**EXERCISE RELATED HYPERTENSION (ERH) MAY NOT BE A BENIGN PHENOMENON**

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Blood Pressure ( BP) increases with exercise. However a Systolic BP(SBP)) reaching or exceeding  200mm Hg  is considered pathological

We recently observed a 78 years old male who, while walking uphill suddenly noticed loss of speech. He was diagnosed as a non-blood clot embolic stroke. The source of embolization was thought to be a calcified plaque at the origin of the left carotid artery. On a subsequent Ambulatory BP monitor he had BP of 150 correlating with the time he had his stroke. WE assumed that with a baseline   HTN he probably increased his SBP further making it possible to dislodge a plaque

Inspired by this experience we went back to our records and explored patients in who had been followed and treated for exercise related HTN. Once ERH was detected patient was placed on a low dose B blocker (BB) or baseline dose was increased. Fine titration was necessary to avoid compromise of resting BP. Every one of the patients had follow-up t treadmills (FUT) to assess the efficacy of the treatment;

*Results*: 143 studies were done on 16 patient. M/F 11/5, age 61.8. Baseline studies 16, subsequent studies 127

*Control*: resting SBP 127.4, peak exercise 208.8  l diastolic bp (DBP)(  ) . peak exercise DBP (   )

*Treatment*: resting SBP 123.8 peak exercise 173.1 . resting DBP(   ) ex DBP (   ) Resting control SBP vs resting FUT  SBP 127.4 vs 123.8. peak SBP at control vs peak SBP in f/u  was  -4. Peak DBP at control vs f/u was (   )

All patients were treated with a low dose BB but at times another non BB medication had to be added for proper control.

*Conclusion*: ERH may be a potential risk factor for an embolic stroke.On a small group with multiple test we were able to determine that ERH t can be effectively controlled using low dose BB without compromising resting BP