Hypertension ≥ 20 weeks: Assessment and management

**Indications for immediate delivery**

- **Maternal**
  - Inability to control hypertension
  - Deteriorating biochemistry
  - Placental abruption
  - Persistent neurological symptoms
  - Persistent epigastric pain, nausea or vomiting
  - Concerns about fetal wellbeing

- **Fetal**
  - Severe fetal growth restriction
  - Abnormal CTG requiring immediate delivery

**Systolic BP >140 mmHg**

**Urgent admission**

- Severe hypertension
- Headache
- Epigastric pain
- Oliguria
- Nausea and vomiting
- Concerns about fetal wellbeing

**Severe Hypertension**

- Systolic BP ≥170 mmHg
- Diastolic BP ≥110 mmHg

**Admit to Hospital for Acute Treatment**

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

**Fluid restriction**

- Nil by mouth
- 80 ml/hr IV crystalloid

**Mild-moderate hypertension**

- 160–170/100–110 mmHg
- Antihypertensive therapy essential

**Ongoing treatment with antihypertensive medication**

- Aim for BP <150/100
- First line agents:
  - Labetalol 100–400 mg TDS
  - Methyldopa 250–750 mg TDS

**Antenatal care – aim for BP <150/100**

- Individualise schedule of antenatal visits
- BP monitoring as clinically indicated
- Routine CTG not indicated
- 28–30 weeks US for growth
- 30–32 weeks US for growth