

Regional Management of Postnatal Hypertension for Obstetricians and GPs

At discharge:

- Ensure BP is <160/110, PET bloods (FBC, U's and E's, LFT'S) are normal or improving and the woman has no symptoms of pre-eclampsia. If preexisting hypertension or renal disease consult individualised plan to ensure safe and ready for discharge (including any outpatient follow up is planned)
- Obstetric team to document diagnosis, current medications and individualised plan to titrate antihypertensives in a discharge summary (Badgernet or letter). Ensure women have a copy.
- Discuss lifestyle factors, future cardiovascular risks and future pregnancy risks.
- The majority of postnatal BP checks can be done by women with SelfBP monitors. If not available, or not appropriate, BP check appointments should be made with a community midwife or scheduled care/maternity day assessment.
- Supply 2/52 worth of antihypertensives.
- Care can be shared between GPs and Obstetrics, but all women should have access to maternity services for BP management until 6 weeks postnatal.

Discharge to 6-8 week check-up:

- Women-led BP monitoring with Self-BP monitors if available.
- Use Tables below to guide treatment adjustments.

6-8 week GP check-up:

- Check BP and urine for all patients with pregnancy hypertension.
- If a woman remains hypertensive, consider conversion to a more appropriate agent, taking breastfeeding into account.
- If remains hypertensive at 6 weeks on urinalysis- send ACR at 3 months and refer to nephrology team if more than 30mgs/ mmol.

Lifestyle advice:

- Inform women that their risk of hypertension either in a future pregnancy, or outside of pregnancy is increased. Their risk of stroke and death from a cardiovascular disease is increased by 2 times.
- This risk can be minimised by maintaining a healthy weight and diet, stopping smoking and exercising regularly.
- Advise women to attend for a BP check with their GP at least once a year.

Future Pregnancies:

- Advise women to consult their GP prior to planning a future pregnancy if they are taking antihypertensive medication. Adjustments may need to be made.
- Prescribe Aspirin 150mg nocte from 12/40 in any future pregnancies unless contra-indicated.
- Women with complex hypertension should be referred for pre-pregnancy counselling (contact details TBC).

	Sys <100 and Dia <80	Sys 100-139 and Dia <90	Sys 140-159 Or Dia 90-110	Sys >159 Or Dia >110
Day 1-5	Medication may need to be reduced/omitted. Advise daily BP checking in case medication needs restarting.	Continue current medications.	Continue current medications.	An increase in medication is indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms and discuss with MDAU (/Maternity Triage) as appropriate
Day 7	Medication can be stopped. BP should be rechecked the next day. *	Medication can be reduced. If contacted for advice, down-titrate as per the treatment tables below. Advise patient to recheck BP on Day 14 or if having side-effects.	Continue current medications, recheck BP on Day 14 or if having side-effects.	An increase/change in medication is indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms and discuss with MDAU (/Maternity Triage) as appropriate
Day 14	Medication can be stopped. BP should be rechecked the next day. *	Medication can be stopped. BP should be rechecked the next day. *	Continue current medications, recheck BP on Day 21 or if having side-effects.	An increase/change in medication is indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms and discuss with MDAU (/Maternity Triage) as appropriate.
Day 21	Medication can be stopped. BP should be rechecked the next day. *	Medication can be stopped. BP should be rechecked the next day. *	Continue current medications, recheck BP on Day 28 or if having side-effects.	An increase/change in medication may be indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms. Most medication adjustments do not require re-admission unless: Severe headache Vomiting or epigastric pain Visual disturbance
Day 28	Medication can be stopped. BP should be rechecked the next day. *	Medication can be stopped. BP should be rechecked the next day. *	Continue current medications, recheck BP on Day 28 or if having side-effects.	An increase/change in medication may be indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms. Most medication adjustments do not require re-admission. unless: Severe headache Vomiting or epigastric pain Visual disturbance
Day 35	Medication can be stopped. BP should be rechecked the next day. *	Medication can be stopped. BP should be rechecked the next day. *	Continue current medications until you see your GP for your 6–8-week check-up.	An increase/change in medication may be indicated. If contacted for advice, up-titrate as per the treatment tables. Assess symptoms. Most medication adjustments do not require re-admission. unless: Severe headache Vomiting or epigastric pain Visual disturbance
*Day after stopping BP medication	Patient can remain off medication and does not need to recheck BP. Review at 6 -8-week GP check-up.	Patient can remain off medication and does not need to recheck BP. Review at 6–8-week GP check-up.	Medication should be restarted at the same dose. Advise patient to check their BP again in 1 week or if they have side-effects. Refer to the instructions above for further adjustments.	Restart medication at the same dose. Individualised plan regarding changes and re-checking BP.

Medication	Comment (all medications listed are safe breastfeeding – caution with labetalol if preterm infant)
Methyldopa	Stop within 48hrs of birth and convert to another antihypertensive if required.
Labetalol	Reduce/stop first in most cases if also on Nifedipine. Max. daily dose 2.4g If on >800mg daily, divide into 3-4 doses. Down-titration either by reducing frequency (not to below BD) or total dosage.
Nifedipine MR	Max. daily dose 40mg BD. Down-titrate by dosage- maintain BD dosing but reduce total dosage
Enalapril	Can be restarted postnatally for women who were taking (or were on another ACE-i) pre-pregnancy or started in difficult to control pregnancy hypertension. Only recommend if hypertension likely to persist for longer than 6 weeks Start at 5mg OD.
Amlodipine	Can be restarted postnatally if taking pre-pregnancy or started in difficult to control pregnancy hypertension. Start at 5mg OD. Do not give amlodipine and nifedipine concurrently