The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

COMMITTEE OPINION SUMMARY

Number 692 • April 2017 *(Replaces Committee Opinion No. 623, February 2015)*

For a comprehensive overview of these recommendations, the full-text version of this Committee Opinion is available at http://dx.doi.org/10.1097/AOG.0000000000002019.

Scan this QR code with your smartphone to view the full-text version of this Committee Opinion.

Committee on Obstetric Practice

This Committee Opinion was developed by the American College of Obstetricians and Gynecologists' Committee on Obstetric Practice in collaboration with committee members Yasser Y. El-Sayed, MD, and Ann E. Borders, MD, MSc, MPH.

This document reflects emerging clinical and scientific advances as of the date issued and is subject to change. The information should not be construed as dictating an exclusive course of treatment or procedure to be followed.

Emergent Therapy for Acute-Onset, Severe Hypertension During Pregnancy and the Postpartum Period

ABSTRACT: Acute-onset, severe systolic hypertension; severe diastolic hypertension; or both can occur during the prenatal, intrapartum, or postpartum periods. Pregnant women or women in the postpartum period with acute-onset, severe systolic hypertension; severe diastolic hypertension; or both require urgent antihypertensive therapy. Introducing standardized, evidence-based clinical guidelines for the management of patients with preeclampsia and eclampsia has been demonstrated to reduce the incidence of adverse maternal outcomes. Individuals and institutions should have mechanisms in place to initiate the prompt administration of medication when a patient presents with a hypertensive emergency. Treatment with first-line agents should be expeditious and occur as soon as possible within 30–60 minutes of confirmed severe hypertension to reduce the risk of maternal stroke. Intravenous labetalol and hydralazine have long been considered first-line medications for the management of acute-onset, severe hypertension in pregnant women and women in the postpartum period. Although relatively less information currently exists for the use of calcium channel blockers for this clinical indication, the available evidence suggests that immediate release oral nifedipine also may be considered as a first-line therapy, particularly when intravenous access is not available. In the rare circumstance that intravenous bolus labetalol, hydralazine, or immediate release oral nifedipine fails to relieve acute-onset, severe hypertension and is given in successive appropriate doses, emergent consultation with an anesthesiologist, maternal–fetal medicine subspecialist, or critical care subspecialist to discuss second-line intervention is recommended.

Recommendations and Conclusions

The American College of Obstetricians and Gynecologists makes the following recommendations and conclusions:

- Introducing standardized, evidence-based clinical guidelines for the management of patients with preeclampsia and eclampsia has been demonstrated to reduce the incidence of adverse maternal outcomes.
- Pregnant women or women in the postpartum period with acute-onset, severe systolic hypertension; severe diastolic hypertension; or both require urgent antihypertensive therapy.
- Close maternal and fetal monitoring by a physician and nursing staff are advised during the treatment of acute-onset, severe hypertension.

- After initial stabilization, the team should monitor blood pressure closely and institute maintenance therapy as needed.
- Intravenous (IV) labetalol and hydralazine have long been considered first-line medications for the management of acute-onset, severe hypertension in pregnant women and women in the postpartum period.
- Immediate release oral nifedipine also may be considered as a first-line therapy, particularly when IV access is not available.
- The use of IV labetalol, IV hydralazine, or immediate release oral nifedipine for the treatment of acute-onset, severe hypertension for pregnant or postpartum patients does not require cardiac monitoring.
- In the rare circumstance that IV bolus labetalol, hydralazine, or immediate release oral nifedipine fails to relieve acute-onset, severe hypertension and is given in successive appropriate doses, emergent consultation with an anesthesiologist, maternal–fetal medicine subspecialist, or critical care subspecialist to discuss second-line intervention is recommended.

The American College of Obstetricians and Gynecologists
409 12th Street, SW, PO Box 96920, Washington, DC 20090-6920

Official Citation
Emergent therapy for acute-onset, severe hypertension during pregnancy and the postpartum period. Committee Opinion No. 692. American College of Obstetricians and Gynecologists. Obstet Gynecol 2017:129:e90–5.