not report illicit drug intake and none of her family members had HTN or kidney disease.

She was admitted to the emergency department, blood pressure (BP) was 180/100 mmHg, unresponsive to intravenous Labetalol 20 mg, whereas other vital signs were stable. Aside from a mild headache, no other symptoms were reported. On physical examination, heart rate was 88 beats per minute and heart sounds were normal. Ankle edema was present without other signs of congestive heart failure. Radial-femoral pulses were congruent, and there were no audible flank bruits.

Methods: Laboratory tests showed: urea 0.13 g/l, serum creatinine 0.55 mg/dl, potassium 3.4 mEq/l, sodium 138 mEq/l, chloride 103 mEq/l, serum bicarbonate 28 mmol/l. Urinalysis was within normal limits, and the urine protein to creatinine ratio was 0.12 g/g.

Results: The patient had evidence of hypertensive end organ damage; funduscopic examination revealed mild hypertensive retinopathy, and transthoracic echocardiographic results indicated left ventricular hypertrophy (left ventricular posterior wall thickness was 13 mm and interventricular septal thickness was 9 mm), normal systolic function and mild mitral regurgitation. On ultrasonographic examination, the longitudinal diameter of the right kidney was 102 mm and the left kidney was 118 mm, with preserved parenchymal thickness. Renovascular HTN was suspected in a patient with severe HTN, hypokalemia, metabolic alkalosis, and asymmetric kidneys. Computed tomography angiography was requested and revealed left kidney longitudinal diameter of 130 mm, right kidney longitudinal diameter of 97 mm, and right renal artery stenosis from its origin, with approximately 15 mm length left. Left renal artery caliber was normal. Preoperative Ambulatory Blood Pressure Monitoring (ABPM) evidenced uncontrollable and severe HTN unresponsive to treatment with Methyldopa (500 mg 4 times daily), Labetalol (200 mg 3 times daily), Hydrochlorothiazide (25 mg daily) and Nifedipine (30 mg daily). Overall average BP was 170/125 mmHg. Angiography revealed 70% ostial stenosis and 60% middle stenosis in the right renal artery. Angioplasty of the two stenoses was performed with NC EMERGE Balloon without complications. Postoperative ABPM evidenced lower overall average BP (155/114 mmHg) without antihypertensive drugs. The patient recovered uneventfully and was discharged under treatment with Methyldopa (500 mg twice daily). She was treated with Nifedipine (30 mg daily). Overall average BP was 155/114 mmHg. Pressure Monitoring (ABPM) evidenced uncontrollable and severe HTN under treatment with Methyldopa (500 mg 4 times daily), Labetalol (200 mg 3 times daily), Hydrochlorothiazide (25 mg daily) and Nifedipine (30 mg daily). Overall average BP was 170/125 mmHg. Angiography revealed 70% ostial stenosis and 60% middle stenosis in the right renal artery. Angioplasty of the two stenoses was performed with NC EMERGE Balloon without complications. Postoperative ABPM evidenced lower overall average BP (155/114 mmHg) without antihypertensive drugs. The patient recovered uneventfully and was discharged under treatment with Methyldopa (500 mg twice daily). She was delivered a term newborn with low birth weight (2360 grams) and there were no neonatal complications.

Conclusions: In this report we describe a patient with refractory HTN, secondary to renal artery stenosis due to fibromuscular dysplasia, successfully treated with percutaneous transluminal angioplasty at 12 weeks gestation. Renal artery stenosis diagnosis and treatment during pregnancy brings concern for maternal complications and fetal radiation, with few cases reported in the literature. In this case, pregnancy continued until term with a significant improvement in BP control.

No conflict of interest

POS-413
MANAGEMENT OF HYPERTENSION AFTER RENAL SYMPATHETIC DENERVATION IN MALE PATIENTS

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Introduction: Renal sympathetic denervation (RSD) is a catheter-based medical procedure that uses radiofrequency ablation on the renal sympathetic nerves to attenuate cardiac pulse pressure as well as juxtaglomerular renin release through beta-1 adrenergic receptor stimulation. Early studies on RSD demonstrated a marked benefit in the patients who underwent the procedure, but early cases have left more to be desired due to heterogeneity of clinical trial designs. Currently, the International Consensus Statement on Renal Denervation reports the need for further evaluation of RSD efficacy and suggested that RDN should not be offered to patients outside of clinical trials. Despite the International Consensus Statement recommendations, there are a number of reported peer-reviewed case reports of hypertensive patients undergoing renal denervation, yet there is currently no literature or systematic review on these cases reports determining if the patient outcomes have produced similar results to the current literature of RSD clinical trials. Therefore, the aim of this study is to evaluate the efficacy of RSD treatment in attenuating hypertension among patients.

Methods: A systematic review of the literature was performed on MEDLINE, Google Scholar, and the Cochrane Database of Systematic Reviews for renal denervation case studies. This study methodology was registered by PROSPERO International prospective register of systematic reviews (National Institute for Health Research). The search was performed following the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines and checklist.