Wessex Maternal Medicine Network

Regional Management of Postnatal Hypertension for Obstetricians and GPs

At discharge:

- Ensure BP is <150/100, 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 hypertension persistent at 6 week check – send ACR in all cases.

- If ACR >30mg/mmol **and** non-visible haematuria present (i.e. dipstick +ve for blood) – refer to nephrology.
- If ACR >70mg/mmol – refer to nephrology in all cases.
- If there is ongoing concern about a patient but outside of these mandatory referral criteria, send Advice and Guidance request to nephrology for further discussion.

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 via WessexObstetricMedicine@uhs.nhs.uk).

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	Sys <100 and Dia <80	**Sys 100-129 and Dia <80**	**Sys 130-149 Or Dia 80-100**	**Sys >150 Or Dia >100**
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 35 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