Eclampsia: Management

**Resuscitate**
- Ensure patent airway
- Oxygen – 10 L/min via mask
- IV access

**Control Blood Pressure**
- Aim for BP <160/100 mmHg

**Commence MgSO₄**
- Loading dose: 4 g IV over 20 minutes
- Maintenance dose: 1 g IV per hour

**Do not prescribe MgSO₄ before discussion with obstetric consultant**

**When woman is stable – deliver the baby**
- Continuous CTG while waiting for delivery
- Senior paediatric clinician to attend delivery

**Prevent further seizures**
- Continue MgSO₄ for 24 hours from birth or last seizure

**Before discontinuing MgSO₄, ensure**
- BP stable (consistently <150/100)
- Adequate diuresis
- Woman clinically improved, with no headache or epigastric pain

**Monitor for magnesium toxicity**
- MgSO₄ serum levels must be taken:
  - if there are signs of toxicity
  - for women with renal impairment and/or low urine output (<30 ml/hr)
- Serum levels may be taken 6-hourly during infusion

**Acute treatment**
**Do not allow BP to fall below 140/80**
- Nifedipine, maximum 40mg, oral
- Labetalol, 20–80mg, IV bolus over 2 minutes
- Hydralazine, 5–10mg, IV bolus over 5 minutes administered by a medical officer, or IM injection

**Fluid restriction**
- Nil by mouth
- 80 ml/hr IV crystalloid

**Observations**
- During loading dose:
  - 5-minute BP, pulse and respiratory rates
- At completion of loading dose, record BP, PR, RR and deep tendon reflexes
- During maintenance dose:
  - hourly BP, PR and RR
  - hourly urine output
  - hourly deep tendon reflexes
- Record strict fluid balance

**Signs of magnesium toxicity**
- Decreased deep tendon reflexes
- Respiratory rate <12 breaths per minute
- Reduced urine output: < 40mL/hr
- Serum magnesium concentration >3.5mmol/L

**Antidote for magnesium toxicity**
- 10% calcium gluconate 10 mL IV

**CALL FOR HELP Code or MET Call**

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