

The goal of treatment in older patients should be the same as in younger patients (to below 140/90 mm Hg if at all possible), although an interim goal of SBP below 160 mm Hg may be necessary in those patients with marked systolic hypertension.^{26Pr} Any reduction in blood pressure appears to confer benefit—the closer to normal, the greater the benefit. Drugs that exaggerate postural changes in blood pressure (peripheral adrenergic blockers, alpha-blockers, and high-dose diuretics) or drugs that can cause cognitive dysfunction (central alpha₂-agonists) should be used with caution. Additional recommendations about hypertension in older persons can be found in the report by the NHBPEP Working Group on Hypertension in the Elderly.^{26Pr}

PATIENTS WITH HYPERTENSION AND COEXISTING CARDIOVASCULAR DISEASES

Patients With Cerebrovascular Disease

Clinically evident cerebrovascular disease is an indication for antihypertensive treatment. However, immediately after the occurrence of an ischemic cerebral infarction, it is appropriate to withhold treatment (unless blood pressure is very high) until the situation has been stabilized. Even when treatment has been withheld temporarily, the eventual goal is to reduce blood pressure gradually while avoiding orthostatic hypotension. Patients with acute ischemic stroke who are treated with fibrinolytic agents require careful blood pressure monitoring, especially over the first 24 hours after starting treatment. SBP of 180 mm Hg or greater or DBP of 105 mm Hg or greater may be controlled with intravenous agents with careful monitoring for worsening of neurological status.^{175C}

Patients With Coronary Artery Disease

Patients with coronary artery disease and hypertension are at particularly high risk for cardiovascular morbidity and mortality. The benefits and safety of antihypertensive therapy in such patients are well established.^{176Pr,177Pr} Excessively rapid lowering of blood pressure, particu-

larly when it causes reflex tachycardia and sympathetic activation, should be avoided. Blood pressure should be lowered to the usual target range (below 140/90 mm Hg), and even lower blood pressure is desirable if angina persists.

Beta-blockers or calcium antagonists may be specifically useful in patients with hypertension and angina pectoris; however, short-acting calcium antagonists should not be used.^{125M,178Re,179Re} **After myocardial infarction, beta-blockers without intrinsic sympathomimetic activity should be given because they reduce the risk for subsequent myocardial infarction or sudden cardiac death.** ACE inhibitors are also useful after myocardial infarction, especially with left ventricular systolic dysfunction, to prevent subsequent heart failure and mortality.^{176Pr}

If beta-blockers are ineffective or contraindicated, verapamil hydrochloride or diltiazem hydrochloride may be used because they have been shown to reduce cardiac events and mortality modestly in two circumstances: (1) following non-Q-wave myocardial infarction, and (2) after myocardial infarction with preserved left ventricular function (LVH).^{119Pr,180Pr,181Pr}

Some patients with hypertension, especially when accompanied by severe LVH, may experience angina without evidence of coronary atherosclerosis. This is thought to reflect an imbalance between myocardial oxygen supply and demand, due in part to changes in the coronary microcirculation. Treatment should be directed at blood pressure control, reversal of LVH, and avoidance of tachycardia, which may exacerbate the supply-demand mismatch.

Patients With Left Ventricular Hypertrophy

Development of LVH permits cardiac adaptation to the increased afterload imposed by elevated arterial pressure. However, LVH is a major independent risk factor for sudden cardiac death, myocardial infarction, stroke, and other cardiovascular morbid and mortal events.^{182F,183F}

Evidence shows that antihypertensive agents (except direct vasodilators such as hydralazine