Four Faces of Baroreflex Failure
Hypertensive Crisis, Volatile Hypertension, Orthostatic Tachycardia, and Malignant Vagotonia

Terry Ketch, MD; Italo Biaggioni, MD; RoseMarie Robertson, MD; David Robertson, MD

Background—The baroreflex normally serves to buffer blood pressure against excessive rise or fall. Baroreflex failure occurs when afferent baroreceptive nerves or their central connections become impaired. In baroreflex failure, there is loss of buffering ability, and wide excursions of pressure and heart rate occur. Such excursions may derive from endogenous factors such as stress or drowsiness, which result in quite high and quite low pressures, respectively. They may also derive from exogenous factors such as drugs or environmental influences.

Methods and Results—Impairment of the baroreflex may produce an unusually broad spectrum of clinical presentations: with acute baroreflex failure, a hypertensive crisis is the most common presentation. Over succeeding days to weeks, or in the absence of an acute event, volatile hypertension with periods of hypotension occurs and may continue for many years, usually with some attenuation of pressor surges and greater prominence of depressor valleys during long-term follow-up. With incomplete loss of baroreflex afferents, a mild syndrome of orthostatic tachycardia or orthostatic intolerance may appear. Finally, if the baroreflex failure occurs without concomitant destruction of the parasympathetic efferent vagal fibers, a resting state may lead to malignant vagotonia with severe bradycardia and hypotension and episodes of sinus arrest.

Conclusions—Although baroreflex failure is not the most common cause of the above conditions, correct differentiation from other cardiovascular disorders is important, because therapy of baroreflex failure requires specific strategies, which may lead to successful control. (Circulation. 2002;105:2518-2523.)

Key Words: baroreceptors ■ hypertension ■ tachycardia

An arterial reflex that maintains blood pressure homeostasis has been known since ancient times. The first reference to the baroreflex effect might have been noted in ancient Rome, where it was observed that pressing on the arteries of the neck in animals produced sedation. Careful human studies in the 1940s indicated that the carotid sinus area represented one site for the location. The arterial baroreflex prevents excessive fluctuations of arterial blood pressure. Regulation of the cardiovascular system by the baroreflex involves multiple components of the baroreflex arc. As demonstrated in Figure 1, baroreceptors in each carotid sinus send information about distention of the vessel wall to the brain stem via the glossopharyngeal nerve (cranial nerve IX). Other baroreceptors in the aortic arch and the great vessels of the thorax transmit similar information by the vagus nerve (cranial nerve X) to the same brain stem nuclei. The glossopharyngeal nerve (cranial nerve IX) and vagus nerve (cranial nerve X) are responsible for touch sensation in Caenorhabditis elegans, components of the baroreceptor mechanosensor. The expression of the γ subunit of ENaC in the fine baroreceptor nerve terminals innervating the aortic arch and carotid sinus is the first indication of the molecular identity of baroreceptor mechanotransduction. The role of this class of channels in baroreceptor function is supported by inhibition of baroreceptor activity with amiloride analogs, which are known to inhibit DEG/ENaC channels. Both β and γ subunits of DEG/ENaC have also been identified in mechanosensory structures in the rat footpad, which are believed to mediate light touch. The glutamate and nitric oxide released in the nucleus tractus solitarii may lead to cardiovascular changes. The caudal ventrolateral medulla and the rostral ventrolateral medulla are crucial brain stem structures involved in the modulation of sympathetic outflow. It is well established that afferent nerve traffic from the thorax and abdomen also provides input to central cardiovascular centers after traveling with sympathetic nerves back to the spinal cord and then to medullary cardiovascular control centers. These afferents are less well understood at the level of clinical presentation and are beyond the scope of this review.

Physiological transduction of stretch is common to many tissues and organs, mediating light touch, hearing, and distention at visceral sites. The carotid sinus itself contains a stretch receptor. It has been proposed that the DEG/ENaC family of cation channels, which are responsible for touch sensation in Caenorhabditis elegans, are components of the baroreceptor mechanosensor. The expression of the γ subunit of ENaC in the fine baroreceptor nerve terminals innervating the aortic arch and carotid sinus is the first indication of the molecular identity of baroreceptor mechanotransduction. The role of this class of channels in baroreceptor function is supported by inhibition of baroreceptor activity with amiloride analogs, which are known to inhibit DEG/ENaC channels. Both β and γ subunits of DEG/ENaC have also been identified in mechanosensory structures in the rat footpad, which are believed to mediate light touch. The glutamate and nitric oxide released in the nucleus tractus solitarii may lead to cardiovascular changes. The caudal ventrolateral medulla and the rostral ventrolateral medulla are crucial brain stem structures involved in the modulation of sympathetic outflow. It is well established that afferent nerve traffic from the thorax and abdomen also provides input to central cardiovascular centers after traveling with sympathetic nerves back to the spinal cord and then to medullary cardiovascular control centers. These afferents are less well understood at the level of clinical presentation and are beyond the scope of this review.
Problems Identifying Baroreflex Failure

Despite the voluminous data from animal studies and in vitro work, our understanding of the clinical manifestations of baroreflex impairment remains incomplete. There are several reasons for this. First, multiple cranial nerves transmit afferent baroreflex information to the medulla oblongata, including the right and left glossopharyngeal nerves and the right and left vagus nerves. For clinical presentation of baroreflex lesions, this is particularly true when there is involvement of the vagus nerve.

Confusion also exists in the difference between baroreflex failure and autonomic failure. Some have used these terms interchangeably. But in reality, the cardiovascular manifestations of these two disorders are quite different (Table 1). The presentation of autonomic failure is dominated by orthostatic hypotension, whereas the presentation of acute baroreflex failure often resembles that of pheochromocytoma.

Focus heretofore has been on completeness of interruption of afferent baroreflex nerves in the presence of baroreflex failure. However, clinical studies have provided evidence for asymmetry in central control of cardiovascular function. Over the last two decades, Janetta and Gendell have described arterial loops impinging on cardiovascular nuclei in the left brain stem as being the cause of unexplained hypertension in some patients. Future studies of baroreflex failure need to address whether left-sided baroreflex input elicits a disproportionate effect on cardiovascular regulation.

Causes of Baroreflex Failure

Abnormalities in the vascular baroreceptors, the glossopharyngeal nerve, their brain stem connections, or interruption of afferent nerves can all potentially lead to baroreflex failure (Table 2). Accidental trauma, trauma either from unilateral or bilateral carotid endarterectomy, or additional surgical therapy for pathology in the relevant anatomic areas, local tumor growth, and brain stem stroke are all recognized causes of baroreflex failure. In addition, patients with a genetic disorder predisposing them to tumors of chromaffin tissue tend to have tumor growth in structures close to the glossopharyngeal nerve and are thus particularly likely to provoke the complication of baroreflex failure. Present advances in surgical techniques of carotid body paraganglioma resection have helped decrease the mortality rates significantly, but the morbidity, especially in regard to postoperative cranial nerve dysfunction, remains high. Genetic linkage to 2 distinct chromosomes, 11q13.1 and 11q22.3–23, has been reported for this autosomal-dominant disorder that is highly penetrant and influenced by genomic imprinting through paternal transmission. Radiation therapy of throat carcinoma may also have the side-effect of damage to cranial nerves, and this damage tends to occur after an interval of months or, in some cases, years after the irradiation, perhaps reflecting local fibrosis as the intervening pathophysiology, whereby the nerves are damaged. Also, patients who have received radiotherapy for head and neck cancer may present with baroreflex failure. The degree to which efferent nerves suffer collateral damage will no doubt have a significant impact on the clinical presentation of baroreflex lesions. This is particularly true when there is involvement of the vagus nerve.

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with lightheadedness or syncope attributable to baroreceptor damage. A patient with impaired function of the nucleus tractus solitarii with no history of radiation, tumor, or trauma was ultimately found to have Leigh’s syndrome. Additionally complicating matters, a patient serendipitously taking intermittent clonidine reproducing the picture of baroreflex failure has been recently reported. Two genetic disorders that seem to entail baroreflex failure have been described, Groll-Hirschowitz syndrome, in which carotid sinus nerve dysfunction, sensory neuropathy, and duodenal diverticula occur, and a syndrome of autosomal-dominant hypertension and brachydactyly with loss of baroreflex buffering.

**Clinical Manifestations of Baroreflex Failure**

**Hypertensive Crisis**

The acute form of baroreflex failure is most often encountered in hospital settings, because it requires urgent treatment. Often patients have had surgical intervention, causing a loss of glossopharyngeal or vagus nerve function. Sometimes accidental injuries lead to acute baroreflex failure. If damage is isolated to the afferent limb of the baroreflex, the clinical presentation is severe, unremitting hypertension, tachycardia, and headache. The systolic blood pressure may exceed 300 mm Hg and is typically >250 mm Hg. Symptoms also include diaphoresis, the mechanism of which is not fully understood. Apneic spells may occur, especially in the first 48 hours of the postoperative period. Whether these apneic spells are related to concomitant loss of innervation of the carotid body or in response to narcotic analgesia for control of postoperative pain remains uncertain.

**Volatile Hypertension**

This is the most commonly encountered presentation of baroreflex failure. It may develop insidiously after a substantial period of time during which baroreflex function gradually declines. Alternatively, hypertensive crisis may evolve over days and weeks into the more chronic volatile hypertension phase. This phase is usually more or less permanent, although the pressor surges moderate over time. These patients display an interrupted afferent baroreflex input from the carotid sinus to the nucleus tractus solitarii with accompanied interrupted efferent parasympathetic output to the heart and blood vessels (Figure 2).

Abrupt sympathetic activation characterizes volatile hypertension. Thus, whereas baseline blood pressure may be normal to elevated, marked abrupt increases or surges of blood pressure lasting minutes to hours occur and are accompanied by tachycardia. These pressor surges are elicited by mental or physical stress, during which sympathetic outflow is increased, and are characterized by dizziness or lightheadedness, palpitations, and severe headaches. Profuse sweating often occurs. Tremulousness, anxiety, and irritability are typical of these episodes, although in some cases, the irritability may trigger the pressor surge rather than vice versa. Mild and transient elevations in plasma glucose have also occasionally been seen. Intraocular pressure may also increase in baroreflex failure. Plasma norepinephrine may increase to levels >1000 mg/mL, as encountered in pheochromocytoma. Values >2000 pg/mL are occasionally seen. Patients with volatile hypertension can have hypotensive valleys as well as pressor peaks, especially during periods of quiet, sedation, or sleep, when sympathetic outflow is diminished. With time, the pressor peaks may attenuate somewhat and the depressor valleys may become a greater problem for the patient, but these changes in the character of baroreflex failure are often played out over many years. Nevertheless, because of the complexity of treating these polar shifts in blood pressure, frequent follow-up of patients is important to make certain they are at an optimal regimen at all times.

**Orthostatic Tachycardia**

Orthostatic tachycardia, defined as an increase in heart rate by >30 bpm from the supine to upright position, is one of the most common findings among patients referred to tertiary centers with complaints
of orthostatic intolerance. Most patients referred for orthostatic tachycardia have neuropathic postural tachycardia syndrome or some other cause for their symptoms rather than baroreflex failure. But this syndrome is also occasionally a presentation of clinical baroreflex impairment. In some cases, it may primarily reflect interruption of efferent right vagus nerve activity, leading to a loss of parasympathetic input to the sinus node, with a consequent increase in heart rate. In other cases, mild sympathetic activation may occur with stress and provoke tachycardia disproportionate to the increase in blood pressure. Occasionally, patients presenting with orthostatic tachycardia will ultimately progress to the volatile hypertension form of baroreflex failure. Other patients have remained stable for a prolonged period of time.

**Malignant Vagotonia**

Severe bradycardia and asystole attributable to increased parasympathetic tone are rarely encountered in baroreflex failure. More commonly, lesions lead to complete or near-complete destruction of afferent baroreflex input, producing denervation of the heart and cardiovascular system and tachycardia.

Nevertheless, patients with selective baroreflex failure (Jordan syndrome) possess interrupted afferent baroreflex input from the carotid sinus to the *nucleus tractus solitarii* with intact efferent sympathetic and parasympathetic output to the heart and blood vessels (Figure 3). They display malignant vagotonia with hypotension, bradycardia, and asystole. Along with the hypertensive episodes encountered in the other forms of baroreflex failure, patients with this form may have episodes of hypotension with a systolic pressure $< 50$ mm Hg. Accompanying symptoms include fatigue and dizziness, with possible progression to frank syncope. The most severe episodes tend to occur during early morning sleep. Episodes have also occurred after intravenous nitroprusside, sublingual nitroglycerin, and the stress of neurosurgery. Also observed in these patients are periods of asystole during rest, lasting for 20 seconds or more, mandating the placement of a cardiac pacemaker.

**Differential Diagnosis of Baroreflex Failure**

Because of the protean manifestations of baroreflex failure, the differential diagnosis can be extensive (Table 3). The most important consideration is usually pheochromocytoma, a condition that may mimic baroreflex failure in many ways, including impaired baroreceptor function. In the usual situation, the diagnosis of baroreflex failure emerges from an unsuccessful work-up for pheochromocytoma. Other entities from which it must be distinguished include panic attack, generalized anxiety disorder, migraine, pure autonomic failure, hyperthyroidism, alcohol withdrawal, and drug use (eg, amphetamines or cocaine). Renovascular hypertension frequently presents with volatility and brittleness and may particularly mimic baroreflex failure. There is a long list of entities that can produce orthostatic intolerance, and an equally long list of disorders that can present with bradycardia and syncope.

Despite the long differential diagnosis, key features of the history and examination of the patient with baroreflex failure make it possible to make the diagnosis. The most important finding is excessive excursion of heart rate during normal daily activities (confirming autonomic control of heart rate), coupled with absent bradycardia in response to a pressor such as phenylephrine or absent tachycardia in response to a depressor such as nitroprusside. In practice, the history of prior trauma exposure is usually the most important consideration in suspecting the diagnosis of baroreflex failure.

**Therapy of Baroreflex Failure**

The primary goal of therapy of patients with baroreflex failure is to reduce the frequency and magnitude of life-threatening surges in blood pressure and heart rate. A secondary goal of therapy is to attenuate symptomatic hypotensive episodes. In patients with selective baroreflex failure, pacemaker placement may be necessary. Innovative therapies have included a proposed bionic baroreflex system.
The pharmacological treatment of choice for blood pressure surges is clonidine (Table 4). Clonidine acts centrally and peripherally to attenuate sympathetic activation and limit the extent to which pressor surges can occur. The \( \alpha \)-adrenergic receptor blocker phenoxybenzamine has been relatively unsuccessful in reducing the frequency of pressor surges, although the magnitude of surges (but not tachycardia) is controlled.\(^{46}\) It may be that the sedative effects of the \( \alpha \)-adrenergic receptor agonists such as clonidine may assist the patients in preventing hypertensive episodes. In the case of clonidine, the inconvenience of frequent oral dosing can be avoided by using patch preparations. Most patients with baroreflex failure will require significant doses, whether oral or transdermal. To reduce the possibility of loss of a patch with consequent provocation of clonidine withdrawal, we sometimes use two No. 1 patches, one placed on Sunday and a second placed on Wednesday of each week, staggered this way to lessen the likelihood of inadvertent, complete discontinuation of clonidine.

In patients who have been well controlled for months to years, it is sometimes possible to modify treatment regimens from \( \alpha \)-adrenergic receptor agonists to benzodiazepines, such as diazepam. Although relatively high doses of benzodiazepines are required, patients often tolerate this extremely well.

Finally, because of the excessive levels of plasma norepinephrine encountered in this patient population, agents that prevent release of norepinephrine may also be helpful. Guanadrel, which inhibits the release of norepinephrine from peripheral sympathetic nerve endings,\(^{47}\) is particularly effective. It has a short half-life and therefore is very useful in instituting therapy. It is excluded from the central nervous system so that no central side effects may occur. Because of a longer half-life, 5 days at its site of action, guanethidine may provide a more efficacious and easy coverage regimen for the long-term. Like guanadrel, guanethidine is excluded from the central nervous system, which limits its side effects. Occasionally, patients experience diarrhea on moderate to high doses of guanethidine.

In some patients, prevention of hypotension is also required. This is quite different, because the hypertensive episodes are usually short lived and most agents have a longer half-life than the usual duration of these spells. Fludrocortisone may still be the best way to treat this problem, because patients with baroreflex failure may have reduced plasma volume. Generally, low doses are sufficient. Fludrocortisone requires time for its full effect, thus its dosage should not be increased more frequently than at 2-week intervals. In highly exceptional cases, where excessive \( \alpha \)-agonist effect has been elicited, with consequent prolonged hypotension, administration of the \( \alpha \)-adrenergic receptor antagonist, yohimbine, at modest doses (1 to 5 mg) will usually lead to improvement.

Finally, if severe bradycardia (<40 bpm) is detected or if the patient has concomitant evidence of significant heart block, the placement of a pacemaker may be necessary. This may free the clinician to use a broader range of pharmacotherapy to manage the pressor and depressor manifestations of the disease.

In addition to issues of therapy, avoidance of agents that may be harmful in baroreflex failure is also an important part of management (Table 5). Because the pressor surges depend on high synaptic norepinephrine concentrations, anything that causes those concentrations to be higher is generally contraindicated. Because 80% to 90% of synaptic norepinephrine is removed by the norepinephrine transporter,\(^{48}\) blockade of this transporter by tricyclic antidepressants will potentiate the pressor effect of sympathetic activation. This may be particularly important in the heart, where up to 90% of norepinephrine removal is mediated by the norepinephrine transporter. Likewise, agents that reduce the breakdown of norepinephrine, such as monoamine oxidase inhibitors, should be avoided. Although not systematically studied, it would seem more appropriate to treat depression in patients with baroreflex failure with selective serotonin reuptake inhibitors than with tricyclic antidepressants or monoamine oxidase inhibitors. Other agents whose ultimate effect is to enhance norepinephrine availability, such as amphetamines and cocaine, should also be avoided. Although yohimbine has occasionally been used in situations where the effect of \( \alpha \)-agonists have led to excessive hypotension, in other circumstances it is likely to result in a profound pressor response and should therefore be avoided.

**Conclusion**

Baroreflex failure resembles many more common disorders, and its diagnosis is frequently missed. Baroreflex failure should be considered in the differential diagnosis of hypertensive crisis, volatile hypertension, pheochromocytoma, poorly controlled hypertension,\(^{49}\) orthostatic tachycardia, headache, hyperhidrosis, bradycardia, and syncope. Important historical clues include medical, surgical, family, and pharmaceutical histories. History is usually crucial to making the

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**TABLE 3. Differential Diagnosis**

<table>
<thead>
<tr>
<th>Condition</th>
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<tbody>
<tr>
<td>Pheochromocytoma</td>
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<tr>
<td>Syncope</td>
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<tr>
<td>Paroxysmal tachycardia</td>
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<tr>
<td>Orthostatic intolerance</td>
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<tr>
<td>Pure autonomic failure</td>
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<tr>
<td>Hyperthyroidism</td>
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<tr>
<td>Renovascular hypertension</td>
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<tr>
<td>Medications/drugs</td>
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<tr>
<td>Mast cell activation disorder</td>
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<tr>
<td>Carcinoid</td>
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<tr>
<td>Intracranial lesions</td>
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<tr>
<td>Alcohol withdrawal</td>
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<tr>
<td>Cerebral vasculitis</td>
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<tr>
<td>Page syndrome</td>
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<tr>
<td>Pseudopheochromocytoma</td>
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<tr>
<td>Migraine</td>
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<td>Psychological disorders (panic attack, generalized anxiety disorder)</td>
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**TABLE 4. Treatment of Baroreflex Failure**

<table>
<thead>
<tr>
<th>For blood pressure reduction</th>
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<tbody>
<tr>
<td>Clonidine 0.1 mg TID to 0.2 mg every 2 h</td>
</tr>
<tr>
<td>Guanadrel 10 mg BID to 20 mg TID</td>
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<tr>
<td>Guanethidine 10 mg OD to 30 mg OD</td>
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<tr>
<td>Diazepam 5 mg BID to 10 mg TID</td>
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<table>
<thead>
<tr>
<th>For blood pressure elevation</th>
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<tbody>
<tr>
<td>Fludrocortisone 0.05 mg BID to 0.1 mg BID</td>
</tr>
<tr>
<td>Yohimbine 1.35 mg to 5.4 mg as needed</td>
</tr>
<tr>
<td>Dietary Salt</td>
</tr>
<tr>
<td>For prevention of bradycardia</td>
</tr>
<tr>
<td>Cardiac pacemaker</td>
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**TABLE 5. Drugs Contraindicated in Baroreflex Failure**

<table>
<thead>
<tr>
<th>Drug Category</th>
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<tbody>
<tr>
<td>Tricyclic antidepressants*</td>
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<tr>
<td>Amphetamines</td>
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<tr>
<td>Monoamine oxidase A inhibitors</td>
</tr>
<tr>
<td>Cocaine</td>
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<tr>
<td>Prednisone</td>
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<tr>
<td>Tyramine-containing food and beverage</td>
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*Peripheral effect would be expected to raise blood pressure and heart rate; central effect would be expected to lower blood pressure and heart rate.
diagnosis. Baroreflex failure is particularly likely to develop in families with chromaffinomas, in patients after carotid artery surgery, in patients after throat irradiation, and in patients with neck injury. Correct diagnosis is important, because therapy in baroreflex failure is specific and usually quite effective.

Acknowledgments
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References
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