HYPERTENSION IN PREGNANCY

Hypertension in Pregnancy: Postpartum Management

SUMMARY: Preeclampsia and eclampsia can present up to 4 weeks after delivery. Appropriate recognition and management of severe hypertension is essential for risk reduction and safe clinical outcomes for women with hypertensive disorders of pregnancy.

**Rationale:** In women with gestational hypertension, preeclampsia or superimposed preeclampsia, blood pressure usually decreases in the first 48 hours following delivery. This is followed by a rise seen 3-6 days postpartum. Some of these patients will require oral agents for the treatment of hypertension and others can be managed with close observation only. Patients may also have new onset preeclampsia or superimposed preeclampsia in the postpartum period and will require care consistent with antepartum evaluation and management discussed elsewhere, including magnesium seizure prophylaxis.

**Diagnostic Criteria:** Persistent systolic blood pressure greater than or equal to 150 mm Hg or diastolic blood pressure greater than or equal to 100 mm Hg diastolic measured on 2 occasions at least 4-6 hours apart.

**Eligible patients:** Any delivered patient with diagnosis of gestational hypertension, preeclampsia, or superimposed preeclampsia.

**Contraindications:** New diagnosis of hypertensive disorder occurring postpartum. See antepartum evaluation and management discussed elsewhere, including potential utility of magnesium seizure prophylaxis.

**Recommendations for Management:**

1. Any woman with a diagnosis of gestational hypertension, preeclampsia, or superimposed preeclampsia, BP should be monitored in the hospital or an equivalent outpatient setting for at least 72 hours postpartum and again 7-10 days after delivery or earlier in those with concerning symptoms.
2. In the postpartum period, the threshold for initiating oral blood pressure treatment is a persistent systolic blood pressure greater than or equal to 150 mm Hg or diastolic blood pressure greater than or equal to 100 mm Hg diastolic measured on 2 occasions at least 4-6 hours apart.
3. Persistent systolic BP of 160 mm Hg or greater or diastolic BP of 100 mm Hg or greater should be treated within 1 hour. IV treatment should be used if needed, and appropriate oral pharmacologic therapy includes labetalol, nifedipine, or methyldopa, though labetalol and nifedipine are preferred. For more information on medication regimens, see the additional toolbox document entitled “Hypertension in Pregnancy: Antepartum and Intrapartum Blood Pressure Management”
Special Considerations:

Nonsteroidal anti-inflammatory agents are associated with increased BP and should be avoided in postpartum women with BP elevations persisting more than 1 day postpartum.

References:


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