Chronic HTN

CC: History of HTN

Updated: 02/23/2012

Orders: **All patients with current hypertensive disorders should have a fetal growth ultrasound every 4-6 weeks, unless indicated earlier.**

Diagnosis	Orders
h/o HTN **BP > 145 or > 95** **on two occasions**	❑ Labetalol 100-200 po BID, titrate q 3-7 days to SBP <140, DBP <90 ❑ EKG ❑ Baseline PIH labs (CBC, Chem 14, LDH, D-Dimer, fibrinogen, PT/PTT/INR, uric acid) ❑ 24 hour urine for protein & creatinine clearance ❑ Maternal echocardiogram if severe HTN and longer than two years since diagnosis, symptoms of CHF, or if signs of peripheral edema (1st/2nd trimester) ❑ Growth sonograms q 4-6 weeks after 24 weeks, with S:D ratios if delayed growth or severe HTN ❑ NST/AFI 2x/week at 32 weeks
h/o HTN **BP wnl**	❑ Antihypertensive medication not indicated ❑ EKG, baseline PIH labs ❑ Consider 24 hour urine protein & creatinine clearance, especially if + protein on dip ❑ If medications initiated for increasing BP after 20 weeks, repeat 24 hour urine for protein, do serial sonograms and start NST at 32 weeks
Hypertensive crisis **SBP > 160** **DBP > 105**	❑ Admit, consider ICU admission (if HTN refractory to medication) ❑ Immediate IV antihypertensive medication: ➢ Labetalol 10-20 mg IV (slow -2 min), expect max effect at 5 minutes ➢ Repeat Labetalol q 10 minutes until adequate response, up to 80 mg IV per dose, max total dose 300 mg ➢ Hydralazine 5-10 mg IV (slow push) ➢ Repeat hydralazine q 20 minutes until adequate response, 40 mg per dose ➢ Change hydralazine to another med if not meeting desired response after 20 mg ❑ Magnesium sulfate 4 g bolus then 2 g q hour for seizure prophylaxis ➢ Place Foley with strict I/O's, monitor DTR and mental status hourly while on magnesium ➢ Check magnesium levels q 4-6 hours ➢ Dose reduce if kidney function impaired ❑ Consider nicardipine drip if refractory HTN, 5 mg/h, increase by 2.5 mg h q 15 min until effect achieved, max 15mg/h ❑ Continuous electronic fetal monitor if fetus viable ❑ Ultrasound for EFW, include S:D ratios ❑ PIH labs ❑ 24 hour urine for protein & creatinine clearance ❑ Consider delivery, steroids for fetal lung maturity

History:

- Elevated BP on two separate occasions, diagnosed prior to pregnancy

Initial Visit:

- Year of diagnosis
- Previous treatment
- Exposure to teratogenic antihypertensive medication (ACE inhibitor)
- Baseline BP, vitals, note presence/absence of peripheral edema
- Baseline deep tendon reflexes

Notes:

- Consider 24 hour urine for catecholamines if HTN is paroxysmal.
- Increase frequency of S:D ratios, venous Doppler, MCA Doppler if fetus shows signs of growth restriction (see IUGR protocol)
- Consider renal artery ultrasound if high index of suspicion for renal artery stenosis, or renal ultrasound if concomitant renal disease is noted.

Note: these orders are in addition to the standard or routine workup for prenatal care.