2/23/19njm

PROBLEM: Hypertensive Disorders in Pregnancy

Chronic HTN

Definition: Mild: SBP ≥140-159 mm Hg, DBP ≥ 90-109 mm Hg
Use of anti-HTN medications before pregnancy
Severe: SBP ≥160 mm Hg DBP ≥110 mm Hg
Onset of HTN before the 20th week of gestation and persists 42 days postpart.

Medications
- ASA 65-85 mg po once a day after 12 – delivery
- Stop Anti-hypertensives initially and recheck BP in one wk
- If BP 160 / 110 mm Hg, then start
  Labetolol 200-2400 mg orally in two or three divided doses
  Nifedipine 30 to 120 mg qd as sustained release tablet

Labs: Baseline – Cr, CBC, LFTs, spot total P/Cr ratio

Second line Tx:
Alpha-methldopa 250-3000 mg orally in two or three divided doses
Avoid ACE Inhibitors

Ultrasound
- 8-10 weeks initial
- 20-22 weeks anatomy
- 28-32 weeks growth, then every 4 weeks

Monitoring
- Kick counts
- Controlled no meds: No testing
- Controlled on meds: Start 36 w, NST / AFI q wk
- Not controlled on meds: 2x NST with weekly AF once Dx'd

Prenatal visits: Every 4 weeks until 32 weeks, then every 2 weeks until 36 weeks, then weekly
Delivery: No meds 39-40 wks / Controlled on meds 39- 40 wks / Difficult control > 37 wks

Pre-eclampsia

Definition: SBP ≥ 140 mm Hg or DBP ≥ 90 mmHg, upright following a 10 minute rest (Repeat in 4 hours to confirm dx)
Total P/Cr ≥ 0.3, or ≥300 mg of protein in a 24 hour urine specimen, or 2+ on urine dipstick
After 20 wks EGA
Can convert from GHTN without proteinuria if develops severe features
If Total P/C is 0.15 - 0.29, then obtain 24 urine PROT

Monitoring
- Kick counts
- NST 2x/wk and AF q week at Dx
- U/S every 3-4 weeks

Labs:
- Baseline – CBC, Cr, AST/ALT
  - PLt ct, Cr, LFTs q wk

Prenatal visits: weekly and check BP twice a week
Delivery: > 37 weeks

Pre-eclampsia with severe features

Definition: SBP ≥ 160 mmHg or DBP ≥ 110 mmHg on 2 occasions on bedrest
Total P/Cr ≥ 0.3, or ≥300 mg of protein in a 24 hour urine specimen, or 2+ on urine dipstick
Can convert from GHTN without proteinuria if develops severe features

Severe Features
- Cerebral or visual changes — BP ≥ 160/110
- Pulmonary edema — Creat > 1.1 or 2 x pt's normal Creat
- LFTs 2x normal — Thrombocytopenia, platelets <100,000

Plan: Admit for Delivery. Magnesium sulfate in active labor with careful fluid management (3,000 cc Total Intake /24 hrs)
If < 34 weeks start steroids –see Guideline for details.
Low dose ASA with subsequent pregnancies

Chronic HTN with superimposed Pre-eclampsia

Management for pre-eclampsia as outlined above
Delivery:
> 37 weeks for superimposed pre-eclampsia
If severe features < 34 weeks start steroids –see Guideline for details.

Gestational HTN

Definition: BP ≥ 140/90 without proteinuria after 20 weeks
HTN does not persist beyond 12 weeks postpartum
Can convert to severe preeclampsia without proteinuria if develops severe features

Labs: Baseline – Cr, LFTs, CBC, Total P/Cr ratio

Management: Same as preeclampsia without severe features, except:
-obtain urine Preeclampsia screen q visit
-weekly NST/AFI

Ultrasound
- 20-22 weeks
- 28-32 weeks, then every 4 weeks

Monitoring
- Kick counts
- At 36 weeks start testing with NST/AFI weekly
- If FGR, then add Doppler q week

Prenatal visits: Every 4 weeks until 32 weeks, then every 2 weeks until 36 weeks, then weekly
Delivery: > 37 weeks

Addressograph	
