

Hypertension

CASE SCENARIO: #10

F.L. is a 65 y/o African-American male who presents for evaluation of high blood pressure which was reported on routine screening. His medical history includes asthma for which he takes albuterol inhalers (a drug which dilates the airways) as needed for frequent shortness of breath, and peptic ulcer disease. His only other complaint is the presence of a pounding, occipital, morning headache. Hypertension was detected 10 years ago and was treated with weight reduction, diet, and sodium (salt) restriction. Presently, he takes no medication for hypertension. A gradual 15-pound weight gain is noted over the previous 15 months. His father had hypertension and died of a myocardial infarction at age 54. His mother died of a stroke at age 62 and was an insulin-dependent diabetic. He has a 40-pack year history of cigarette smoking (smoked 2 packs per day for 20 years). Physical examination reveals a well-developed, overweight African-American male in no acute distress. His blood pressure (BP) measurements are as follows 165/115 mmHg and 162/112 mmHg on repeated determinations. Besides an accentuated second heart sound and mild eye changes (arterial narrowing, sharp discs), the rest of the examination was within normal limits. The laboratory evaluation was unremarkable except for a serum creatinine (Cr) of 2.0 mg/dL (normal range 0.6-1.5) and blood urea nitrogen (BUN) of 30 mg/dL (normal 8-25). Urinalysis reveals mild proteinuria. The chest X-ray reveals mild left ventricular hypertrophy. What stage of

hypertension would this patient be classified as? What are the cardiovascular risks factors in this patient? What are the symptoms/complications of hypertension in this case? How should FL be treated?