Pre-eclampsia: Assessment and management

Suspected pre-eclampsia
Woman to attend hospital

Management

Assessment

• History: headache, visual disturbances, epigastric or right upper quadrant pain
• Vital signs: BP, pulse, respiratory rate, temperature
• General examination: abdominal palpation, reflexes, clonus

Investigations
• Spot urine protein:creatinine ratio
• Mid-stream urine
• FBE
• UEC
• LFT
• Uric acid

Fetal assessment
• CTG if >28 weeks
• US for biometry, AFI, Doppler studies, biophysical profile
• SFH and/or EFW

Ongoing inpatient care
Aim for BP <150/100
• Control severe hypertension
• Optimise fluid status
• Correct coagulopathy
• Administer corticosteroids
• Consider MgSO4
• Daily CTG

Outpatient monitoring may be appropriate if BP is stable, pending obstetric advice
Perform the following as clinically indicated
• CTG
• Antenatal clinic visits
• Blood & urine tests
• US for AFI/Doppler & growth

Severe early-onset pre-eclampsia
Service Levels 1–5
Consult with PIPER 1300 137 650 to organise transfer to a Level 6 service

Birth is indicated if
• Inability to control hypertension
• Deteriorating organ function
• Eclampsia
• Pulmonary oedema
• Non-reassuring fetal status

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

< 37 weeks
• Control blood pressure
  • Aim for BP <160/100 mmHg

≥ 37+0 weeks
• Birth is indicated
• Control blood pressure
  • Aim for BP <160/100 mmHg

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to organise transfer to a Level 6 service

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