SOMANZ

SOCIETY OF OBSTETRIC MEDICINE OF AUSTRALIA AND NEW ZEALAND

Target BP <160/110 (PP)^

Continuous fetal monitoring (CTG) and repeated maternal blood pressure monitoring (at least every 10-15 minutes) should be continued throughout treatment of acute (severe) hypertension (PP) The location of this needs to be based on local policy and expertise. Close monitoring and supervision needs to be undertaken until the establishment and maintenance of the identified target BP.

^ Target BP should be individualised particularly in the presence of features of fetal compromise

	Antihypertensives	Class of agent	Onset of action	Dose (Start from low dose and titrate as required)
FIRST LINE*	**Oral nifedipine (IR)	Calcium channel blocker	30-45 minutes	10-20mg every 30 minutes maximum of 45mg
	±†IV hydralazine	Vasodilator	15-20 minutes	5-10mg every 20 minutes maximum of 30 mg
	***±IV labetalol	Beta blocker	5 minutes	20-40mg every 10-15 minutes maximum of 80mg
	±IV diazoxide	Benzothiazide diuretic	3-5 minutes	15mg every 5-10 minutes
	#Oral methyldopa	Alpha blocker	30-120 minutes	1,000mg as a single dose
	#Oral labetalol	Beta blocker	30-120 minutes	200mg every hour to a maximum of 600mg

The use of the agents above for management of acute (severe) hypertension should be done concurrently with either commencing, supplementing or uptitrating regular antihypertensives (Flowchart 5.3) to avoid rebound acute (severe) hypertension

SECOND & THIRD LINE	Persistent or refractory severe hypertension may require repeated doses of these agents or even an intravenous infusion of labetalol 20-160 mg/hr† or hydralazine 10-20 mg/hr†, titrated to the blood pressure response (PP) Magnesium infusion should be initiated in refractory hypertension (≥160/110) or if features of cerebral irritation are present (irrespective of blood pressure) (Flowchart 6.7)

*The most important consideration in choice of antihypertensive agent is that the unit has access and familiarity with that agent. Agents should be uptitrated as indicated in the table and if target BP is not reached, second and third line treatment options should be employed.
**Supply and access maybe limited in Australia and New Zealand
± Administration of IV agents should be followed by a 10-20mls normal saline intravenous flush to ensure systemic circulation of the administered agent
Slower onset of action (up to 2 hours). Use can be individualised based on clinical setting (i.e.: in the absence of short acting agents)
† 250mls IV fluid preloading (normal saline 0.9%) should be considered to minimise the risk of hypotension (PP)