be used first or alongside. Pyridostigmine is a milder option that tends not to worsen lying-down pressure.
Fludrocortisone (a fluid-holding pill), if prescribed	Worsens lying-down high pressure, can cause swelling and low potassium, and should be used with caution or avoided if you have heart failure. Needs lab checks.	Builds up blood volume to support standing pressure when salt and water alone are not enough.	Midodrine or droxidopa act on vessels instead of volume. Pyridostigmine is gentler. A binder adds support without any drug.

Option	Risks	Benefits	Alternatives
Nighttime short-acting medicine for severe lying-down highs (specialist-directed)	All such uses are off-label and individualized. The wrong choice or timing can drop your morning standing pressure and raise fall risk. Specialist oversight is essential.	Can blunt very high nighttime pressure to protect the heart, brain, and kidneys, with the effect gone by morning.	Often head-of-bed elevation and a bedtime snack are tried first. Some people need no nighttime medicine at all.

3. Lifestyle That Helps Both Sides

- Raise the head of your bed 6 to 12 inches, or sleep propped up. This is the single most important step. It lowers nighttime pressure and softens the morning crash. Never lie fully flat; recline for daytime rest.
- Use an abdominal binder by day. In a randomized trial, a binder improved standing tolerance about as well as a pressor pill, and the two together were better than either alone.
- Drink about 2 cups of cool water quickly before getting up or before activity. In autonomic failure this can raise blood pressure for 1 to 2 hours.
- Stand in stages, use leg-crossing and muscle squeezing, and eat small low-carb meals so blood does not pool in the gut after eating.
- Do: take salt and fluids by day if your doctor allows. Do not: lie flat after a daytime pressor dose, take a BP-raising medicine at bedtime, add big amounts of salt on your own with heart or kidney disease, or drive when you feel symptomatic.

Common Misconceptions

Myth	Reality
My blood pressure is high, so I should take more pills to get it down to normal.	Not here. Your high readings are mostly when you lie down. Lowering them hard can make your standing pressure crash and cause falls. Your doctor treats the standing pressure and your symptoms, not a single 'normal' number.
If I have low pressure standing, I can't also have high pressure — that makes no sense.	It is the rule, not the exception, in autonomic failure. The same broken thermostat lets pressure fall when you stand and rise when you lie down. Both are real and both matter.
Lying flat to rest is the safest thing for me.	For this condition, lying fully flat is one of the worst things. It drives your pressure up and starts the overnight fluid-loss cycle. Keep the head of your bed raised and recline rather than lie flat.
Adding salt is always bad.	For many people with OH and no heart failure, more salt helps support standing pressure. But it can worsen lying-down highs and is limited in heart failure or kidney disease. Let your doctor set the amount.
If midodrine helps me stand, I should take it at night too so I never get dizzy.	Never. Daytime pressors taken near bedtime can spike your already-high lying-down pressure and raise stroke risk. The last dose is taken hours before you lie down, exactly as prescribed.
There must be one pill that fixes both problems.	There is not. The two problems pull in opposite directions. Good care uses timing, body position, and a careful balance of steps that your doctor tunes for you.
Because it is so complicated, nothing can really be done.	A lot can be done. Head-of-bed elevation, a binder, a water bolus, smart meal and medicine timing, and home monitoring in different positions can greatly cut falls and protect your organs.

4. Medicines — For Standing-Up Lows vs Lying-Down Highs

- For the standing lows (daytime only): midodrine is FDA-approved for symptomatic OH, and droxidopa (Northera) is FDA-approved for neurogenic OH. Both are taken early so the effect is gone by bedtime. See our Midodrine guide.
- Also for the lows, but off-label: fludrocortisone holds fluid but worsens lying-down highs, can lower potassium, and is used with caution or avoided in heart failure. Pyridostigmine is milder and tends NOT to worsen lying-down pressure.
- For severe lying-down highs at night, a specialist may use a short-acting medicine at bedtime — chosen so the effect is gone by morning. Examples include a bedtime dose of certain BP-lowering pills or a patch removed in the morning. These uses are off-label and individualized.
- Medicines to review and often stop or swap because they worsen the standing lows: prostate pills like tamsulosin, water pills, nitrates, erection pills like sildenafil, some mood drugs, and alcohol.
- Every choice and dose here is made and adjusted by your doctor. Do not start, stop, or re-time any of these on your own.

Possible Complications

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

Where / What	What Can Happen
Falls and fall injuries (the low side)	The most urgent risk. Standing lows cause dizziness and fainting. A single fall can cause a broken hip or head injury. Fear of falling then shrinks daily life.
Heart strain (the high side)	High pressure at night, year after year, can thicken the heart muscle and stiffen it. This can lead to or worsen heart failure, especially the stiff-heart type (HFpEF).
Brain injury over time	Repeated standing drops starve the brain of blood and can cloud thinking. High nighttime pressure raises the risk of small strokes and white-matter damage. Both sides harm the brain.
Kidney harm	High nighttime pressure and the overnight salt-and-water dumping stress the kidneys. Over time this can lower kidney function.
The morning crash	Because the body loses fluid overnight, standing pressure is lowest in the morning. This is when most faints and falls happen.
Lower quality of life	Living between two opposite problems is tiring and frightening. Low mood and doing less are common. A good, balanced plan usually brings back both function and confidence.

5. The 'Unholy Trinity' — When Heart Failure Joins In

- Sometimes a third problem is present: heart failure, often the stiff-heart type called HFpEF. Now three conditions collide, and each treatment can worsen another.
- Water pills for heart failure remove fluid — which worsens the standing lows. The salt and fluid loading that helps the lows can flood the lungs and worsen heart failure.
- Many heart and blood pressure medicines used for heart failure also lower standing pressure. Fludrocortisone, a common OH drug, is usually avoided here because it holds fluid.
- There is no clean answer. Care is a careful, individualized balance, often needing both a cardiologist and an autonomic specialist working together.
- If this is you, lean hard on the non-drug steps — head-of-bed up, a binder, smart timing — and keep every member of your care team in the loop. See our HFpEF and Heart Failure guides. This is teamwork, not a do-it-yourself balance.

Points to Know

If you remember nothing else, remember these key points.

- You can have both: pressure too low when you stand and too high when you lie down. The two pull in opposite directions.
- The goal is to keep you safe standing, not to reach a 'normal' number. Your doctor sets your personal targets.
- Sleep with the head of the bed raised 6 to 12 inches. Never lie fully flat. Recline for daytime rest too.
- Take daytime BP-raising medicine early, exactly as prescribed, so it wears off before bedtime. Never take it near bedtime.
- Stand in stages, use leg-crossing and muscle squeezing, and try a fast 2-cup water drink before activity.
- Wear an abdominal binder or waist-high compression during the day.
- Keep a home blood pressure log lying down, sitting, and standing at 1 and 3 minutes. Bring it to every visit.
- Do not start, stop, or change any dose or target on your own. This balance is delicate and specialist-guided.

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.

- Falls, near-falls, or fainting — call us today.
- Dizziness so bad you cannot do daily tasks even with fluids and slow stands — call us today.
- A pounding headache, chest pain, blurred vision, or trouble speaking or moving when you lie down — this may be dangerously high pressure. Call 911.
- New shortness of breath or swelling in your legs, especially after starting a fluid-holding medicine — call us today.
- Home readings that swing far outside the range your doctor gave you — call us this week.
- New or worse symptoms after any medicine or timing change — call us; do not adjust the dose yourself.
- Symptoms that will not settle even with full treatment — call us. You may need an autonomic specialist.
- If you are ever unsure, call. We would rather hear from you twice than miss a real problem.

Office: (727) 943-5200

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.

- Cleveland Clinic — Orthostatic Hypotension (Postural Hypotension) - Patient-friendly overview of the low-pressure side, its causes, and self-care.
- Mayo Clinic — Orthostatic Hypotension: Diagnosis and Treatment - Diagnosis steps and treatments, including head-up sleeping and compression.
- MedlinePlus (NIH) — Orthostatic Hypotension - Plain-language NIH reference on symptoms, causes, and home management.
- Dysautonomia International — Resources for Patients - Patient support and education for autonomic disorders, including neurogenic OH.
- Our Orthostatic Hypotension guide - A deeper look at the low-pressure-on-standing side and how it is diagnosed.
- Our Midodrine guide - How this daytime BP-raising medicine works, and why the last dose is early.
- Our Dysautonomia guide - An overview of autonomic nervous system disorders behind this problem.
- Our Heart Failure with Preserved EF (HFpEF) guide - Background for the three-way bind when heart failure is also present.

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.

- Consensus statement on the definition of neurogenic supine hypertension in cardiovascular autonomic failure (Fanciulli, Jordan, Biaggioni et al; AAS/EFAS, Clin Auton Res 2018) *[Consensus]*
  American Autonomic Society / European Federation of Autonomic Societies consensus defining neurogenic supine hypertension (systolic 140 or higher, and/or diastolic 90 or higher after 5 minutes supine) with mild/moderate/severe grades. Source for the supine-BP thresholds and home/24-hour monitoring framing.
- Recommendations of a consensus panel for the screening, diagnosis, and treatment of neurogenic orthostatic hypotension and associated supine hypertension (Gibbons, Biaggioni, Freeman, Kaufmann et al; AAS/Parkinson Foundation, J Neurol 2017) *[Consensus]*
  Core management algorithm for coexisting neurogenic OH and supine hypertension — the dual-target problem at the heart of this guide. Source for treat-to-standing-symptoms principle, head-up sleeping, and short-acting nighttime agents.
- Consensus statement on the definition of orthostatic hypotension, neurally mediated syncope and the postural tachycardia syndrome (Freeman, Wieling, Low, Kaufmann et al, Clin Auton Res 2011) *[Consensus]*
  Foundational definition of orthostatic hypotension (fall of 20 systolic or 10 diastolic within 3 minutes of standing) used throughout the guide.
- Blood pressure regulation in autonomic failure by dietary sodium, blood volume and posture (Biaggioni, Auton Neurosci 2021) *[Review]*
  Explains pressure natriuresis: lying flat raises BP, triggers salt and water loss overnight, and worsens morning OH — the vicious cycle. Source for 'avoid the flat supine posture' being as important as salt, and the fludrocortisone-in-heart-failure caution.
- Efficacy of servo-controlled splanchnic venous compression in the treatment of orthostatic hypotension: a randomized comparison with midodrine (Okamoto, Shibao, Raj, Biaggioni et al, Hypertension 2016) *[Rct]*
  Randomized crossover trial in autonomic failure showing abdominal (splanchnic) compression improves standing tolerance as well as midodrine, and the two together are better than either alone. Source for the abdominal-binder recommendation.
- Efficacy of midodrine vs placebo in neurogenic orthostatic hypotension: a randomized, double-blind multicenter study (Low, Gilden, Freeman, Sheng, McElligott et al, JAMA 1997) *[Rct]*
  Pivotal randomized trial supporting midodrine, the FDA-approved daytime pressor for symptomatic OH. Source for midodrine's standing-BP benefit and daytime-only dosing.
- Integrated analysis of droxidopa for neurogenic orthostatic hypotension in Parkinson disease (Hauser, Biaggioni, Vernino et al, Mov Disord Clin Pract 2018) *[Rct]*
  Pooled phase-3 randomized trial data for droxidopa (Northera), FDA-approved for neurogenic OH. Source for droxidopa's standing-BP and symptom benefit, and the supine-hypertension and headache cautions.
- Water potentiates the pressor effect of ephedra alkaloids (Jordan, Shannon, Biaggioni, Robertson et al, Circulation 2004) *[Rct]*
  Demonstrates the powerful acute pressor effect of drinking water in baroreflex-impaired (autonomic failure) patients. Supports the rapid water-bolus maneuver to raise BP for 1 to 2 hours before activity.

- Successful use of octreotide for refractory postural hypotension in a patient with Parkinson's disease and heart failure with preserved ejection fraction (Thet & Duric, Cureus 2025) *[Case Report]*
  Illustrates the 'unholy trinity' bind — OH plus supine hypertension plus HFpEF — where fludrocortisone had to be stopped for fluid-overload risk and an off-label specialist agent was used. Source for the three-way-conflict and team-based-care messaging.
- Diagnosis and treatment of autonomic failure, pain and sleep disturbances in Parkinson's disease: German Society of Neurology guideline (Fanciulli, Hoglinger et al, J Neurol 2025) *[Guideline]*
  Current (2025) evidence-based national guideline on managing autonomic failure in Parkinson disease, including OH and supine hypertension. Source for the staged non-drug-first, drug-second approach and contemporary recommendations.
- Cleveland Clinic — Orthostatic Hypotension (Postural Hypotension) *[Patient Education]*
  Plain-language framing for symptoms, evaluation, and self-care reviewed for patient-voice and reading-level alignment.
- Mayo Clinic — Orthostatic Hypotension: Diagnosis & Treatment *[Patient Education]*
  Patient-facing diagnosis and treatment steps, including head-up sleeping and compression, used to calibrate plain-language explanations.
- MedlinePlus / NIH — Orthostatic Hypotension *[Patient Education]*
  NIH plain-language reference for symptoms, causes, and home management; trusted-resource for patients.

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

Version: 2026-08-15

Reviewer note: Reviewed against Cleveland Clinic, Mayo Clinic, and MedlinePlus orthostatic hypotension pages and the dysautonomia patient community. Ours adds: the paradox explained in one picture, the overnight pressure-natriuresis cycle, the standing-versus-lying target concept framed as physician-set, a do/don't medicine map with on- and off-label status, a head-of-bed-up rule, an hour-by-hour action plan, and the heart-failure 'unholy trinity' that most patient pages skip.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.

Take This Guide With You

Scan or visit: https://go.riasalimd.com/supine-htn-oh-guide

Online: https://go.riasalimd.com/supine-htn-oh-guide

Office: (727) 943-5200

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