Pre-pregnancy advice

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]].

Antenatal care

Consultations

- Schedule additional appointments based on individual needs.

Timing of birth

If BP < 160/110 mmHg with or without antihypertensive treatment:

- do not offer birth before 37 weeks
- after 37 weeks, timing of and maternal and fetal indications for birth should be agreed between woman and senior obstetrician.

If refractory severe chronic hypertension, offer birth after course of corticosteroids (if required) has been completed.

Antihypertensive treatment

- Stop ACE inhibitors and ARBs within 2 days of notification of pregnancy and offer alternatives.
- Offer antihypertensive treatment based on pre-existing treatment, side-effect profile and teratogenicity.
- Aim for BP < 150/100 mmHg.
- If target organ damage, aim for BP < 140/90 mm Hg.
- Do not offer treatment to lower DBP to < 80 mmHg.
- If secondary chronic hypertension, offer referral to specialist in hypertensive disorders.

Fetal monitoring

At 28–30 and 32–34 weeks carry out

- Ultrasound fetal growth and amniotic fluid volume assessment.
- Umbilical artery doppler velocimetry.

If results normal do not repeat after 34 weeks unless clinically indicated.

If fetal activity abnormal carry out

- Cardiotocography.

Intrapartum care

Mild or moderate hypertension (BP ≤ 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.

Postnatal care

Antihypertensive treatment

- Aim to keep BP < 140/90 mmHg.
- Measure BP:
  - daily for first 2 days after birth
  - at least once 3–5 days after birth
  - as clinically indicated if antihypertensive treatment changed.
- If methyldopa† was used during pregnancy, stop within 2 days of birth and restart pre-pregnancy antihypertensive treatment.
- Continue antenatal hypertensive treatment.

If woman breastfeeding

- Avoid diuretic treatment for hypertension.
- Assess clinical wellbeing of baby, especially adequacy of feeding, at least daily for first 2 days after birth.
- Offer woman information about safety of drugs for babies receiving breast milk (see section 1.6).

Follow-up care

- 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.