Hypertension in pregnancy: gestational hypertension – antenatal care

Assessment in secondary care

- Arrange for a healthcare professional trained in the management of hypertensive disorders of pregnancy to assess the woman.
- Take into account previous history of pre-eclampsia or gestational hypertension, pre-existing vascular or kidney disease, risk factors for pre-eclampsia (for example, nulliparity, age 40 years or over, pregnancy interval more than 10 years, family history of pre-eclampsia, multi-fetal pregnancy, BMI 35 kg/m^2 or more) and gestational age at presentation.

Factor	Hypertension: BP 140/90 to 159/109 mmHg	Severe hypertension: BP of 160/110 mmHg or more
Admission to hospital	Do not routinely admit to hospital	Admit, but if BP falls below 160/110 mmHg then manage as for hypertension
Antihypertensive pharmacological treatment	Offer pharmacological treatment if BP remains over 140/90 mmHg	Offer pharmacological treatment to all women
Target BP on antihypertensive treatment	Aim for BP of 135/85 mmHg or less	Aim for BP of 135/85 mmHg or less
BP measurement	Once or twice a week (depending on BP) until BP is 135/85 mmHg or less	Every 15 to 30 minutes until BP is less than 160/110 mmHg
Dipstick proteinuria testing	Once or twice a week (with BP measurement)	Daily while admitted
Blood tests	Measure full blood count, liver function and renal function at presentation and then weekly	Measure full blood count, liver function and renal function at presentation and then weekly
Placental growth factor (PlGF)-based testing	Carry out PlGF-based testing on 1 occasion (NICE diagnostic guidance DG49) if there is suspicion of pre-eclampsia	Carry out PlGF-based testing on 1 occasion (NICE diagnostic guidance DG49) if there is suspicion of pre-eclampsia
Fetal heart auscultation	Offer fetal heart auscultation at every antenatal appointment	Offer fetal heart auscultation at every antenatal appointment
Fetal ultrasound	Carry out ultrasound assessment of the fetus at diagnosis and, if normal, repeat every 2 to 4 weeks, if clinically indicated	Carry out ultrasound assessment of the fetus at diagnosis and, if normal, repeat every 2 weeks, if severe hypertension persists
Cardiotocography (CTG)	Carry out a CTG only if clinically indicated	Carry out a CTG at diagnosis and then only if clinically indicated

NICE National Institute for Health and Care Excellence

Hypertension in pregnancy: gestational hypertension – antenatal care (continued)

Antihypertensive treatment

Use labetalol, nifedipine or methyldopa. Base the choice on any pre-existing treatment, side-effect profiles, risks (including fetal effects) and the woman's preference.

Mode of birth

Choose mode of birth according to clinical circumstances and a woman's preference.

Timing of birth

- Do not offer planned early birth before 37 weeks unless there are other medical indications.
- After 37 weeks, timing of and maternal and fetal indications for birth should be agreed between woman and senior obstetrician.
- If planned early birth offer antenatal corticosteroids and magnesium sulfate if indicated, in line with the NICE guideline on preterm labour and birth.

Nifedipine: at the time of publication (June 2019), some brands of nifedipine were specifically contraindicated during pregnancy by the manufacturer in its summary of product characteristics (SPC). Refer to the individual SPCs for each preparation of nifedipine for further details.

NICE National Institute for Health and Care Excellence