The hypertensive disorders of pregnancy (HDPs) – best practices

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Women Deliver
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Guidelines for the hypertensive disorders of pregnancy (HDP)

2010-2014

WHO recommendations for Prevention and treatment of pre-eclampsia and eclampsia

Hypertension in Pregnancy
Report of the American College of Obstetricians and Gynecologists’ Task Force on Hypertension in Pregnancy
Executive Summary
Review of the clinical practice guidelines (CPGs), 2014

BROAD SEARCH, 2003-13, ENGLISH, FRENCH, GERMAN, OR DUTCH
13 CPGs, 3 MULTINATIONAL (ISSHP, WHO, AND ESC)
TOUGH TO SUMMARISE: 3-1188 PAGES IN LENGTH, 8 DIFFERENT GRADING SYSTEMS, NO GUIDELINE SCORED ≥80% ON EVERY DOMAIN OF AGREED II FOR ASSESSMENT OF GUIDELINE METHODOLOGICAL QUALITY
Consistency – potential for prioritisation and standardisation

- **Definitions**
  - Hypertension
  - Chronic hypertension, gestational hypertension

- **Prevention of pre-eclampsia among women at increased risk**
  - Low-dose aspirin
  - Calcium when baseline intake is low
  - NOT vitamins C&E or diuretic therapy

- **Management**
  - Antihypertensives for severe hypertension
  - MgSO4 for eclampsia, ‘severe’ pre-eclampsia
  - Antenatal corticosteroids when delivery likely within 7d
  - Delivery for pre-eclampsia either before fetal viability or at term
  - Active management of third stage of labour with oxytocin
Consistency – potential for prioritisation and standardisation

• Definitions
  – Hypertension
  – Chronic hypertension, gestational hypertension

• Prevention of pre-eclampsia among women at increased risk
  – Low-dose aspirin
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• Management
  – Antihypertensives for severe hypertension
  – Antihypertensive therapy for non-severe hypertension (target dBP)
  – MgSO4 for eclampsia, ‘severe’ pre-eclampsia, and fetal neuroprotection
  – Antenatal corticosteroids when delivery likely within 7d
  – Delivery for pre-eclampsia either before fetal viability or at term
    • Expectant care at 34-36 weeks
  – Active management of third stage of labour with oxytocin
Diagnosing hypertension requires BP measurement

- Guidelines are based on the assumption that BP is measured and that we can find the 5-10% of pregnant women who are hypertensive.
- Although BP measurement is one of the more commonly received components of ANC in under-resourced settings, many women still do not have their BP measured.
- AND there is variability in rates of BP measurement from country to country, according to DHS results:
  - >90% of women in Cambodia and Ghana
  - ~85% in Nepal, Pakistan and Rwanda
  - Only 53% in Laos
  - Variable in many African countries, such as 75% in Malawi, 52.5% in Uganda, and 40% in Kenya.

Diagnosing hypertension

- Low-cost devices and novel technologies for interpretation are being tested

**CRADLE device (BMGF)**

**mHealth application – POM (Piers On the Move) (BMGF)**
Prevention of pre-eclampsia

- Screening only by clinical risk markers is recommended with no guideline recommending routine use of biomarkers or ultrasound.

- The actual risk markers were not reviewed, and the list is long...

- Among women at increased risk of pre-eclampsia
  - Low-dose aspirin (60–162 mg/d) [ACOG, AOM, NICE, SOGC, WHO]
    - From early pregnancy [ACOG, AOM, NICE, SOGC, WHO] until delivery [AOM, NICE, SOGC]
  - Calcium supplementation (1–2.5 g/d) if calcium intake is low [AOM, WHO, SOGC]
Clinical risk factors for pre-eclampsia determined in early pregnancy: systematic review and meta-analysis of large cohort studies

Emily Bartsch,1 Karyn E Medcalf,1 Alison L Park,2 Joel G Ray3 on behalf of the High Risk of Pre-eclampsia Identification Group

BMJ 2016;353:i1753 (http://dx.doi.org/10.1136/bmj.i1753)
1. aPL
2. Chronic hypertension
3. Prior pre-eclampsia
4. Pre-gestational diabetes

5. Pre-pregnant BMI >30 kg/m²
6. ART (artificial reproductive technologies)

BMJ 2016;353:i1753 (http://dx.doi.org/10.1136/bmj.i1753)
Population attributable fraction (PAF)

BMJ 2016;353:i1753 (http://dx.doi.org/10.1136/bmj.i1753)

1. aPL
2. Chronic hypertension
3. Prior pre-eclampsia
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5. Pre-pregnancy BMI >30
6. ART
CHIPS Trial results
(The Control of Hypertension In Pregnancy Study)
(ISRCTN 714169114)

Less-Tight versus Tight Control of Hypertension in Pregnancy
Laura A. Magee, M.D., Peter von Dadelszen, M.B., Ch.B., D.Phil., Evelyne Rey, M.D., Susan Ross, M.B.A., Ph.D.,
Elizabeth Asztalos, M.D., Kellie E. Murphy, M.D., Jennifer Menzies, M.Sc., Johanna Sanchez, M.I.P.H.,
Joel Singer, Ph.D., Amiram Gafni, D.Sc., Andrée Gruslin, M.D., Michael Helewa, M.D., Eileen Hutton, Ph.D.,
Shoo K. Lee, M.D., Ph.D., Terry Lee, Ph.D., Alexander G. Logan, M.D., Wessel Ganzvoort, M.D., Ph.D.,
Ross Welch, M.B., B.S., D.A., M.D., Jim G. Thornton, M.B., Ch.B., M.D., and Jean-Marie Moutquin, M.D.

ABSTRACT

• 987 recruits, 94 sites in 15 countries
• Open, international, multicentre RCT of women
• At 14+0 weeks to 33+6 weeks gestation
• Non-proteinuric, non-severe pre-existing or gestational hypertension
• Live fetus
• Randomly assigned to ‘less tight’ control (target diastolic BP, 100mmHg) or ‘tight’ control (target diastolic BP, 85mmHg)
CHIPS – management of non-severe hypertension

• 987 women; 74.6% had pre-existing hypertension
• Mean diastolic BP was 4.6mmHg (95% CI 3.7, 5.4) higher in ‘less tight’ control
• Composite primary outcome (pregnancy loss or high-level neonatal care for >48hr) during the first 28 postnatal days
  – 31.4% [‘less tight’] vs. 30.7% [‘tight’]; adjOR 1.02; 95% CI 0.77, 1.35
• Secondary outcome (serious maternal complications) up to 6wk post partum or until hospital discharge, whichever was later
  – 3.7% [‘less tight’] vs. 2.0% [‘tight’]; adjOR 1.74; 95% CI 0.79, 3.84
• Severe hypertension (≥160/110mmHg)
  – 40.6% [‘less tight’] vs. 27.5% [‘tight’]; p<0.001
• Platelets <100x10⁹/L
  – 4.3% [‘less tight’] vs. 1.6% [‘tight’]; p<0.05
• Elevated liver enzymes with symptoms
  – 4.3% [‘less tight’] vs. 2.0% [‘tight’]; p<0.05
CHIPS - management of non-severe hypertension

- ‘Less tight’ control is not a sound investment because it offers no rewards (perinatal or maternal) in exchange for risk (maternal, at minimum severe hypertension)

<table>
<thead>
<tr>
<th>Province</th>
<th>‘Less tight’</th>
<th>‘Tight’</th>
<th>Difference in means</th>
<th>95% CI</th>
<th>p value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ontario</td>
<td>$30,191.62</td>
<td>$24,469.06</td>
<td>CAD$5,723</td>
<td>-$296</td>
<td>$12,272</td>
</tr>
<tr>
<td>BC</td>
<td>$30,593.69</td>
<td>$24,776.51</td>
<td>CAD$5,817</td>
<td>-$385</td>
<td>$12,349</td>
</tr>
<tr>
<td>Alberta</td>
<td>$31,510.72</td>
<td>$25,510.49</td>
<td>CAD$6,000</td>
<td>-$154</td>
<td>$12,781</td>
</tr>
</tbody>
</table>
Management of severe hypertension

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Quality of evidence</th>
<th>Strength of recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>In areas where dietary calcium intake is low, calcium supplementation during pregnancy (at doses of 1.5–2.0 g elemental calcium/day) is recommended for the prevention of pre-eclampsia in all women, but especially those at high risk of developing pre-eclampsia.</td>
<td>Moderate</td>
<td>Strong</td>
</tr>
<tr>
<td>Low-dose acetylsalicylic acid (aspirin, 75 mg) is recommended for the prevention of pre-eclampsia in women at high risk of developing the complications should be initiated before 34 weeks' gestation.</td>
<td>Low</td>
<td>Weak</td>
</tr>
<tr>
<td>Hypertension during pregnancy should receive antihypertensive drugs.</td>
<td>Very low</td>
<td>Strong</td>
</tr>
<tr>
<td>The choice and route of administration of an antihypertensive drug for severe hypertension during pregnancy, in preference to others, should be based primarily on the prescribing clinician's experience with that particular drug, its cost and local availability.</td>
<td>Very low</td>
<td>Weak</td>
</tr>
<tr>
<td>Magnesium sulfate is recommended for the prevention of eclampsia in women with severe pre-eclampsia in preference to other anticonvulsants.</td>
<td>High</td>
<td>Strong</td>
</tr>
<tr>
<td>Magnesium sulfate is recommended for the treatment of women with eclampsia.</td>
<td>High</td>
<td>Strong</td>
</tr>
</tbody>
</table>

WHO recommendations for Prevention and treatment of pre-eclampsia and eclampsia.

Women with severe hypertension in pregnancy should receive treatment with antihypertensive drugs.
Management of severe hypertension

• Uncontrolled severe hypertension is the most widely regarded maternal indication for delivery (and treatment) [NICE, WHO, ACOG]

• Recognition that standardisation of treatment is necessary
  – Safe Motherhood Initiative, NY State

• Most commonly used agents that are endorsed internationally achieve treatment success in about 80% of women
  – Nifedipine (orally, tablets or capsules)
  – Labetalol (usually iv)
  – Hydralazine (usually iv)

• Interest in focussing on oral therapy [BJOG. 2014 Sep;121(10):1210-8]
  – Further explored in a RCT of oral nifedipine, oral labetalol, and oral methyldopa [Gnyuity oral antihypertensive trial]
MATERNAL DEATH FROM PRE-ECLAMPSIA
by diagnosis – UK; 1952 – 2008

Data from CEMD, UK
MATERNAL DEATH FROM PRE-ECLAMPSIA
by diagnosis – UK; 1952 – 2008

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Surveillance,
Timed delivery &
Reproductive choice

Antihypertensives

Magnesium

Data from CEMD, UK
Management – timed delivery

- Recommendations focus on women with pre-eclampsia [ACOG, NICE, NVOG, SOGC, WHO]
  - Delivery at a pre-viable gestational age if the disease severe [WHO, ACOG, SOGC], and at term [NICE, WHO, ACOG, SOGC]
- Expectant management possible at viability at <34 wk [NICE, ACOG, SOGC] may decrease perinatal risk without increasing maternal risk
  - Only about 40% of women are eligible
- Expectant care at 34-36 wk is reasonable
  - HYPITAT II [Lancet 2015]
    - Adverse maternal outcomes: 4 (1.1%) vs. 11 (3.1%), p=0.069
    - Respiratory distress syndrome: 20 (5.7%) vs. 6 (1.7%), p=0.005
    - There were no maternal or perinatal deaths
- Gestational hypertension
  - Delivery at term - HYPITAT [WHO, ACOG, SOGC]
- Chronic hypertension - ??
Consistency – potential for standardisation

• Definitions
  – Hypertension
  – Chronic hypertension, gestational hypertension

• Prevention of pre-eclampsia among women at increased risk
  – Low-dose aspirin
    • Women with prior pre-eclampsia and pre-pregnancy BMI >30
    • Calcium when baseline intake is low
  – NOT vitamins C&E or diuretic therapy

• Management
  – Antihypertensives for severe hypertension – more oral therapy?
    • Antihypertensive therapy for non-severe hypertension to prevent maternal risk (at minimum, severe hypertension)
  – MgSO4 for eclampsia, ‘severe’ pre-eclampsia, and fetal neuroprotection
  – Antenatal corticosteroids when delivery likely within 7d
  – Delivery for pre-eclampsia either before fetal viability (with severe disease) or at term
    • Expectant care can be undertaken at 34-36 weeks for neonatal reasons
  – Active management of third stage of labour with oxytocin
"Women are not dying of diseases we can't treat... They are dying because societies have yet to make the decision that their lives are worth saving."

[M Fathalla]

“Safer motherhood will happen when evidence for best practice is integrated into systems of care for all patients.”

[Martin JN Jr, Semin Perinatol 2016]