The Royal HOSPITAL FOR WOMEN

LOCAL OPERATING PROCEDURE – CLINICAL

Approved Quality & Patient Safety Committee December 2020
Review December 2025

PRE-ECLAMPSIA – INTRAPARTUM CARE

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Appropriate diagnosis and management of woman with pre-eclampsia in labour

2. PATIENT

- Woman with pre-eclampsia in labour. Pre-eclampsia is defined by the de novo onset of hypertension (≥ 140/90) after 20 weeks gestation in pregnancy with one or more of the following signs of organ involvement:
  - proteinuria
  - liver function abnormalities
  - renal impairment
  - thrombocytopenia/haemolysis
  - pulmonary oedema
  - neurological impairment
  - intra-uterine fetal growth restriction

3. STAFF

- Medical and midwifery staff

4. EQUIPMENT

- Crystalloid/non-mercury auditory sphygmomanometer with cuff of appropriate size
- Cardiotocograph (CTG)
- 16-gauge intravenous (IV) cannula
- Indwelling Urinary Catheter (IDC)

5. CLINICAL PRACTICE

- Complete midwifery admission as per RHW Midwifery Assessment and/or Admission LOP
- Complete medical admission and assessment by obstetric registrar or consultant
- Insert IV cannula
- Perform the following blood tests:
  - Full blood count (FBC)
  - Urea, electrolytes, and creatinine (UEC)
  - Liver function tests (LFT)
  - Group and hold (G&H)
  - Coagulation studies when platelets <150 x 10^9 or if severe pre-eclampsia
- Perform urinalysis and send urine protein/creatinine ratio (PCR)
- Notify obstetrics medicine team if required
- Notify anaesthetic registrar of admission of woman with pre-eclampsia, and request review if platelet count <100 x 10^9/per litre to discuss regional anaesthesia if needed
- Recommend continuous CTG monitoring during labour
- Perform hourly blood pressure (BP) recordings or more frequently if indicated
- Measure blood pressure with woman in a comfortable position, sitting or recumbent position if possible, using the same arm for a consistent approach

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- Treat severe and urgent hypertension as per RHW Severe and Urgent Hypertension LOP
- Maintain accurate fluid balance chart
- Ensure total fluid intake does not exceed 120mL/hr
- Measure and record urine output. If <120mL over four hours, insert IDC and measure hourly output
- Consult with anaesthetic registrar regarding fluid pre-loading for epidural block
- Consider need for seizure prophylaxis (i.e. Magnesium Sulphate - $MgSO_4$) where pre-eclampsia is worsening

- Manage second stage of labour as per RHW Second Stage of Labour LOP if hypertension is controlled
- Consider operative delivery in the second stage if severe hypertension present and not responsive to treatment
- Manage third stage actively with IV or intramuscular (IM) Syntocinon® 10 units. Avoid Ergometrine® or Syntometrine®
- Monitor blood pressure, urine output and serum biochemistry in the postpartum period

6. DOCUMENTATION

- Medical record

7. EDUCATIONAL NOTES

- Oedema is not included in the diagnostic features of pre-eclampsia. It is a common feature of normal pregnancy and severe pre-eclampsia may be present in the absence of any oedema Nevertheless, rapid development of generalised oedema should alert the clinician to screen for pre-eclampsia. Be wary of pulmonary oedema
- Low dose aspirin therapy is not a contraindication to neuraxial analgesia[1]
- Women with a platelet count of <100 x 10^9/per litre should consult with the anaesthetist about epidural block prior to labour
- Ergometrine® and Syntometrine® are contraindicated as both can have hypertensive effects
- Syntocinon® is structurally related to anti-diuretic hormone and can cause fluid retention[1]
- Postpartum oliguria can occur and does not require fluid therapy unless the serum/plasma creatinine is rising

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE GUIDELINES

- Eclampsia Management
- Magnesium Sulphate for Eclampsia or Eclampsia Prophylaxis
- Severe and/or Urgent Hypertension in Pregnancy Guideline
- Thrombocytopenia in Pregnancy
- Labetalol – Intravenous Labetalol for Management of Severe/Urgent Hypertension
- Postpartum Haemorrhage – Prevention and Management
- Fetal Heart Rate Monitoring – Maternity – MoH GL2018/025
- Induction of labour policy and procedure

PRE-ECLAMPSIA – INTRAPARUM CARE cont'd

9. RISK RATING
- Low

10. NATIONAL STANDARD
- Standard 5 – Comprehensive Care

11. REFERENCES
1. Lowe SA, Bowyer L, Lust K, McMahon LP, Morton MR, North RA, Paech MJ, Said JM, Guideline for the Management of Hypertensive Disorders of Pregnancy. Society of Obstetric Medicine of Australia and New Zealand, 2014.
2. National Institute of Health and Care Excellence (NICE). Hypertension in pregnancy: diagnosis and management 2019 (NICE guideline - NG133)

REVISION & APPROVAL HISTORY
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