Suspicion of SRC

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

Admit to Hospital

Assess Severity

Is SBP >180 or DBP >110

Yes

Admit to HDU & consider invasive monitoring with Oesophageal Doppler or Swan 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

No

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

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

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

Use nitrates or Iloprost where available

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 as per local practice
2. CVVHD
3. Intermittent HD

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