HYPERTENSION IN PREGNANCY

For background information see KEMH Clinical Guidelines Hypertension in Pregnancy and Blood Pressure Measuring

Clinical Assessment of New Onset Hypertension in the Community.

- Review maternal medical and obstetric history taken at the booking visit.

- Review previous antenatal BP readings, noting clinical warning signs indicative of possible pre-eclampsia\(^1\)\(^2\):
  
  a. A blood pressure that is not representative of normal physiological changes during the mid-trimester
  b. The appearance of 1+ or more proteinuria during the second half of pregnancy.
  c. Severe headaches.
  d. Problems with vision (e.g. blurring or flashing before eyes)
  e. Epigastric pain
  f. Vomiting
  g. Sudden onset oedema to face, hands or feet
  h. Reduced fetal movements

- Perform an abdominal palpation, noting the fundal height and fetal growth in relation to the current gestation. Auscultate the fetal heart rate.

- Document the findings of the assessment and management plan, including referral details.

Management of Severe Hypertension and/or Symptomatic Client.

1. Explain concerns to the client and reason for recommendation to transfer to hospital.

2. Contact the support maternity hospital or obstetrician immediately, discuss your concerns with the consultant on call and arrange immediate transfer (CMP guideline Transfer from Home to Hospital).

3. If transfer by ambulance is indicated, accompany the client in the ambulance and continue to monitor her BP.
Management of the Asymptomatic Client.

1. If the woman is asymptomatic, continue to assess BP and general wellbeing as described below.

2. Check BP half hourly X 4 for a BP profile and record each reading.

3. Determine the mean systolic and the mean diastolic reading.

4. Check the urine for presence of protein on urinalysis.

5. If 1+ or more of protein is present on urinalysis, collect a MSU to assess the Protein Creatinine Ratio and exclude urinary tract infection (following obstetric consultation and verbal order if required – 2 samples and 2 forms will be required to complete both tests as they are tested in different places in the laboratory).

6. Document all findings in the client records.

7. If the mean BP is elevated with or without proteinuria, consultation and/or referral to the support hospital must occur.

8. Contact the obstetric consultant or GP/obstetrician on call at the support hospital and discuss assessment and management.

9. Arrange transfer as per CMP guideline 9.1.1 Transfer from home to hospital.

10. Consider accompanying the client to hospital with all maternity records.

11. If unable to attend in person, provide a comprehensive verbal handover with medical practitioner accepting responsibility for this case and complete a Consultant Referral Form for the woman to take to hospital with her Pregnancy Health Record.

12. Arrange regular reviews at home if transfer is not required after consultation with the obstetrician. Ensure a comprehensive plan of management is documented. King Edward Memorial Hospital recommend twice weekly BP & urinanalysis checks for hypertension in pregnancy. If more frequent monitoring is required this should be communicated following consultant review.

13. Women referred for assessment but found to have normal BP and investigations should be followed up within 3-7 days as many will subsequently develop pre-eclampsia.

14. Reassess on each visit and consult with obstetric consultant or GP/obstetrician if concerned or condition changes.
Do not keep printed versions of guidelines as currency of information cannot be guaranteed. Access the current version from the WNHS website.