

key points

SELECTED BY

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Pre-eclampsia is an important cause of maternal

morbidity and mortality. It is a multisystem disorder of pregnancy characterised by new onset hypertension after 20 weeks' gestation, usually accompanied by proteinuria. Women with either one high risk factor or two or more moderate risk factors for the development of pre-eclampsia should take 75-150 mg of aspirin daily from 12 weeks' gestation until delivery.

Women with chronic hypertension who are planning

a pregnancy should be investigated for secondary causes of hypertension prior to conception. As there is a potential risk of teratogenesis, women taking ACEi, ARB or diuretics should stop these medications within 2 days of confirmation of pregnancy. They should be offered a suitable alternative such as labetalol, nifedipine or methyldopa.

If a urine dipstick is positive for protein, the amount should

be quantified: a protein: creatinine ratio ≥ 30 mg/mmol is abnormal. There should be a high index of suspicion for pre-eclampsia if there is biochemical disturbance consistent with the diagnosis or evidence of fetal growth restriction when plotted on a customised growth chart.

Women with severe hypertension ($\geq 160/110$ mm Hg),

new onset hypertension with $\geq 1+$ proteinuria or any red flag symptoms should be referred for urgent obstetric review (within 4 hours). Women presenting with new isolated non severe hypertension or $\geq 1+$ proteinuria should be referred for obstetric review, ideally within 24 hours. Placental growth factor testing reduces the time to diagnosis of pre-eclampsia and the incidence of adverse maternal outcomes; NICE recommends using this as a one-off test between 20 and 35 weeks' gestation.

NICE recommends admitting women at high risk of

adverse events, those with severe hypertension or where there are other concerns for the wellbeing of the woman or baby. However, many units routinely admit all patients with pre-eclampsia because of concerns about rapid deterioration, specifically placental abruption, eclampsia and intracranial haemorrhage. NICE recommends antihypertensive therapy if blood pressure remains $\geq 140/90$ mmHg, with labetalol first line. Delivery is recommended if there are serious maternal or fetal concerns, or by 37 weeks' gestation.

On discharge from hospital, women who are taking

antihypertensive medication should have their blood pressure measured every 1-2 days for 2 weeks until it has normalised. Women should see their GP 2 weeks postnatally to assess the need for ongoing antihypertensive treatment. Blood pressure, urinary protein and blood results (if previously abnormal) should be reviewed by their GP or hospital specialist at 6-8 weeks after birth.