



Aim for a reduction in MAP by 10-20% (depending on severity) during the first hour with a target DBP of 100-110mmHG

Aim for a reduction in blood pressure of 10% per day

Admit to HDU & consider invasive monitoring with Oesophageal Doppler or Swann Ganz catheter. Can titrate management to:

- decrease SVR by 1/3
- increase CI by 1/3
- increase SV
- decrease HR

1st line Ramipril 2.5mg od (or locally available ACEi)
2nd line ARB (if ACEi intolerant, probably at least as good)
3rd line Calcium Channel blocker (preferably short-acting)
4th line Doxazosin 1mg od

Early ITU/HDU referral if any of the following **warning signs** are positive

Use nitrates or Iloprost where available

Seizures
commence iv phenytoin, Brain imaging & Neurology opinion

Acute pulmonary oedema
IV nitrates and IV diuretic (reduce SVR using IV prostacyclin or nitrate)

Acute Kidney Injury
Control BP. If refractory or AKI worsening consider dialysis

Tachyarrhythmias
beta blockers are a relative c/i

PD has the advantage of avoiding intra-vascular volume fluid shifts but individual patient's hands (contractures) or occasionally the severely thickened abdominal skin may preclude this choice

Peritoneal Dialysis
Can use immediately. Low volume and automated to avoid leaking

Haemodialysis
1. CVVHF
2. CVVHD
3. Intermittent HD
as per local practice

- In dialysis dependent patients, Cr can rise for 7-10 days before plateauing or falling
 - Small intravascular changes in the early stages of SRC can alter a patients clinical situation quickly and dramatically, therefore continuous treatment or PD preferred if available
 - ACEi must be continued whilst on dialysis
 Ref: Ann Intern Med. 2000; 133:600-603

If no signs of renal recovery, consider Renal transplantation after 1-2 years [median time to renal recovery after SRC is 11mths (1-34mths)]
 Ref: QJM 2007 100:485-494