this & that

03

OBSTETRIC QUICK GUIDES · IF THIS, THEN THAT

NO.



Hypertensive Disorders of Pregnancy

& pre-eclampsia and eclampsia

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Diagnosis & management

Verified against ACOG · SMFM · RCOG · SOGC — October 2026

Hypertensive disorders of pregnancy

At a glance: the numbers to remember

≥160/110	140/90	81 mg	4–6 g	37^{+0} · 34^{+0}
persisting ≥15 min → treat within 30–60 min	treat and target in chronic hypertension (CHAP)	aspirin daily from 12–16 wk until birth (ACOG)	$MgSO_4$ load, then 1–2 g/h to 24 h after birth	deliver: without vs with severe features

Where societies disagree, each position carries the society name; follow your local protocol. Doses are for singleton pregnancies unless stated. Creatinine 1.1 mg/dL ≈ 97 µmol/L.

01 Definitions and classification

Disorder	Criteria (ACOG PB 222 / 203)	Notes
Chronic hypertension	BP ≥140/90 before pregnancy or before 20 wk, or already on treatment	1–5% of pregnancies; superimposed pre-eclampsia in 20–50% (Maternal-Fetal EBG)
Gestational hypertension	New BP ≥140/90 on two readings ≥4 h apart after 20 wk, without proteinuria or organ dysfunction	Up to half progress to pre-eclampsia; about 50% if onset <30 wk or BP severe
Pre-eclampsia	Gestational hypertension plus proteinuria (≥300 mg/24 h, PCR ≥0.3 mg/mg, dipstick 2+ only if nothing else) **or** new organ dysfunction (below)	NICE: uPCR ≥30 mg/mmol or uACR ≥8 mg/mmol; also counts uteroplacental dysfunction (FGR). ISSHP adds angiogenic imbalance and drops the mild/severe labels
Severe features	SBP ≥160 or DBP ≥110 twice 4 h apart (sooner if treated) · platelets <100 × 10^9/L · creatinine >1.1 mg/dL or doubled · AST/ALT ≥2 × normal · severe persistent RUQ/epigastric pain · pulmonary oedema · new headache unresponsive to analgesia · visual disturbance	Massive proteinuria and FGR are **not** severe features (ACOG)
Superimposed pre-eclampsia	Chronic hypertension with new proteinuria, a sudden rise in proteinuria, or new organ dysfunction after 20 wk	ACOG: sudden BP escalation may suggest it. ISSHP: a BP rise alone is not enough
HELLP	LDH ≥600 IU/L · AST/ALT >2 × normal · platelets <100 × 10^9/L	15% have no hypertension and 13% no proteinuria; 28% present postpartum (Maternal-Fetal EBG)
Eclampsia	New generalised seizure in a woman with a hypertensive disorder, with no other cause	About 15% had no hypertension or proteinuria beforehand; 10–40% occur postpartum

Measure it right

- Seated, arm at heart level, after rest; cuff bladder covering ≥80% of the arm circumference; Korotkoff V for diastolic; validated device.
- Severe-range readings can be confirmed within minutes so treatment is not delayed.
- Dipstick ≥1+ → quantify with PCR or ACR (NICE). Uric acid does not help diagnosis or management.

02 Triage and diagnosis

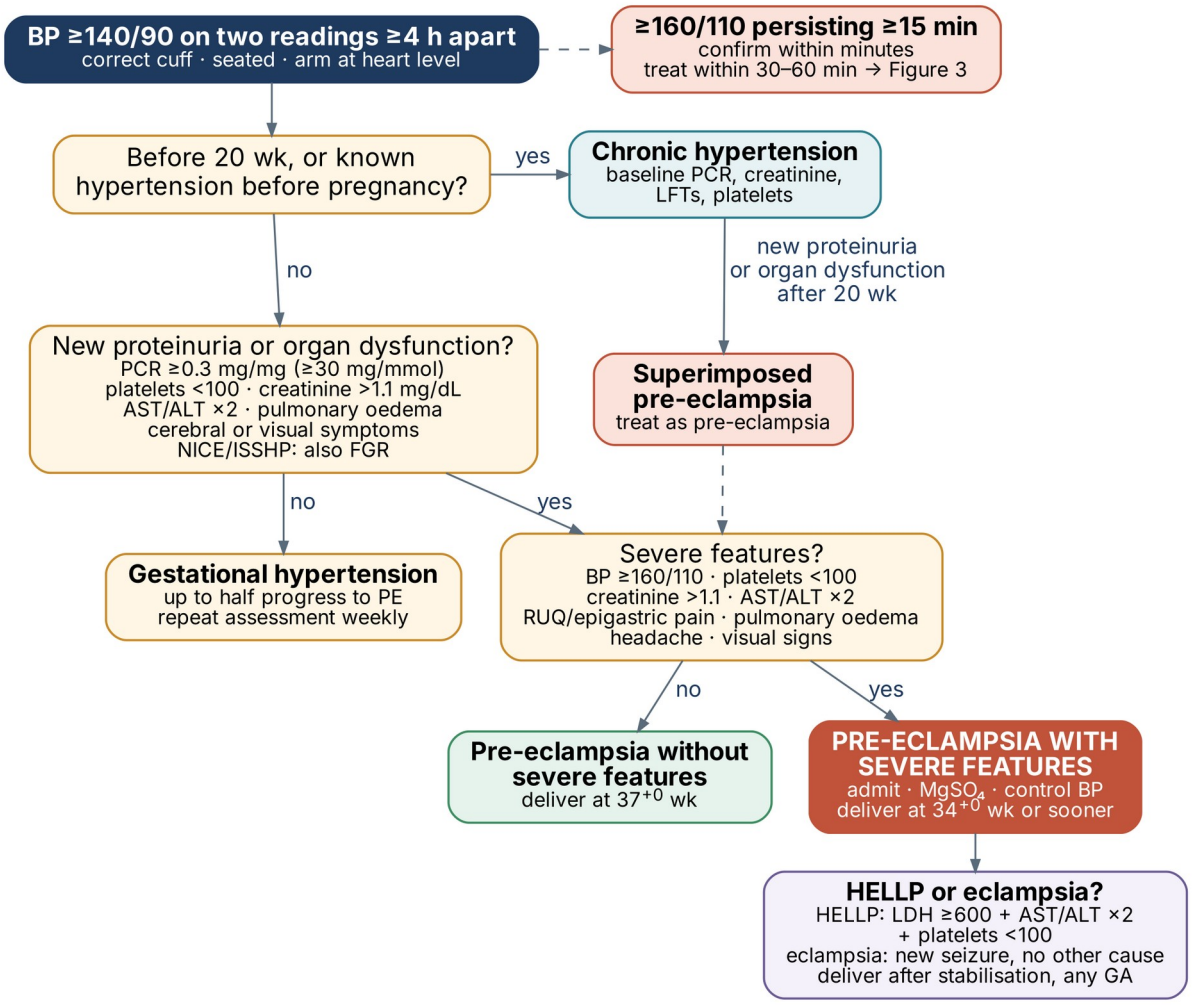


Figure 1. *Classifying a raised blood pressure in pregnancy.*

IF	THEN
New BP ≥140/90 after 20 wk	• Repeat after 4 h (ACOG); ask about headache, visual symptoms, epigastric pain, breathlessness • Bloods: platelets, creatinine, AST/ALT (LDH and film if HELLP suspected); urine PCR • CTG; ultrasound for growth, liquor and umbilical artery Doppler
Severe-range BP	Confirm within minutes, treat within 30–60 min (Section 4), admit, assess for severe features and start $MgSO_4$ if indicated.
Headache or visual symptoms, BP normal or only mildly raised	Do not dismiss: eclampsia can come before hypertension or proteinuria. Examine, check labs, observe.
RUQ pain, nausea, malaise	• Treat as HELLP until proven otherwise: FBC and film, LDH, LFTs, bilirubin, creatinine, coagulation • Differential: acute fatty liver, TTP/HUS, lupus flare, cholecystitis/pancreatitis

IF	THEN
Suspected preterm pre-eclampsia, diagnosis unclear	• NICE DG49 (20^{+0}–36^{+6} wk): one PlGF-based test alongside clinical assessment to help **rule out** pre-eclampsia; Elecsys sFlt-1/PlGF ≤38 rules out for 1 week; Triage PlGF ≥100 pg/mL is normal • ACOG 2024 update: FDA-cleared sFlt-1/PlGF ratio in admitted women with HDP at 23^{+0}–34^{+6} wk; ≥40 = high risk of severe features within 2 weeks (NPV about 96%) • An adjunct only: never the sole basis for diagnosis, discharge or timing of birth
Chronic hypertension at booking	Baseline PCR, creatinine, LFTs, platelets so that superimposed pre-eclampsia can be recognised later. ECG ± echo if long-standing or severe.

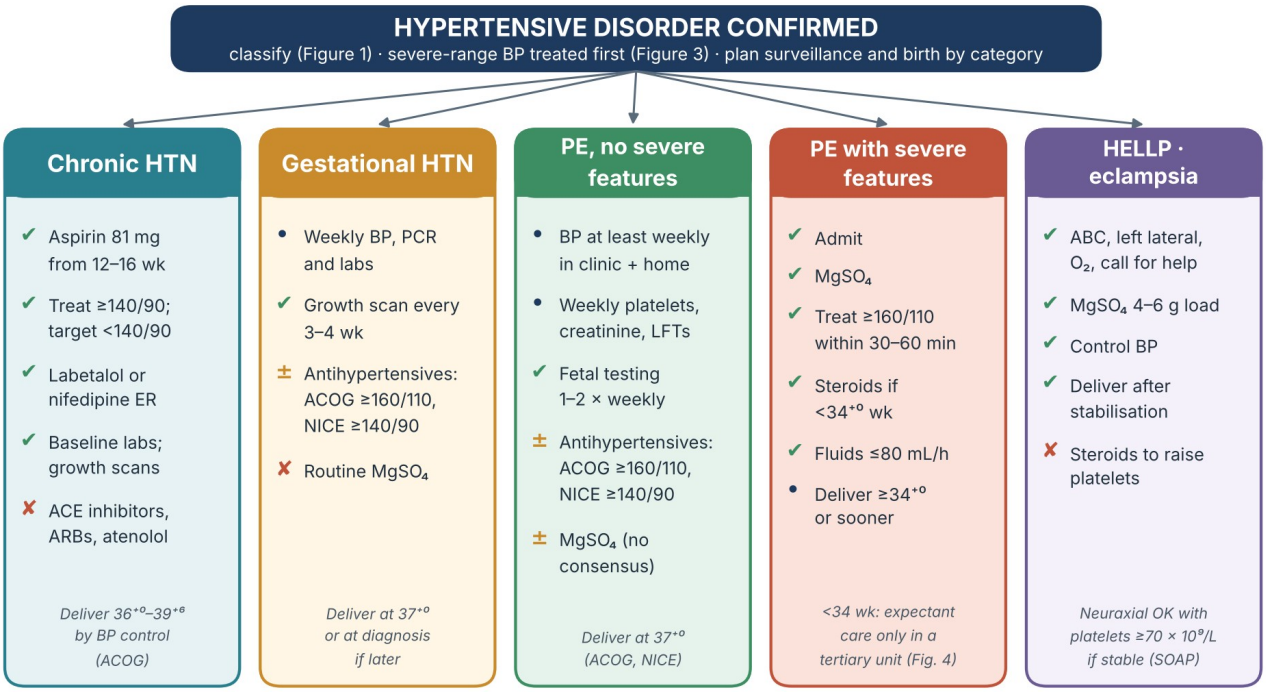


Figure 2. *Surveillance, treatment and birth by category of hypertensive disorder.*

03 Prevention: aspirin and calcium

IF	THEN
One high-risk factor	• **ACOG/USPSTF:** previous pre-eclampsia, multifetal pregnancy, chronic hypertension, type 1 or 2 diabetes, renal disease, autoimmune disease (SLE, APS) • **NICE:** hypertensive disease in a previous pregnancy, CKD, SLE/APS, type 1 or 2 diabetes, chronic hypertension • → Offer aspirin
Moderate-risk factors	• **ACOG (more than one):** nulliparity, BMI >30, mother or sister with pre-eclampsia, age ≥35, Black race or low income (as markers of social risk), previous SGA or adverse outcome, interval >10 years, IVF • **NICE (two or more):** nulliparity, age ≥40, interval >10 years, BMI ≥35, family history, multifetal pregnancy • ACOG: consider aspirin with a single moderate factor
First-trimester combined screening available	FIGO and ISSHP: maternal factors, MAP, uterine artery PI and PlGF at 11–14 wk; high risk ≥1 in 100 → aspirin 150 mg at night (ASPRE: preterm pre-eclampsia ↓62%).

IF	THEN
Pre-eclampsia already diagnosed	Aspirin does not treat it; no benefit from starting it after diagnosis.
On aspirin and needs neuraxial	Low-dose aspirin alone is not a contraindication (Obstetric EBG, SOAP).
Low dietary calcium	• **WHO:** 1.5–2 g elemental calcium daily in 3 doses with meals (low-intake populations) • **SOGC:** ≥500 mg/day if intake <900 mg/day · **ISSHP:** ≥500 mg/day if intake <600 mg/day • Pre-eclampsia ↓55% in the meta-analysis, mostly with low baseline intake; NICE and ACOG make no calcium recommendation
Other preventives	Do not offer vitamins C/E, diuretics, salt restriction, LMWH, fish oil, progesterone, nitric oxide donors or bed rest (NICE; Maternal-Fetal EBG).

Aspirin dose and timing

Society	Dose	Start	Stop
ACOG / SMFM / USPSTF	81 mg daily; 162 mg not endorsed (2026 RCT: no benefit, more abruptions)	12–28 wk, ideally before 16 wk	At birth
NICE	75–150 mg daily	From 12 wk	At birth
SOGC 426	81 or 162 mg at bedtime	Before 16 wk	By 36 wk
ISSHP / FIGO	150 mg at night after screening (ISSHP: 100–162 mg if risk is clinical; never <100 mg)	11–14 wk (before 16 wk)	36 wk, birth or diagnosis
WHO	75 mg daily	Before 20 wk	—

04 Acute severe hypertension

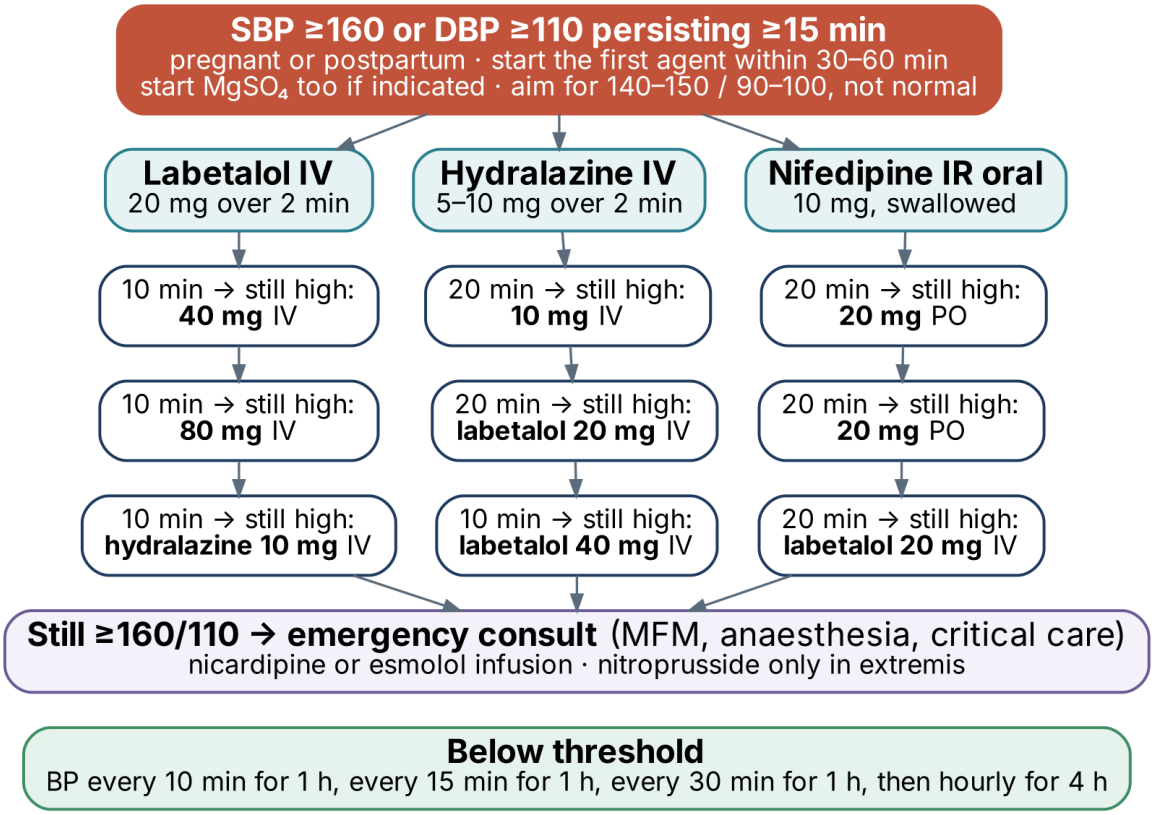


Figure 3. *ACOG order sets for severe hypertension in pregnancy and postpartum (CO 767).*

IF	THEN
SBP ≥160 or DBP ≥110 for ≥15 min	• Give a first-line agent within 30–60 min: **IV labetalol, IV hydralazine or oral immediate-release nifedipine** (ACOG); NICE lists the same three • Aim for 140–150 / 90–100 (ACOG). A precipitous fall can cause fetal compromise • Start $MgSO_4$ in parallel if indicated; it does not treat BP
No IV access	Nifedipine IR 10 mg orally, or **labetalol 200 mg orally**, repeated in 30 min if needed.
Asthma, heart failure, heart block or bradycardia	Avoid labetalol; use nifedipine or hydralazine.
Using hydralazine antenatally	NICE: consider up to 500 mL crystalloid before or with the first dose. Expect tachycardia and headache.
Cumulative doses	IV labetalol up to 300 mg; hydralazine 20 mg before switching (ACOG PB 222 table).
Nifedipine with $MgSO_4$	Can be used together; rare neuromuscular blockade reverses with calcium gluconate.
Still ≥160/110 after the full sequence	Emergency MFM, anaesthesia and critical care input: nicardipine or esmolol infusion; nitroprusside only in extremis and briefly.
Postpartum severe BP	Same thresholds, same drugs, same 30–60 min target.

Oral maintenance agents

Agent	Regimen	Avoid if	Watch for
Labetalol	100–200 mg PO twice daily; up to 2400 mg/day in 2–3 doses	Asthma, heart failure, heart block	Bradycardia, fatigue, bronchospasm; rare transaminase rise that can mimic HELLP
Nifedipine ER	30–60 mg once daily; up to 120 mg/day	Use ER, not IR, for maintenance	Headache, flushing, ankle oedema, tachycardia
Methyldopa	250 mg 2–3 times daily; up to 3 g/day	Liver disease, depression	Sedation, low mood; stop within 2 days of birth (NICE)
Hydrochlorothiazide	12.5–50 mg daily (second or third line)	Pre-eclampsia, FGR	Hypokalaemia
ACE inhibitors, ARBs, atenolol, renin inhibitors	Contraindicated in pregnancy	—	Fetopathy (renal failure, oligohydramnios); atenolol and FGR

05 Magnesium sulphate and eclampsia

IF	THEN
Pre-eclampsia with severe features, severe gestational hypertension, eclampsia	• **$MgSO_4$** (ACOG). Eclampsia ↓59% vs placebo; NNT about 71 with severe disease (Magpie, Maternal-Fetal EBG) • NICE: give in eclampsia; consider in severe pre-eclampsia if birth is planned within 24 h or with neurological symptoms
Pre-eclampsia without severe features	ACOG: no consensus; decide by unit policy (NNT about 400).
Recurrent seizure on $MgSO_4$	**2–4 g IV over 5 min** (NICE: over 5–15 min). About 10% have a second fit.
No infusion pump, IV maintenance not possible, or transfer needed	Use the **IM (Pritchard) regimen** below; it is as effective as IV infusion (Williams, ACOG). It is equally suitable on the ward and in transit.
Caesarean	Start before surgery and continue during and after it.
Creatinine 1.0–1.5 mg/dL or urine <30 mL/h for >4 h	Usual load, then 1 g/h or less; serum Mg 4-hourly; stop if >9.6 mg/dL and restart lower below 8.4 (ACOG).
BMI >30	Williams: over 60% had subtherapeutic levels on 2 g/h; check levels if seizures occur.
Toxicity	• Check patellar reflexes, respiratory rate, urine output and SpO_2 regularly • Reflexes lost about 9 mg/dL (7 mEq/L); respiratory arrest about 12 mg/dL (10 mEq/L); cardiac arrest about 30 mg/dL (25 mEq/L) • Stop the infusion; **calcium gluconate 10% 10 mL (1 g) IV over 3 min**
Myasthenia gravis	$MgSO_4$ contraindicated; get neurology input.

Regimens

Regimen	Load	Maintenance	Duration
ACOG IV	4–6 g IV over 20–30 min	1–2 g/h IV	24 h after birth
NICE IV (Collaborative Eclampsia Trial)	4 g IV over 5–15 min	1 g/h IV	24 h after birth or after the last fit, whichever is later

Regimen	Load	Maintenance	Duration
IM (Pritchard)	4 g IV (20%, ≤1 g/min) + 10 g IM (5 g of 50% into each buttock)	5 g IM every 4 h, alternate buttocks, if checks pass (see box)	24 h after birth
WHO, low-resource	Loading dose, then transfer if the full regimen is not possible	—	—

IM (Pritchard) regimen, step by step

- **Load:** 4 g $MgSO_4$ IV as a 20% solution (20 mL), no faster than 1 g/min, **then at once** 10 g IM: 5 g of 50% solution (10 mL) deep into the upper outer quadrant of **each** buttock with a 3-inch 20-gauge needle; adding 1 mL of 2% lidocaine eases the pain.
- **Convulsions persisting 15 min after the load:** up to 2 g more IV as 20% solution at ≤1 g/min (up to 4 g in a large woman).
- **Maintenance:** 5 g of 50% solution (10 mL) IM every 4 h into alternate buttocks, **only if** the patellar reflex is present, respirations are not depressed and urine output exceeded 100 mL over the previous 4 h. Otherwise withhold the dose and reassess.
- **Duration:** stop 24 h after birth, or 24 h after the last fit if eclampsia occurred postpartum.
- **Toxicity or renal impairment:** same rules as IV; check serum Mg if creatinine is raised; antidote calcium gluconate 10% 10 mL (1 g) IV over 3 min.
- **IV not available at all (WHO):** give the loading dose and transfer; do not withhold $MgSO_4$ because a pump is unavailable.

Eclamptic seizure: what to do

- Call for help; left lateral position; protect the airway and prevent injury; oxygen; IV access.
- **$MgSO_4$ 4–6 g IV** load (or the IM regimen), then maintenance. Not diazepam or phenytoin as first line.
- Treat severe-range BP (Figure 3).
- Fetal bradycardia during and after a fit usually recovers in 3–10 min with maternal resuscitation; do not rush to caesarean unless it persists >10–15 min.
- Deliver once the mother is stable. Eclampsia alone is not an indication for caesarean.
- Refractory seizures (ACOG): sodium amobarbital 250 mg IV over 3 min, thiopental, or phenytoin 1250 mg IV at 50 mg/min; intubate; ICU; imaging.
- Brain imaging if focal deficits, prolonged coma, seizures despite $MgSO_4$, or seizures >48 h after birth.

06 Chronic hypertension

IF	THEN
Planning pregnancy or just pregnant	• Switch ACE inhibitors and ARBs to labetalol or nifedipine ER; stop atenolol • Baseline creatinine, PCR, LFTs, platelets; ECG ± echo if long-standing or severe • Look for secondary causes if young, resistant or with hypokalaemia (renal, renovascular, hyperaldosteronism, phaeochromocytoma)
BP ≥140/90	• Start or titrate treatment; **target <140/90** (ACOG 2022 Practice Advisory, SMFM, after CHAP) • CHAP: fewer adverse composite outcomes (pre-eclampsia with severe features, birth <35 wk, abruption, fetal or neonatal death) with no rise in SGA • NICE: target 135/85 · SOGC and ISSHP: diastolic 85
BP falls in the second trimester	NICE: reduce or stop treatment if SBP <110, DBP <70 or symptomatic hypotension.

IF	THEN
Every woman with chronic hypertension	Aspirin from 12–16 wk until birth (Section 3).
Surveillance	• Growth scans in the third trimester; more often with severe disease or end-organ damage • Weekly fetal testing from about 32 wk if on treatment, poorly controlled or growth restricted (Maternal-Fetal EBG) • Repeat PCR and labs if BP escalates or symptoms appear
New proteinuria, organ dysfunction or BP escalation after 20 wk	Superimposed pre-eclampsia: manage as pre-eclampsia, with severity criteria (Sections 7–8).
Timing of birth	• **ACOG CO 831:** not on medication 38^{+0}–39^{+6} · controlled on medication 37^{+0}–39^{+6} · hard to control 36^{+0}–37^{+6} • NICE: not before 37^{+0} if BP <160/110; then agree timing with a senior obstetrician · SOGC: offer 38^{+0}–39^{+6}

07 Gestational hypertension and pre-eclampsia without severe features

IF	THEN
Reliable, no severe features, reassuring fetus	Outpatient or day-unit care is acceptable and as safe as admission (Maternal-Fetal EBG). Teach warning symptoms; home BP readings.
Surveillance (ACOG)	• BP at least weekly in clinic plus home readings • Weekly platelets, creatinine and LFTs; weekly PCR in gestational hypertension (no need to repeat once pre-eclampsia is diagnosed) • Growth scan every 3–4 wk; liquor at least weekly; fetal testing 1–2 times a week • NICE: bloods twice weekly in pre-eclampsia, three times weekly with severe hypertension, weekly in gestational hypertension
BP 140–159 / 90–109	• **ACOG:** antihypertensives only at ≥160/110; CHAP thresholds have not been extended to gestational hypertension or pre-eclampsia • **NICE:** treat at ≥140/90, target 135/85 · **SOGC / ISSHP:** treat at ≥140/90, target diastolic 85
≥37^{+0} wk	Deliver; induction preferred (HYPITAT: maternal composite ↓29% with induction at ≥37 wk).
34^{+0}–36^{+6} wk, stable	• ACOG and NICE: continue surveillance to 37^{+0} • SOGC: discuss birth at 34^{+0}–35^{+6}, consider it at 36^{+0}–36^{+6} • PHOENIX: planned birth ↓ maternal morbidity but ↑ neonatal unit admission; HYPITAT-II: ↓ maternal adverse outcome, ↑ neonatal RDS
Any severe feature appears	Reclassify, admit and manage as Section 8.
Bed rest	Not recommended (SMFM).

08 Pre-eclampsia with severe features and HELLP

IF	THEN
≥34^{+0} wk	Deliver after maternal stabilisation; do not delay for late-preterm steroids.

IF	THEN
<34^{+0} wk, mother and fetus stable	• Expectant care only in a unit with maternal and neonatal intensive care (ACOG) • Steroids; $MgSO_4$ during initial assessment; oral labetalol or nifedipine; daily maternal and fetal assessment • Usual gain 7–14 days (Maternal-Fetal EBG); deliver at 34^{+0} or at once if any criterion in Figure 4 appears
NICE thresholds for birth before 37 wk	BP uncontrolled on ≥3 drug classes · SpO_2 <90% · progressive liver, renal, haemolysis or platelet deterioration · ongoing neurological features or eclampsia · abruption · reversed end-diastolic flow, abnormal CTG or stillbirth.
HELLP	• ACOG: deliver regardless of GA once stable • At 24^{+0}–33^{+6} wk a 24–48 h delay for steroids only if mother and fetus are stable (Maternal-Fetal EBG) • **Do not give steroids to raise platelets** (ACOG, NICE, ISSHP)
RUQ pain with hypotension or falling Hb	Suspect subcapsular liver haematoma or rupture: imaging, blood products, surgery or interventional radiology.
Fluids	• Restrict: NICE ≤80 mL/h maintenance unless ongoing losses; no routine volume expansion • Oliguria: do not chase it with boluses; check creatinine and Mg level. Pulmonary oedema occurs mostly postpartum
Platelets and anaesthesia	• Neuraxial is acceptable with platelets ≥70 × 10^9/L if stable, with no other coagulopathy or anticoagulant (SOAP, ACOG) • SOGC: transfuse platelets if <20 × 10^9/L for vaginal birth or <50 × 10^9/L for caesarean • General anaesthesia: blunt the intubation surge (e.g. labetalol); $MgSO_4$ potentiates non-depolarising blockers
Mode of birth	• Induction is reasonable; caesarean for the usual indications • Induction at <28 wk usually ends in caesarean: caesarean rates 87% at 24–28 wk, 53% at 28–32 wk, 32% at 32–34 wk (Maternal-Fetal EBG)

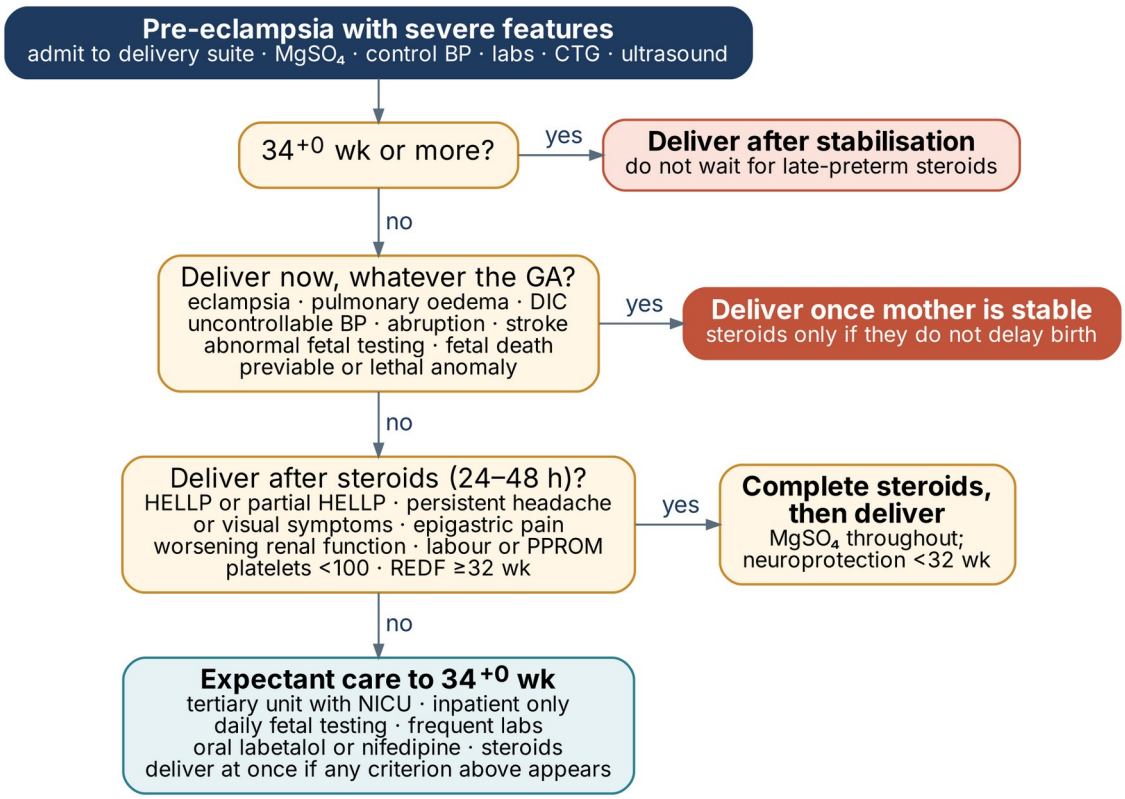


Figure 4. *Deliver now, deliver after steroids, or continue expectant care.*

09 Timing of birth

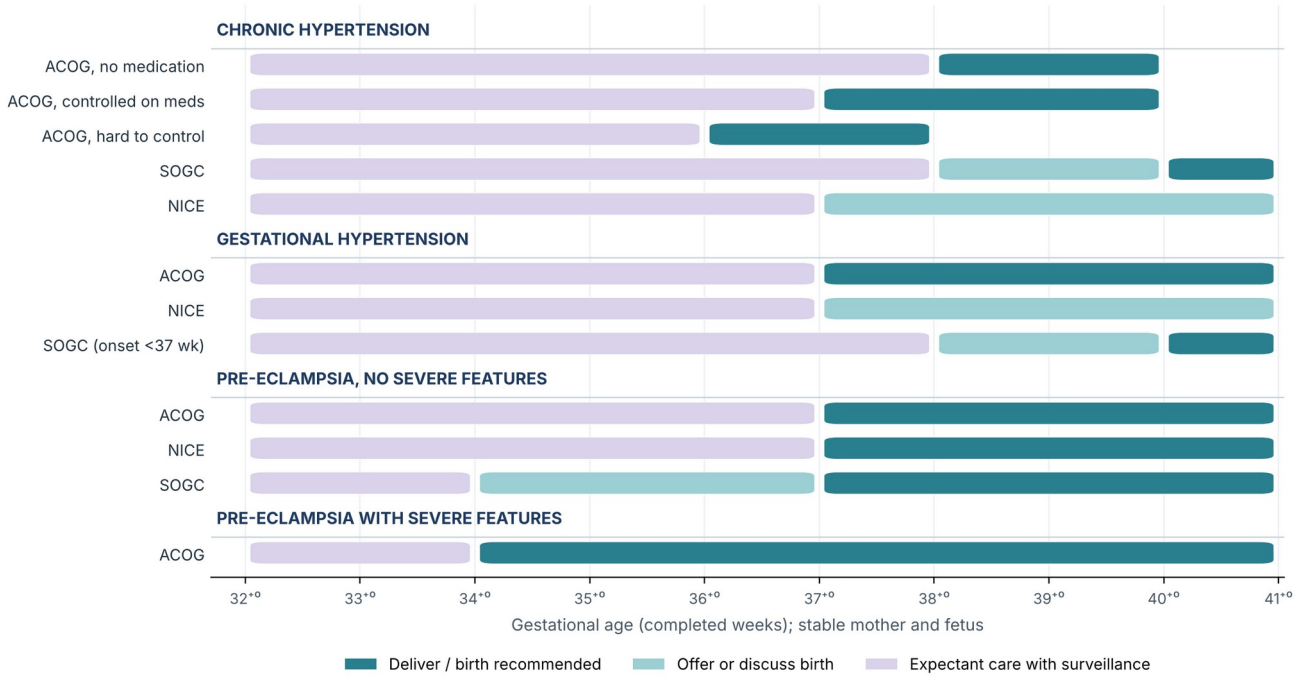


Figure 5. *When to deliver a stable woman, by disorder and society.*

Any of the indications in Figure 4, labour, PPROM, abnormal fetal testing or abruption overrides these windows. Induction is preferred over caesarean; $MgSO_4$ and BP control continue through labour.

10 Postpartum hypertension and long-term risk

IF	THEN
Any hypertensive disorder, after birth	• BP check within 72 h if there was severe hypertension (ACOG/SMFM) and at 3–10 days for all (ACOG CO 736); BP peaks on days 3–6 • NICE: daily for 2 days, at least once on days 3–5, then as needed; pre-eclampsia at least 4 times a day as an inpatient
Postpartum ≥160/110 for ≥15 min	Treat as in Figure 3 within 30–60 min; $MgSO_4$ for postpartum pre-eclampsia with severe features or eclampsia.
Persistent ≥150/100	• Start or increase oral treatment (ACOG, NICE) • NICE: reduce treatment if <130/80; in chronic hypertension keep <140/90 • ACC 2026: aim for <140/90 before discharge; consider treatment at ≥130/80
Choosing a drug (breastfeeding)	• Nifedipine ER, labetalol and enalapril are all compatible • **NICE:** enalapril first line (check creatinine and potassium); nifedipine or amlodipine first for Black African or Caribbean women • Stop methyldopa within 2 days (depression); diuretics may reduce milk supply • Furosemide 20 mg daily for 5 days after severe pre-eclampsia speeds BP control (Maternal-Fetal EBG)
Analgesia	NSAIDs are acceptable (ACOG); avoid with acute kidney injury (ISSHP).
New headache, visual symptoms or high BP up to 6 wk postpartum	Postpartum pre-eclampsia or eclampsia until proven otherwise: $MgSO_4$ and BP control. Consider RCVS, PRES, cerebral venous thrombosis and stroke.
6–8 weeks	NICE: medical review; dipstick after pre-eclampsia, and kidney review at 3 months if ≥1+ persists. Persistent hypertension → investigate and treat.
Counselling	• Recurrence (NICE): any HDP about 21%; pre-eclampsia about 14%, about 33% if the last birth was at 28–34 wk; gestational hypertension about 9% • Lifetime risk: major cardiovascular events about 2×, stroke 2–3×, later hypertension 2–5× after pre-eclampsia • Annual BP check; lipids, glucose and weight by 6–12 wk and hand over to primary care (ACC 2026) • Next pregnancy: aspirin from 12 wk and early baseline labs

11 Do not

- Leave severe-range BP untreated for more than 60 minutes, or drop it to normal quickly.
- Give nifedipine sublingually, puncture the capsule, or use immediate-release nifedipine for maintenance.
- Use ACE inhibitors, ARBs or atenolol in pregnancy; keep methyldopa going after birth.
- Use $MgSO_4$ as an antihypertensive, or diazepam or phenytoin as first-line anticonvulsants.
- Give steroids to raise platelets in HELLP, or delay delivery in HELLP once the mother is unstable.
- Give routine fluid boluses for oliguria or plasma volume expansion.
- Continue expectant care with severe features beyond 34^{+0} wk, or with eclampsia, pulmonary oedema, DIC or abruption.
- Rush to caesarean for transient fetal bradycardia during an eclamptic fit.
- Prescribe bed rest, vitamins C/E, diuretics or salt restriction to prevent pre-eclampsia, or routinely give aspirin 162 mg in the US model (not endorsed by ACOG/SMFM).
- Use a PlGF or sFlt-1/PlGF result alone to diagnose, discharge or time birth.
- Discharge without a BP plan and a check within 72 h to 10 days.

12 Where the guidelines differ

Topic	ACOG / SMFM	NICE (UK)	SOGC	ISSHP / WHO / FIGO
Proteinuria	PCR ≥0.3 mg/mg; dipstick 2+ only if nothing else	uPCR ≥30 mg/mmol or uACR ≥8 mg/mmol	—	ISSHP: PCR ≥30, ACR ≥8 mg/mmol
Pre-eclampsia definition	With or without severe features; FGR excluded	Includes uteroplacental dysfunction (FGR)	—	ISSHP: includes FGR and angiogenic imbalance; no mild/severe labels
Aspirin	81 mg, 12–28 wk (<16) to birth; >1 moderate factor	75–150 mg from 12 wk to birth; ≥2 moderate factors	81 or 162 mg at bedtime, <16 to 36 wk	ISSHP/FIGO 150 mg at night to 36 wk; WHO 75 mg
Calcium	No US recommendation	Not addressed	≥500 mg if intake <900 mg	WHO 1.5–2 g (low intake); ISSHP ≥500 mg
Treat non-severe BP	Chronic HTN ≥140/90; GHTN/PE only ≥160/110	≥140/90 in all	≥140/90	ISSHP ≥140/90
BP target	<140/90 (chronic HTN)	135/85	Diastolic 85	ISSHP diastolic 85
First-line oral drug	Labetalol or nifedipine ER	Labetalol, then nifedipine, then methyldopa	—	ISSHP: methyldopa, labetalol or nifedipine
$MgSO_4$ indication	Severe features or eclampsia; non-severe no consensus	Eclampsia; consider severe PE with birth in 24 h	Severe hypertension or adverse conditions	WHO: full regimen, or load and transfer
$MgSO_4$ dose	4–6 g, then 1–2 g/h	4 g, then 1 g/h	—	WHO: IV or IM full regimens
PE at 34–36^{+6} wk	Expectant to 37^{+0}	Continue surveillance	Discuss 34–35^{+6}, consider 36–36^{+6}	ISSHP: individualise
Chronic HTN at term	36^{+0}–39^{+6} by BP control	Not before 37^{+0}; senior decision	38^{+0}–39^{+6}	ISSHP 38^{+0}–39^{+6}
Postpartum treatment	≥150/100	≥150/100; enalapril first	Several agents compatible with lactation	ISSHP diastolic target 85
PlGF testing	sFlt-1/PlGF ≥40 at 23–34^{+6} wk, inpatient risk adjunct	Rule-out at 20^{+0}–36^{+6} wk	Supported by Canadian expert panels	ISSHP: adjunct and part of the definition

A dash means no verified position. The SOGC 426 full text could not be accessed; SOGC cells rest on its abstract and secondary sources. RCOG has no current hypertension guideline (GTG 10A is archived); UK practice follows NICE NG133.

13 Sources

Textbooks

- Cunningham FG et al. Williams Obstetrics, 26th ed. Ch. 40 Hypertensive Disorders; Ch. 41 Clinical Management of the Preeclampsia Syndrome; Ch. 53 Chronic Hypertension.
- Berghella V (ed). Maternal-Fetal Evidence Based Guidelines, 4th ed. Ch. 1 Hypertensive Disorders.
- Berghella V (ed). Obstetric Evidence Based Guidelines, 4th ed. Analgesia and Anesthesia (hypertensive disorders, thrombocytopenia, aspirin).

Guidelines checked (October 2026)

- ACOG Practice Bulletin 222, Gestational Hypertension and Preeclampsia (2020); current, updated by ACOG Clinical Practice Update on biomarker prediction (2024).
- ACOG Practice Bulletin 203, Chronic Hypertension (2019); thresholds superseded by ACOG Practice Advisory on the CHAP study (2022). SMFM Statement on CHAP (2022).

- ACOG Committee Opinion 767, Emergent Therapy for Acute-Onset Severe Hypertension (2019). ACOG Committee Opinion 831, Late-preterm and Early-term Deliveries (2021). ACOG Committee Opinion 736, Postpartum Care (2018, reaffirmed).
- ACOG Committee Opinion 743, Low-dose Aspirin (2018) with ACOG/SMFM Practice Advisory (2021); USPSTF (2021); SMFM pre-eclampsia risk checklists (2026).
- SOAP Consensus on neuraxial procedures and thrombocytopenia (2021). ACC Expert Consensus Decision Pathway on postpartum cardiovascular care (2026); AHA/ACC High Blood Pressure Guideline (2025).
- NICE NG133, Hypertension in Pregnancy (2019, updated 2023); NICE DG49, PlGF-based Testing (2022). RCOG GTG 10A archived.
- SOGC Guideline 426, Hypertensive Disorders of Pregnancy (2022). ISSHP recommendations (2021, published 2022). FIGO pre-eclampsia initiative (2019).
- WHO recommendations: pre-eclampsia and eclampsia (2011), calcium (2018; under review 2026), severe hypertension (2018), non-severe hypertension (2020), antiplatelet agents (2021). Khander A et al. Aspirin 162 vs 81 mg RCT, Obstet Gynecol 2026.

Decision aid only: it does not replace clinical judgement or local protocols. Verify drug doses against your formulary.