Clevidipine

IV calcium channel blocker (CCB) is selective for vascular smooth muscle, with minimal effect on myocardial contractility or cardiac conduction. Reduces MAP by decreasing systemic vascular resistance. Is rapidly degraded by esterases in blood and extravascular tissues

∴ Dosing does not need to be adjusted for liver insufficiency or renal insufficiency. It is even metabolized rapidly in pseudocholinesterase-deficient patients. Onset and end time are rapid which is an advantage for finely titrating blood pressure. Does not require an arterial line, does not raise ICP. Does not reduce heart rate, but may be used in conjunction with, e.g., labetalol or esmolol if that is desired.

Side effects: H/A 15%, nausea 5%, hypotension 5%, reflex tachycardia 3.5%. It is a lipid emulsion, with a milky white appearance similar to propofol is (possible confusion) and may induce hypertriglyceridemia when used simultaneously. [1)]

In a perioperative setting, there is a 4–5% reduction in SBP within 4–5 minutes after infusion is started, and BP fully recovers in 5–15 minutes in most patients.

℞ start at 1–2 mg/hr IV. Titrate up by doubling the dose every 90 seconds until nearing the desired BP then smaller increments are made less frequently up to a maximum of 32 mg/hr (control is usually achieved at ≤ 16 mg/hr). The drug is not diluted before administration.

✖ Because of lipid loading, it is recommended to limit infusion to ≤ 1000 ml per 24 hours (an average of 21 mg/hr). There is little information regarding infusions > 72 hours.

1)
Kaur H, Nattanamai P, Qualls KE. Propofol and Clevidipine-induced Hypertriglyceridemia. Cureus. 2018; 10. DOI: 10.7759/cureus.3165