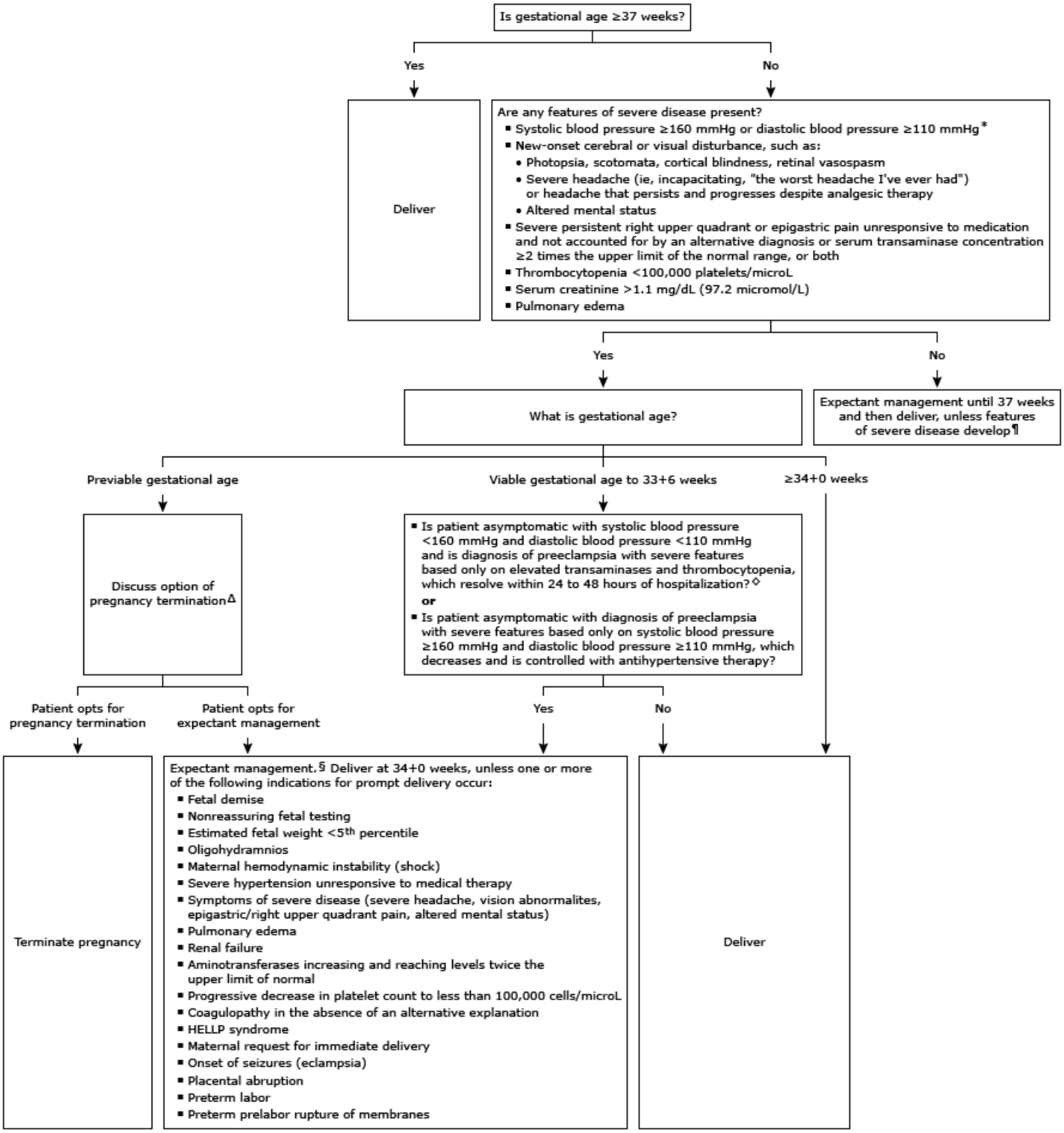
Timing of delivery in women with preeclampsia



Patients with suspected preeclampsia should be admitted to the hospital to confirm the diagnosis; assess severity; closely monitor maternal and fetal status; initiate supportive, therapeutic, and prophylactic therapies (eg, antihypertensive drugs for treatment of severe hypertension, antenatal corticosteroids, magnesium sulfate to prevent

maternal seizures and, in some cases, fetal/neonatal neuroprotection); and either undergo delivery or expectant management. For expectantly managed patients, the sFlt-1:PlGF ratio may be used as a component of decision-making regarding whether close maternal/fetal monitoring is conducted in the inpatient versus outpatient setting. Refer to UpToDate topics on Preeclampsia: Management and prognosis and Expectant management of preterm preeclampsia with severe features.

ALT: alanine aminotransferase; AST: aspartate aminotransferase; HELLP: hemolysis, elevated liver enzymes, low platelet count.

* Blood pressure should be evaluated on at least 2 occasions at least 4 hours apart. However, if systolic pressure is ≥160 mmHg or diastolic pressure is ≥110 mmHg, confirmation after a short interval, even within a few minutes, is acceptable to facilitate timely initiation of antihypertensive therapy.

¶ In patients with no severe features of preeclampsia, guidelines from major medical organizations generally recommend expectant management before 34 weeks of gestation. There is less consensus about the optimum approach at 34+0 to 36+6 weeks. Although there are serious maternal risks with expectant management, we believe it is reasonable in fully informed patients because the absolute maternal risk of an adverse outcome is low and, although there is no benefit to the mother of continuing the pregnancy, the neonatal benefits from the additional time for in utero growth and maturation are substantial.

Δ If onset of preeclampsia with severe features is at a previable gestational age, we offer termination of pregnancy to reduce the mother's risk of developing life-threatening morbidity (eg, cerebrovascular hemorrhage) and to prevent the birth of an infant at the limit of viability and thus at high risk of death or severe permanent disability. Factors critical in making this decision are the estimated fetal weight, actual gestational age, presence of growth restriction, and the neonatologist's judgment of the neonatal prognosis.

◇ In otherwise asymptomatic or mildly hypertensive women with features of severe disease by laboratory criteria, it is reasonable to delay delivery, administer antenatal corticosteroids, and repeat the laboratory tests (AST, ALT, platelet count) every 6 to 8 hours while the patient is on the labor unit to see if they improve. We would promptly deliver patients with worsening liver chemistries or falling platelet counts and those who develop other signs of preeclampsia with severe features. We often continue expectant management if the initially abnormal laboratory test results remain stable, but this decision is made on a case-by-case basis.

§ These patients should be hospitalized and cared for by, or in consultation with, a maternal-fetal medicine specialist. Such an approach should be undertaken only at facilities with adequate maternal and neonatal intensive care resources. After initial observation on the labor unit, these patients are closely monitored on an antepartum unit. Refer to UpToDate topic on Expectant management of preterm preeclampsia with severe features.

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