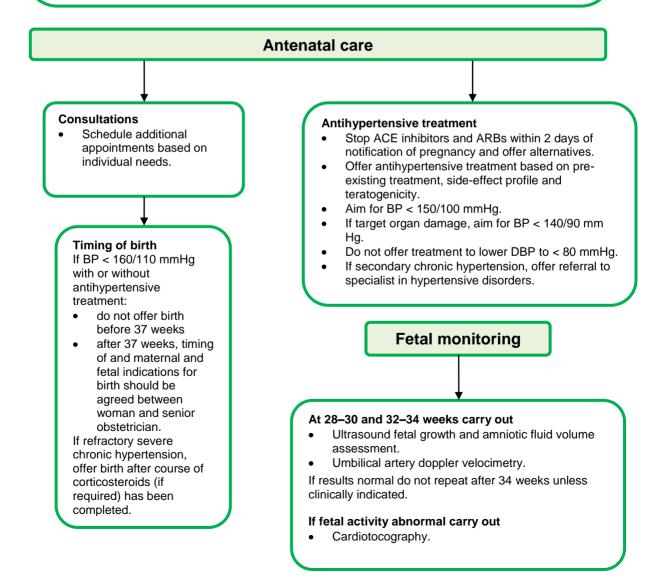
Antihypertensive treatment

Tell women who are taking ACE inhibitors, ARBs or chlorothiazide:

- there is an increased risk of congenital abnormalities if ACE inhibitors or ARBs are taken during pregnancy
- there may be an increased risk of congenital abnormalities and neonatal complications if chlorothiazide is taken during pregnancy
- limited evidence shows no increased risk of congenital abnormalities with other antihypertensive treatments
- to discuss other antihypertensive treatments with the healthcare professional responsible for managing their hypertension, if they are planning pregnancy.

Dietary sodium

• Encourage the woman to lower dietary sodium intake or use sodium substitute. [This recommendation is adapted from 'Hypertension: management of hypertension in adults in primary care' (NICE clinical guideline 34)^{3;4}].



Intrapartum care

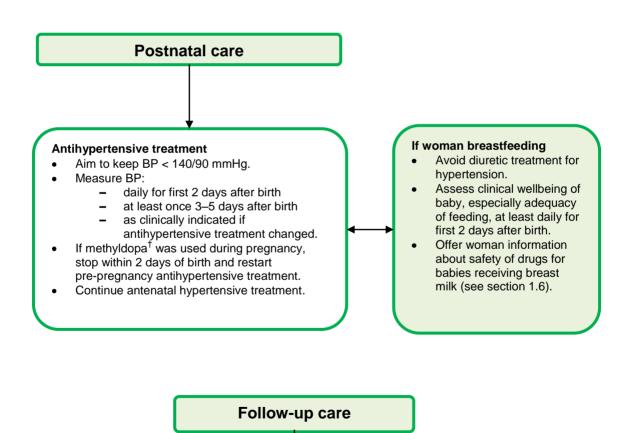
Mild or moderate hypertension (BP \leq 159/109 mmHg)

- Continue antenatal antihypertensive treatment.
- Measure BP hourly.
- Carry out haematological and biochemical monitoring according to criteria from antenatal period, even if regional analgesia being considered.
- If BP stable do not routinely limit duration of second stage.

Severe hypertension

(BP ≥ 160/110 mmHg)

- Continue antenatal antihypertensive treatment.
- Measure BP continually.
- If BP controlled within target ranges do not routinely limit duration of second stage.
- If BP does not respond to initial treatment advise operative birth.



- Review long-term treatment 2 weeks after birth,
- Offer medical review at 6–8 week postnatal review with pre-pregnancy care team.

† See section 1.6 for contraindications and special warnings during pregnancy and lactation.