

# Acute Hypertension in Pregnancy & Postpartum Algorithm

Ask the patient:

**“Are you pregnant or have you been pregnant in the last 6 weeks?”**

If yes, these symptoms may be related to pregnancy and can occur up to 6 weeks postpartum.

≥20 weeks pregnant **OR** ≤6 weeks postpartum

**AND**

SBP ≥ 140 or DBP ≥ 90 (with normal BP previously):

- Monitor BP every 15 minutes for up to 4 hours
- Assess for signs/symptoms (**see Box 1**)
- Consider obtaining labs (**see Box 2**)

**NOTE: If at any time the SBP ≥ 160 or DBP ≥ 110, confirm in 15 minutes and then proceed directly to “Preeclampsia with severe features” box – do NOT wait to initiate therapy.**

## Box 1

### Potential Signs/Symptoms

- New-onset headache
- Visual disturbances
- RUQ or epigastric pain
- Shortness of breath; pulmonary edema
- Oliguria
- **If your pregnant or postpartum patient has hypertension and severe headache, consider STROKE.**



- SBP < 140 and DBP < 90
- Normal labs
- No symptoms

SBP 140–159 or DBP 90–109 persisting for 4 hours

**NOTE: If at any time during monitoring, the SBP ≥ 160 or DBP ≥ 110, confirm in 15 minutes and refer to “Preeclampsia with severe features” box – do NOT wait for 4 hours to initiate therapy.**

## Box 2

### Labs to Consider

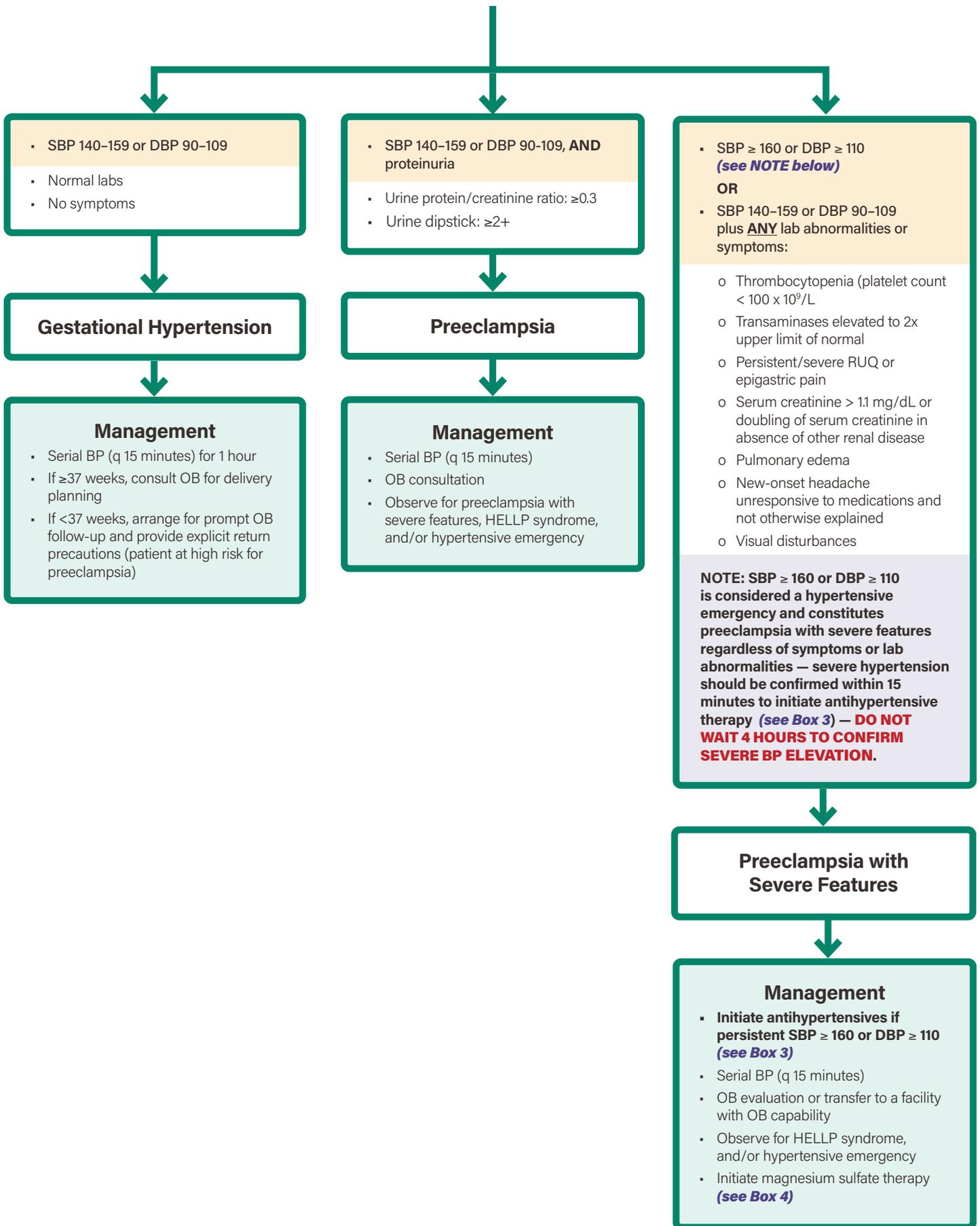
- CBC
- AST, ALT
- Serum creatinine
- Urine protein:
  - Urine protein/creatinine ratio
  - Urine dipstick if 24-hour urine protein or protein/creatinine ratio is not available

### Imaging to Consider

- Head CT if severe headache or any neurological symptoms

### “Normal”

- No acute treatment required
- Create plan for follow-up BP assessment and OB follow-up



Reference Boxes 3 & 4



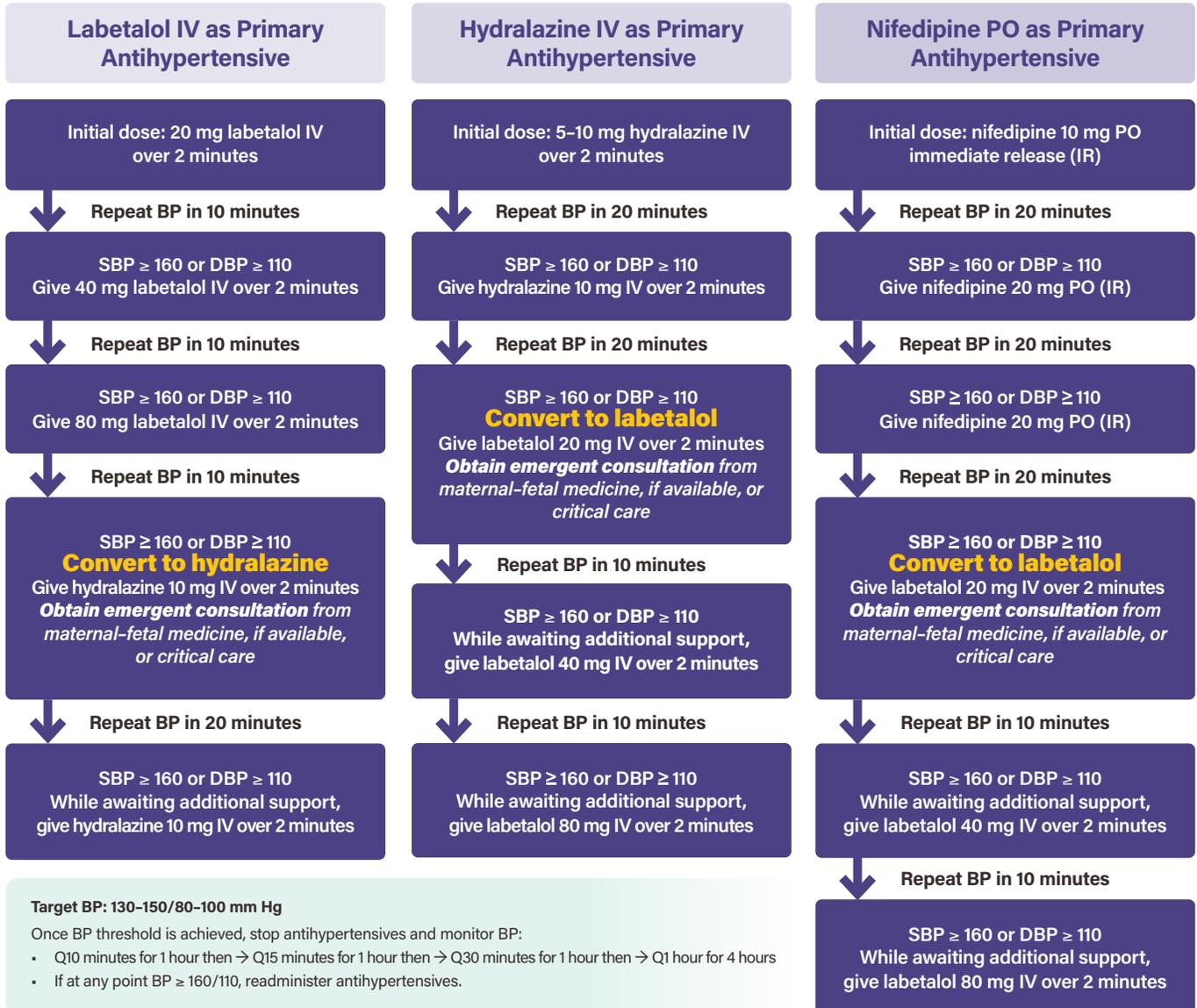
**Box 3**

**Treatment Recommendations for Sustained Systolic BP  $\geq$  160 mm Hg OR Diastolic BP  $\geq$  110 mm Hg\***

\*Antihypertensive treatment and magnesium sulfate should be administered simultaneously. If concurrent administration is not possible, antihypertensive treatment should be first priority.

**Management Considerations — Choose any of the three agents as primary antihypertensive but consider the following:**

- If no IV access initially, choose nifedipine.
- If the patient has a history of asthma **OR** is bradycardic, choose hydralazine or nifedipine as the initial agent.



Adapted from Druzin ML, Shields LE, Peterson NL, Sakowski C, Cape V, Morton CH. Improving Health Care Response to Hypertensive Disorders of Pregnancy, a California Maternal Quality Care Collaborative Quality Improvement Toolkit, 2021.

## Box 4



### Magnesium Sulfate Treatment

- Loading dose: 4–6 g IV over 20–30 minutes
- Maintenance dose: 1–2 g/h
- See Eclampsia Algorithm if IV access cannot be established or if patient has altered renal function
- Be aware of potential magnesium toxicity. For more information, see Eclampsia Algorithm.



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