Sir,

We read with interest the case report by Gallagher *et al.*[1] where a patient with accelerated hypertension and anterior ischaemic optic neuropathy was treated using sublingual nifedipine 10 mg, reducing the blood pressure from 220/150 mmHg to 160/110 mmHg in a short period.

We are concerned at the continuing use of sublingual nifedipine for the urgent treatment of hypertension, especially when it is not even absorbed by the oral or oesophageal mucosa.[2] The liquid released from the crushed nifedipine capsule is erratically absorbed later from the gastric mucosa, resulting in fluctuating effects, including a sudden rapid fall in blood pressure. The latter is undesirable, especially when cerebral autoregulation is disordered in accelerated hypertension, and excessive blood pressure falls are potentially dangerous, resulting in cerebral and optic nerve head ischaemia or infarction.[3–5] Several cases of (sublingual) nifedipine-induced myocardial ischaemia or infarction in patients with or without ischaemic heart disease have also been published.[6,7] In patients with known cardiac ischaemia, such a precipitous fall in blood pressure accompanied by reflex acceleration of the heart rate and increase of myocardial oxygen demand is undesirable.[7] In addition, the nifedipine-induced preferential vasodilation in non-ischaemic myocardium at lower pressures may cause diversion of blood flow away from ischaemic areas, commonly referred to as a 'steal phenomenon'.

The acute hypotensive effect of nifedipine is therefore unpredictable and, in some cases, hazardous. This adverse haemodynamic profile renders sublingual nifedipine an inappropriate choice for hypertensive emergencies, especially when treating patients with cerebral, optic or coronary ischaemia, and may even be dangerous. Its continued use in clinical practice for the urgent reduction of high blood pressure should therefore be discouraged.

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Sir,

We thank Drs Lip and Lip for their interest in our publication[1] concerning the use of sublingual nifedipine in the treatment of accelerated hypertension. We believe that the use of this drug in clinical practice is substantiated, but is dependent on the clinical situation.

Hypertensive crises have been classified as: (a) true emergencies requiring immediate reduction of blood pressure using antihypertensive agents parenterally, and (b) hypertensive urgencies that can usually be treated with orally administered drugs to reduce blood pressure within 24 h.[2] Accelerated hypertension is a hypertensive emergency if target organ disease is present (e.g. encephalopathy, left ventricular failure, or ischaemic heart disease), but is an urgency in the absence of these conditions.[3]

Therapeutic evaluation in our case was dependent on the age of the patient, duration and history of onset of present symptoms, lack of pre-existing cardiac or cerebral vascular disease, and absence of extensive progressive target disease. Clearly our patient represents an atypical urgent case and sublingual nifedipine proved a successful therapeutic choice in this clinical situation.

It must be stated that in these clinical situations, precipitous reduction of the patient's blood pressure must be avoided, and the advice of a physician should be sought without undue delay.

References

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Sir,

Inkster *et al.*[1] present interesting data suggesting that as well as a higher cure rate, Mohs surgery can allow conservation of tissue including important structures such as the lacrimal canaliculi, leading to smaller than anticipated reconstruction in 37% of cases. They claim that in the 20% of cases where the reconstruction was larger than expected this was because of the presence of occult tumour which would have led to tumour recurrence if the traditional approach had been employed.

We routinely carry out surgical excision with a 2 mm margin of healthy tissue instead of the traditional 3–4 mm margin[2] for well-defined basal cell carcinomas in the peri-ocular region. We delay surgical repair until the tissue has been examined histologically and the margins pronounced free of tumour. Unlike Mohs technique 100% of the tumour surface is not examined. So far we have no tumour recurrences after 3 years' follow up. We feel that 2 mm margin excision with delayed repair following confirmation of histological clearance is appropriate treatment for