



Suspicion of SRC

Admit to Hospital

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

Is SBP >180 or DBP >110

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

Assess Severity

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 } as per local practice  
2. CVVHD }  
3. Intermittent HD

- 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