A case of high risk hypertension

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A 46-year-old woman was referred for severe hypertension with her blood pressure 210/130 mmHg in September 2000, presenting with polydipsia, palpitation, face numbness and progress to left side limbs. MRI showed lacunae stroke and her symptoms resolved with medical treatment. She had been placed on Nifedipine 30 mg twice daily, enalapril 20 mg daily, and aspirin 100 mg daily since then. She developed cough on ACEI later. She has history of hypertension for 20 years, type 2 diabetes for 10 years; and mixed hyperlidemia, paroxysmal atrial fibrillation were also diagnosed after first this stroke event. During the following five years, the blood pressure was kept around 160~180/90~100 mmHg, total cholesterol 200~250 mg/dl, triglyceride 300~450 mg/dl, and blood sugar around 200~300 mg/dl with combination multiple drug therapy. She may developed dizzy whenever blood pressure was lowered to 140/80 mmHg.

In March, 2006, she developed angina and coronary angiogram was done, which revealed - LM -normal, LAD -atherosclerosis, irregular surface; LCX - atherosclerosis, irregular surface; - RCA atherosclerosis, irregular surface, PL: 60-70% stenosis. Medical treatment was continued. She later developed frequent unsteadiness & near-syncope in December 2006. Late in 2007, and March 2008, nephrotic syndrome was diagnosed without definite pathological proof after renal biopsy. She also had been bothered by peripheral neuropathy for couple years.

The clinical condition remains redundant in past two years.