EMERGENCY ACTION CARD

retrieve
Adult Critical Care Transfer Service

Obstetrics: Hypertension in Pregnancy

v1.1

See Hypertension EAC for non-pregnant patients

START: IMMEDIATELY NOTIFY DRIVER, STOP SAFELY

❶ **Immediate actions**
- Follow Key Basic Plan
- Deliver 100% oxygen

❷ **Confirm diagnosis (Box B) and examine for signs of pre-eclampsia**
- Severe headache, visual disturbance
- Epigastric tenderness, oedema, clonus, hyperreflexia

❸ **Treat hypertension (Box C)**
- Start IV labetalol unless still at referring hospital

❹ **Fluid restrict to 80ml/hr (or 1ml/kg/hr)**

❺ **Monitor BP every 15 minutes**

❻ **Next steps**
- Consider arterial blood gas
- Key Basic Plan
- Inform receiving hospital Central Delivery Suite and obstetrician

Box A: CRITICAL CHANGES

- If problem worsens significantly, or a new problem arises, go back to START of Key Basic Plan
- If Transfer Practitioner or Transfer Doctor transfer, contact Remote Duty Consultant
- Consider contacting Leadership SPOC for support, if required

Box B: PHYSIOLOGICAL PARAMETERS

- **Target BP** <135/85mmHg (≤150/80-100mmHg if in labour)
- **Target SpO_2** >95%
- Degrees of hypertension in pregnancy:
  - Mild/moderate: 140-159/90-109mmHg
  - Severe: ≥160/110mmHg

Box C: DRUGS FOR HYPERTENSION IN PREGNANCY

- First line: labetalol 200mg PO
- Second line: nifedipine 10mg PO
- **Third line (and when in transfer):** IV labetalol (see Box D)
- Fourth line: IV hydralazine

Box D: IV LABETALOL FOR HYPERTENSION IN PREGNANCY

Loading dose (IV):
- 50 mg (10mls of 5mg/ml neat solution) over at least 1 min – BP should fall below threshold within 5 mins
- Repeat at 15 mins intervals to a max dose of 200mg until BP controlled

Maintenance dose (IV infusion):
- Infusion 4ml/hr (5mg/ml neat solution)
- Double every 30 mins to a max of 32 ml/hr (160mg) until BP is controlled
- Titrate to keep SBP 140-150mmHg DBP 90-100 mmHg