In Reference to, "As-Needed Intravenous Antihypertensive Therapy and Blood Pressure Control"

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We read with great interest the study by Lipari et al. published recently in the *Journal of Hospital Medicine*.[1] The authors addressed a commonly encountered issue about frequent use of intravenous (IV) antihypertensives in asymptomatic hospitalized patients.

There is little published about treatment of acutely elevated blood pressure in asymptomatic inpatients, although the practice seems to be common and based on poorly justified beliefs.[2] We believe that many healthcare providers "treat the numbers" in such situations by dangerous misuse of potent medications leading to potential safety concern, which is associated with unnecessary risks and excess costs and possibly increased length of stay, as demonstrated in previous reports[3] but not specifically addressed in this study.

So what can be done to address this problem? We argue against routine ordering of "as needed" IV antihypertensives, but rather encourage a confirmation of the accuracy of measurements, assess patients and pay attention to concomitant conditions (eg, anxiety or pain), consider short-acting oral antihypertensive medications, and focus on patient safety rather than a false sense of healthcare team self-comfort. We believe that hospitals' leadership should stress the importance of proper use of medications to both clinicians and nursing staff.

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The Authors Reply, "As-Needed Intravenous Antihypertensive Therapy and Blood Pressure Control"

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We appreciate the comments of Drs. Ayach and Mirrakhimov. Our study found that the routine ordering of "as needed" intravenous (IV) antihypertensives was commonly done for patients who had blood pressure (BP) elevations that did not post any imminent danger to the patients.[1] Thus, the preemptive ordering of IV BP medications that would be administered without any clinical assessment is a practice that cannot be defended. We are in complete agreement that the accuracy of the BP measurement should be undertaken along with consideration of factors that might explain the BP elevation such as hypoxia, hypercarbia, pain, and IV saline infusions. However, we would not shift our prescribing habits toward short-acting antihypertensives drugs (eg, nifedipine) that were never approved for hypertension treatment despite their use for this condition.[2] Rather, we put forth the approach of primarily focusing on the aforementioned patient factors that may explain BP elevations and, in situations where such conditions do not exist, gradually up-titrate/optimize the prescribed oral antihypertensive drug regimen while also emphasizing prudent dietary changes (eg, low-sodium diet).[3]

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