COMPLICATIONS OF PREGNANCY

HYPERTENSION IN PREGNANCY

GESTATIONAL HYPERTENSION AND PRE
ECLAMPSIA: MATERNAL FETAL ASSESSMENT
UNIT - QUICK REFERENCE GUIDE

This Quick Reference Guide must be used in conjunction with its respective evidence-based guideline [Hypertension in pregnancy - Medical management]. Medical and midwifery staff should be familiar with the contents of the full guideline.

CRITERIA FOR REFERRAL

Blood pressure ≥ 140/90mmHg on 2 occasions at least 30 minutes apart +/- proteinuria

ASSESSMENT

The multiple visit sheet (MR 226) is to be used each visit to record the assessment, any test results or treatments given and the plan of management.

1. Assess for the following signs and symptoms. Arrange review by obstetric registrar or above, if any of the following symptoms are present:
   - headache
   - visual disturbance
   - epigastric or right upper quadrant pain
   - significant oedema
   - hyper-reflexia / clonus
   - Intrauterine growth restriction

2. Check the BP 4 times at 15-minute intervals (use K5 disappearance of sounds) and calculate the average BP.
   Note: Inform the obstetric registrar immediately if a woman has two BP recordings of ≥160mmHg systolic or > 105mmHg diastolic.

3. Obtain a blood sample for:
   - Biochemistry – creatinine and electrolytes, uric acid, LDH, ALT, AST
   - FBP
   - Blood

4. Obtain an MSU for urinalysis sending a sample to Biochemistry for a spot protein: creatinine ratio where there is proteinuria of +1 or +2. Proteinuria of magnitude +3 or +4 on dipstick is always abnormal and no laboratory confirmation is required.

5. If the woman’s gestation is ≥ 30 weeks perform a CTG and ultrasound.

   If the woman is < 30 weeks gestation, arrange an USS only.
6. Arrange **ultrasound assessment** of fetal well-being as follows:
   - First visit - fetal biometry, amniotic fluid index (AFI) and umbilical artery (UA) Doppler studies
   - Subsequent visits – weekly fetal wellbeing assessment, including AFI and UA Doppler and fetal

7. Follow flow chart on page 3 for Assessment of Gestational Hypertension and Pre-eclampsia.

8. New proteinuria of > +2 on dipstick with hypertension in late pregnancy is a sign of severity requiring hospital admission for observation, irrespective of any other test results.

9. IUGR with new hypertension is also an indication for hospital admission and usually reflects severe placental vascular disease.

FLOW CHART ON PAGE 3
FLOW CHART FOR THE MANAGEMENT OF GESTATIONAL HYPERTENSION AND PRE-ECLAMPSIA

Woman presents to Maternal Fetal Assessment unit with suspected Gestational Hypertension or Pre-Eclampsia

Midwife/ Resident performs the assessment and establishes mean BP as outlined in the Quick Reference Guide

Mean BP ≤ 140/90 mm of Hg and <1+ proteinuria or <25g/L protein creatinine ratio

USS +/- CTG

Notify Obstetric Registrar and return to routine antenatal care with referring team or clinic

Mean BP ≤ 140/90 mm of Hg and >1+ proteinuria or >25g/L Protein/Creatinine ratio

USS +/- CTG

Obstetric registrar review (can be discharged by level 1 registrar or above)

Mean BP 140-160/ 90-99 mm of Hg and >1+ proteinuria or >25g/L protein/creatinine ratio

USS +/- CTG

Mean BP ≥160/100mm of Hg and >1+ proteinuria or >25 g/L protein/Creatinine ratio

USS +/- CTG

Review by obstetric registrar. Management to be discussed with senior registrar or consultant

Are blood results and fetal well-being assessments normal?

YES

Obstetric registrar review. If admission is not arranged, the woman’s management must be discussed with senior registrar or consultant

NO

Review by obstetric registrar. Management to be discussed with senior registrar or consultant

All guidelines should be read in conjunction with the Disclaimer at the beginning of this manual
REFERENCES (STANDARDS)

National Standards – 1 Clinical Care is Guided by Current Best Practice

Legislation - Nil

Related Policies – Nil

Other related documents – B.2.2.1 Medical Management of Hypertension in Pregnancy

RESPONSIBILITY

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Initial Endorsement

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