HYPERTENSION IN PREGNANCY

- In pregnancy, hypertension is defined as SBP ≥ 140, DBP ≥ 90 or both (140/90) measured on 2 occasions at least 6 hours apart
    - BP is measured on LEFT arm with patient sitting (not lying down)

- Complicates 6-8% of pregnancies, a leading cause of fetal morbidity and mortality
- Treat BP when > 160/110 for maternal benefit [see HTN treatment]

Four types:

1. Chronic HTN: preexisting hypertension present before 20 weeks gestation, persists more than 12 weeks postpartum
    - Mild ≥ 140/90
    - Severe ≥ 180/110
    - Women who have had HTN for several years should have baseline tests for ventricular hypertrophy, retinopathy and renal disease
    - At increased risk for preeclampsia
    - Fetal assessment includes watching for IUGR, if suspected order HCMC OBTU ultrasound and start weekly NST's

2. Gestational HTN (nonproteinuric HTN of pregnancy): elevation of BP after 20 weeks or closer to term, more likely to get preeclampsia; resolves by 6-12 weeks postpartum

3. Preeclampsia: HTN + proteinuria after 20 weeks [see Preeclampsia/Eclampsia]
    - Mild: 140-159/90-109 with ≥ 300 mg protein/24 hours (≤ 2+ proteinuria on cathed UA)
    - Severe: 160/110 with 3-4+ proteinuria, epigastric pain, oliguria or HELLP syndrome
    - Eclampsia: maternal seizure caused by preeclampsia

    - If preterm, consult HCMC OB/GYN regarding treatment and timing of delivery
    - If term, induce

    - BP normalizes by 6-12 weeks postpartum

4. Chronic hypertension with superimposed preeclampsia (a diagnostic challenge)
    - BP > 160/110
    - Proteinuria > 2000 mg (2g) protein/24 hours or proteinuria suddenly worsens
    - BP that was well controlled suddenly increases
    - Serum creatinine > 1.2 mg/dl

REFERENCES:
ACOG Practice Bulletin, Number 29, July 2001
NHBPEP Report on High Blood Pressure in Pregnancy 2000