b. Patients in second or third trimester of pregnancy should be transported on left side or with uterus manually displaced to left to ensure adequate uterine perfusion

Patient Safety Considerations

1. Magnesium toxicity (progression)
   a. Hypotension followed by
   b. Loss of deep tendon reflexes followed by
   c. Somnolence, slurred speech followed by
   d. Respiratory paralysis followed by
   e. Cardiac arrest
2. Treatment of magnesium toxicity
   a. Stop magnesium drip
   b. Give calcium gluconate 3 g IV or calcium chloride 1 g IV in cases of pending respiratory arrest
   c. Support respiratory effort

Notes/Educational Pearls

Key Considerations

1. Delivery of the placenta is the only definitive management for pre-eclampsia and eclampsia
2. Early treatment of severe pre-eclampsia with magnesium for seizure prophylaxis and anti-hypertensive significantly reduces the rate of eclampsia. Use of magnesium encouraged if signs of severe pre-eclampsia present to prevent seizure
3. Patients with a history of chronic hypertension may have superimposed pre-eclampsia
4. Although less frequent, eclampsia, including eclampsia-related seizures, can occur in postpartum patients

Pertinent Assessment Findings

1. Vital signs assessment with repeat blood pressure monitoring before and after treatment
2. Assessment of deep tendon reflexes after magnesium therapy
3. Examination for end organ involvement
4. Evaluate fundal height

Quality Improvement

Associated NEMSIS Protocol(s) (eProtocol.01) *(for additional information, go to www.nemsis.org)*

- 9914157 – OB/GYN - Eclampsia
- 9914159 – OB/GYN - Gynecological Emergencies
- 9914161 – OB/GYN - Pregnancy Related Disorders

Key Documentation Elements

Document full vital signs and physical exam findings

Performance Measures

- Patients with signs of hypertension and greater than 20-week gestation or recent postpartum should be assessed for signs of pre-eclampsia
- Recognition and appropriate treatment of eclampsia