PRE-ECLAMPSIA (SEVERE EARLY ONSET): MANAGEMENT POST DELIVERY

Keywords: Pre-eclampsia, postpartum pre-eclampsia, management after pre-eclampsia

MANAGEMENT

- Women who give birth with severe pre-eclampsia (or eclampsia) should have continued close observation postnatally.\(^1\) As eclampsia has been reported up to 10 days postnatally, the optimum length of inpatient postnatal stay is unclear but the incidence of eclampsia is extremely low - no more than one in 30,000 pregnancies after the fourth postpartum day.\(^3\)

- After delivery, patients with eclampsia should receive close monitoring of vital signs, fluid intake and output, and symptoms for at least 48 hours.\(^2\) These women may have received large amounts of intravenous fluids during labour, delivery, and postpartum. In addition, during the postpartum period there is mobilisation of extracellular fluid leading to increased intravascular volume. As a result, women with severe pre-eclampsia / eclampsia, particularly those with abnormal renal function or oliguria, are at increased risk for pulmonary oedema, adult respiratory distress syndrome,\(^2\) and exacerbation of severe hypertension postpartum.\(^4\) Additionally, often one to two days after the birth the woman’s thrombocytopaenia and liver enzyme elevations worsen before improving.\(^1\)

- The decision about discharge from hospital needs to take account of the risk of late seizures. Most women with severe pre-eclampsia or eclampsia will need inpatient care for 4 days or more following delivery. Clinicians should be aware that up to 45% of eclampsia occurs postpartum, especially at term, so women with signs or symptoms compatible with pre-eclampsia should be carefully assessed. Careful review to ensure improving clinical signs is needed before discharge.\(^3\)

- Women whose pregnancies have been complicated by severe pre-eclampsia or eclampsia should be offered a formal postnatal review to discuss the events of the pregnancy.

- Preconception counselling should be offered where the events that occurred, any risk factors and any preventative therapies can be discussed.\(^1,\)\(^3\)

POST PARTUM INVESTIGATION

An assessment of blood pressure and proteinuria by the general practitioner at the 6 weeks postnatal review is recommended. If hypertension or proteinuria persists then further investigation is recommended.\(^1,\)\(^3\)

DISCHARGE INFORMATION FOR THE GENERAL PRACTITIONER

Discharge advice/information for the General Practitioner (GP) should include:

- Blood pressure monitoring frequency following discharge
- Referral to KEMH for preconception counselling\(^1,\)\(^5\)
- Early referral to KEMH if pregnant.\(^5\)

BLOOD PRESSURE FOLLOW-UP

1. Regular blood pressure monitoring for 3 months postpartum.
2. If the woman is still hypertensive after 3 months postpartum the woman should have the appropriate investigations to exclude underlying causes of the hypertension.\(^1\)
3. Automated instruments for blood pressure measurement are generally not validated for use during pregnancy and pre-eclampsia. Therefore, the use of mercury sphygmomanometers remains preferable. If used, automated instruments require the calibration to be checked regularly.\(^5\)
SCREENING TESTS

1. Test women who have had pre-eclampsia, once in 6 months for hyperlipidaemia and then once every 5-8 years if normal.
2. Screen for diabetes every 5 years.

REFERRAL TO KEMH FOR PRE-CONCEPTION COUNSELLING
Discharge information for the GP should include advice to refer the woman to KEMH for pre-conception counselling if she is planning a future pregnancy.

REFERRAL TO KEMH DURING A FUTURE PREGNANCY
Discharge information for the GP should include advice to arrange early referral to KEMH if the woman becomes pregnant.

LIFE STYLE CHANGES
Encourage women to achieve ideal BMI prior to another pregnancy.

COUNSELLING WOMEN POST PARTUM
Prior to discharge also include discussion about:

- Blood pressure monitoring management with the GP
- Management for a future pregnancy including recommended pre-conception counselling at KEMH
- Need for early pregnancy monitoring and referral to KEMH
- Maintenance of a normal BMI
- Importance of regular monitoring and management of medical conditions e.g. diabetes
- Significant risk factors of pre-eclampsia in following pregnancies.

See Clinical Guideline Section B 2.2.4.1 Pre-conception Counselling for Women with a History of Pre-eclampsia or Significant Risk Factors.

- The experience of severe pre-eclampsia, which may have overwhelmed or distressed the woman / her family, and psychological / family support should be offered as appropriate. The Department of Psychological Medicine at KEMH or an external organisation (such as patient advocacy organisation- Australasian Action on Pre-eclampsia) may be appropriate.
# REFERENCES / STANDARDS


---

**National Standards** – 1 - Care Provided by the Clinical Workforce is Guided by Current Best Practice
4 - Medication Safety
9 - Recognising and Responding to Clinical Deterioration in Acute Health Care

**Legislation** – *Poisons Act 1964*


**Other related documents** –
- KEMH Clinical Guidelines *Hypertension in Pregnancy: Pre-conception Counselling for Women with a History of Pre-eclampsia or Significant Risk Factors*.
- E-learning: *Global Voices: Pre-eclampsia and Eclampsia modules; K2 Pre-eclampsia*

---

**RESPONSIBILITY**

<table>
<thead>
<tr>
<th>Policy Sponsor</th>
<th>Medical Director OGCCU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initial Endorsement</td>
<td>April 2012</td>
</tr>
<tr>
<td>Last Reviewed</td>
<td>January 2015</td>
</tr>
<tr>
<td>Last Amended</td>
<td>January 2018</td>
</tr>
</tbody>
</table>

---

Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.