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Diagnosis and Treatment of Hypertension and Pre-eclampsia in Pregnancy in Aotearoa New Zealand

Transcript of the webinar for health practitioners

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# Introduction

This document is a verbatim transcript of the webinar for health practitioners on the clinical guideline, Diagnosis and Treatment of Hypertension and Pre-eclampsia in Pregnancy in Aotearoa New Zealand.

# Transcript

1

00:00:13,000 --> 00:00:17,560

This is a webinar to inform health

practitioners looking after mothers and babies

2

00:00:17,560 --> 00:00:19,480

in Aotearoa New Zealand

3

00:00:19,480 --> 00:00:22,920

with high blood pressure

and pre-eclampsia in pregnancy

4

00:00:23,200 --> 00:00:26,280

and it's an update to the Guideline.

5

00:00:26,600 --> 00:00:28,080

My name is Michelle Wise.

6

00:00:28,080 --> 00:00:29,400

I'm an associate professor

7

00:00:29,400 --> 00:00:31,320

in the Department of Obstetrics and Gynecology

8

00:00:31,320 --> 00:00:32,960

at the University of Auckland,

9

00:00:33,280 --> 00:00:36,560

and I'm an obstetrician

at Te Whatu Ora Auckland,

10

00:00:36,560 --> 00:00:41,800

and I was on the project team

to update this Guideline.

11

00:00:42,400 --> 00:00:43,560

Tēnā koutou katoa,

12

00:00:43,560 --> 00:00:44,960

My name is Lesley Dixon.

13

00:00:44,960 --> 00:00:46,080

I'm a midwifery advisor

14

00:00:46,080 --> 00:00:47,480

with the New Zealand College of Midwives,

15

00:00:47,480 --> 00:00:50,000

and I was also on the Steering Group

16

00:00:50,000 --> 00:00:53,040

as a midwifery representative

for this Guideline update.

17

00:00:54,200 --> 00:00:56,360

The purpose of the update

18

00:00:56,360 --> 00:00:59,560

was to actually review

the evidence for this Guideline,

19

00:01:00,880 --> 00:01:05,400

but the Guideline itself is a summary

to support midwives and health practitioners

20

00:01:05,400 --> 00:01:07,880

when they're working

with pregnant women and people

21

00:01:07,880 --> 00:01:11,360

who may have hypertensive disorder

during pregnancy.

22

00:01:12,000 --> 00:01:16,320

It provides information

that can help to identify,

23

00:01:16,320 --> 00:01:20,320

diagnose and treat and monitor women

during pregnancy,

24

00:01:20,480 --> 00:01:22,600

during the birth and postpartum.

25

00:01:22,760 --> 00:01:26,760

We know that hypertension during pregnancy

can affect up to 10% of pregnancies

26

00:01:27,040 --> 00:01:29,360

and for those with major risk

factors, that can be up to

27

00:01:29,360 --> 00:01:31,760

20% percent of pregnancies.

28

00:01:31,760 --> 00:01:35,160

It's important that we are able

to identify those with a high risk

29

00:01:35,400 --> 00:01:41,320

and ensure close monitoring,

diagnosis and treatment going forward.

30

00:01:41,320 --> 00:01:44,600

But also this Guideline will also help

health practitioners

31

00:01:44,600 --> 00:01:48,280

to ensure consistency of

practice across Aotearoa New Zealand.

32

00:01:49,320 --> 00:01:53,880

Now publishing this national Guideline

on a website is only the first step.

33

00:01:53,880 --> 00:01:58,560

It's really important that each hospital

and each midwife and doctor

34

00:01:58,560 --> 00:02:03,240

really reviews it and makes sure

that their local guidelines align

35

00:02:03,240 --> 00:02:04,920

and if there are any differences,

36

00:02:04,920 --> 00:02:07,520

that it's important

to provide a rationale for that.

37

00:02:08,040 --> 00:02:13,080

The scope that was given to the project team

and the Steering Group was quite narrow.

38

00:02:13,080 --> 00:02:17,080

It wasn't to update the entire Guideline,

but really to focus on

39

00:02:17,080 --> 00:02:19,360

six primary research questions.

40

00:02:20,160 --> 00:02:23,400

Two of them were

with the antenatal period.

41

00:02:23,400 --> 00:02:26,120

One question was around

42

00:02:26,120 --> 00:02:28,520

low-dose aspirin in preventing

43

00:02:28,800 --> 00:02:33,840

pre-eclampsia and the other was around

using predictive models

44

00:02:34,200 --> 00:02:41,880

of a combination of risk factors

and ultrasound and blood tests

45

00:02:41,880 --> 00:02:46,200

to try to better predict people

who were going to get pre-eclampsia.

46

00:02:46,680 --> 00:02:51,240

The question during labour

and birth was around timing of birth,

47

00:02:51,560 --> 00:02:55,000

and the postpartum question was around

48

00:02:55,000 --> 00:02:59,200

monitoring and how often and how

and where should we be monitoring

49

00:02:59,200 --> 00:03:01,920

high blood pressure after the birth.

50

00:03:01,920 --> 00:03:05,280

The final question that permeated

the entire Guideline was around

51

00:03:05,520 --> 00:03:09,320

equitable outcomes for women

and whether we should be tailoring

52

00:03:09,320 --> 00:03:12,680

certain parts of the Guideline

to specific groups of women

53

00:03:13,160 --> 00:03:16,120

and that's really the focus

of the webinar today.

54

00:03:16,680 --> 00:03:19,880

One of the other changes

to the 2022 update

55

00:03:19,920 --> 00:03:25,440

is that the Guideline from 2018

was separated into two separate documents.

56

00:03:25,840 --> 00:03:29,960

The first one is much shorter and contains

all of the recommendations

57

00:03:29,960 --> 00:03:33,000

and flow charts and tables.

58

00:03:33,880 --> 00:03:37,800

The second document is a lot

has a lot more detail

59

00:03:37,800 --> 00:03:42,000

on the recommendations

and the evidence review summaries.

60

00:03:42,240 --> 00:03:46,880

It also grades the quality of the evidence

underlying each of them

61

00:03:46,920 --> 00:03:50,880

and is a lot more detailed

about the methodology of the Guideline.

62

00:04:00,040 --> 00:04:01,800

Kia ora and welcome to the section

63

00:04:01,800 --> 00:04:04,760

on pre-pregnancy and antenatal care

64

00:04:05,280 --> 00:04:07,200

for women who have hypertensive disorders

65

00:04:07,200 --> 00:04:08,280

during pregnancy.

66

00:04:08,560 --> 00:04:11,920

The pre conceptual care has not changed

within this Guideline

67

00:04:12,120 --> 00:04:16,480

and continues to advise that women seek

pre-pregnancy counselling

68

00:04:16,480 --> 00:04:18,960

if they have had hypertension during pregnancy.

69

00:04:19,480 --> 00:04:21,600

For women when they are pregnant

70

00:04:21,600 --> 00:04:24,560

it's important that midwives

undertake a full assessment

71

00:04:25,200 --> 00:04:30,320

during the booking or registration visit

to identify if they have any risk factors

72

00:04:30,360 --> 00:04:32,800

for hypertensive disorders

during pregnancy.

73

00:04:33,480 --> 00:04:37,920

This involves looking at table

1 in the Guideline,

74

00:04:37,920 --> 00:04:40,880

which identifies the risk factor

75

00:04:41,120 --> 00:04:43,320

and the odds ratio for that risk factor.

76

00:04:43,920 --> 00:04:46,680

These will include women who have had previous

77

00:04:46,680 --> 00:04:49,080

pPre-eclampsia or eclampsia or HELLP syndrome,

78

00:04:49,840 --> 00:04:52,160

women who have pre-existing diabetes,

79

00:04:52,560 --> 00:04:54,000

women with renal disease,

80

00:04:54,000 --> 00:04:59,120

women with chronic hypertension

and antiphospholipid antibodies.

81

00:04:59,680 --> 00:05:02,760

These are all conditions

that require referral

82

00:05:03,000 --> 00:05:05,040

through the maternity Referral Guidelines

83

00:05:05,040 --> 00:05:09,440

so these women with any of these issues

would be expected to be referred

84

00:05:09,440 --> 00:05:12,760

through to the obstetric team

for their input as well.

85

00:05:13,320 --> 00:05:16,760

Two additional identified as a major risk factor

86

00:05:17,480 --> 00:05:22,040

are a family history

of pre-eclampsia or eclampsia,

87

00:05:22,320 --> 00:05:25,600

which would be a sister

or a mother who's had pre-eclampsia,

88

00:05:26,240 --> 00:05:31,280

and also assisted reproductive technology,

which would be oocyte donation.

89

00:05:31,760 --> 00:05:37,160

These two areas also have been identified

as major risk factors

90

00:05:37,560 --> 00:05:40,640

and need to be identified

as such with women

91

00:05:40,640 --> 00:05:43,000

advised of the increased risk for them.

92

00:05:43,920 --> 00:05:48,040

Other risk factors identified in the table as well,

93

00:05:48,720 --> 00:05:52,200

these risk factors have a

lower adjusted odds ratio,

94

00:05:53,160 --> 00:05:56,600

but so they’re things that midwives

should bear in mind.

95

00:05:56,600 --> 00:05:58,960

They don't necessarily mean

that they need to be referred

96

00:05:58,960 --> 00:06:01,920

or have immediate treatment, but

they should be considered very carefully.

97

00:06:02,920 --> 00:06:05,440

For example, ethnicity:

98

00:06:06,120 --> 00:06:08,840

women who are African, Māori, Pasifika,

99

00:06:10,080 --> 00:06:14,160

Indian ethnicity have an increased chance

of hypertensive disorders as well,

100

00:06:14,400 --> 00:06:16,320

but not that is not a major risk factor.

101

00:06:16,320 --> 00:06:20,400

But these are things that need to be kept

in mind as the pregnancy progresses,

102

00:06:20,880 --> 00:06:24,640

so that if there are any signs at all

that further monitoring can be undertaken.

103

00:06:24,960 --> 00:06:28,240

Women with a major risk

factor should be offered low-dose aspirin.

104

00:06:29,000 --> 00:06:32,320

This can be started

between 12 and 16 weeks of pregnancy.

105

00:06:32,760 --> 00:06:35,360

The dosage is 100 milligrams per day

106

00:06:35,640 --> 00:06:40,000

and the optimal time to take

that is before bedtime or in the evening.

107

00:06:40,960 --> 00:06:44,160

The studies that we reviewed identified

this as an optimal time.

108

00:06:44,160 --> 00:06:47,760

Obviously, if women have forgotten

any time during the day is fine,

109

00:06:48,200 --> 00:06:51,440

but it appears to work better

if it's taken in the evening.

110

00:06:52,840 --> 00:06:57,000

When to stop the aspirin was reviewed

by the Steering Group

111

00:06:57,320 --> 00:06:59,400

and there is not

a huge amount of evidence

112

00:06:59,400 --> 00:07:04,600

but what we did what we have suggested

is that the aspirin is stopped at 36 weeks,

113

00:07:04,600 --> 00:07:08,120

which is when a lot of the studies

were looking at stopping them.

114

00:07:08,600 --> 00:07:12,480

So that we've offered that as a suggestion

that aspirin is stopped at 36 weeks.

115

00:07:12,920 --> 00:07:17,080

The recommendation for calcium

supplementation has not changed.

116

00:07:17,080 --> 00:07:21,040

It remains that calcium supplementation

be considered

117

00:07:21,040 --> 00:07:25,800

also to start around 12 to 16 weeks

at the same time as the low-dose aspirin

118

00:07:25,800 --> 00:07:28,280

and to be continued

throughout the pregnancy.

119

00:07:28,280 --> 00:07:33,520

With respect to the dose, it probably depends

a bit on the dietary intake of calcium,

120

00:07:33,520 --> 00:07:38,080

but is recommended

around 1.5 grams per day.

121

00:07:38,600 --> 00:07:43,440

The Steering Group had a long discussion

about the predictive tools

122

00:07:43,440 --> 00:07:47,800

for using a combination of the history

123

00:07:47,800 --> 00:07:51,800

and the risk factors you were discussing

that are listed in Table 1,

124

00:07:51,800 --> 00:07:55,640

plus some biochemistry markers such as

125

00:07:55,640 --> 00:07:58,960

sFlt and PlGF

126

00:07:59,640 --> 00:08:01,600

plus some ultrasound markers,

127

00:08:01,600 --> 00:08:06,160

and using all of those in combination

as a tool of prediction.

128

00:08:06,840 --> 00:08:12,360

The use of this combined prediction

model is going to be updated

129

00:08:12,360 --> 00:08:17,120

when better evidence is available

in the Aotearoa New Zealand context.

130

00:08:18,120 --> 00:08:22,240

This next set of recommendations is around

the antihypertensives.

131

00:08:22,680 --> 00:08:27,600

This also has not been updated

for the 2022 version, but it does

132

00:08:27,600 --> 00:08:32,600

reiterate that any of the following

are appropriate first-line medications.

133

00:08:32,600 --> 00:08:36,680

These include labetalol,

nifedipine or methyldopa.

134

00:08:36,680 --> 00:08:40,440

(methyldopa being the longest one

that we have a lot of safety data on;

135

00:08:41,080 --> 00:08:43,600

labetalol is probably a bit more effective),

136

00:08:43,600 --> 00:08:46,520

but essentially all are considered

appropriate for first-line

137

00:08:46,840 --> 00:08:50,880

and then there are some recommendations

around monitoring and around the targets

138

00:08:50,880 --> 00:08:55,160

for what you want the blood pressure

to be. In stable pre-eclampsia,

139

00:08:55,160 --> 00:08:59,800

it would be around

130 - 150 over about 80 to 100

140

00:08:59,800 --> 00:09:02,880

so you're not looking for having it

go too low

141

00:09:03,720 --> 00:09:07,800

but we also don't want

people developing severe hypertension.

142

00:09:07,800 --> 00:09:10,640

For people who do develop

severe hypertension,

143

00:09:10,960 --> 00:09:12,720

there's a separate algorithm for that,

144

00:09:12,720 --> 00:09:16,680

and that's where you want to go on and start using

some of your intravenous medications.

145

00:09:17,040 --> 00:09:20,240

Again, there's not a lot

of good quality evidence

146

00:09:21,840 --> 00:09:23,880

that supports one over the other.

147

00:09:23,880 --> 00:09:26,400

So the following are all appropriate:

148

00:09:26,760 --> 00:09:32,080

IV labetalol, IV hydralazine or

Short-acting nifedipine capsules.

149

00:09:32,080 --> 00:09:37,200

It will depend on your local protocols

and what's available in your own hospital,

150

00:09:37,200 --> 00:09:40,560

but really important

to have really clear protocols

151

00:09:40,560 --> 00:09:43,600

so that they can be used

as safely as possible

152

00:09:43,600 --> 00:09:46,680

since we tend not to use these as often.

153

00:09:46,680 --> 00:09:49,960

In the beginning of the Guideline,

there are classifications and definitions

154

00:09:50,240 --> 00:09:53,480

so that midwives and health

practitioners can identify

155

00:09:53,480 --> 00:09:56,560

which type of hypertensive disorders

that they're working with.

156

00:09:56,880 --> 00:09:58,520

And the flow charts then provide

157

00:09:58,520 --> 00:10:00,960

a way of identifying the care

158

00:10:00,960 --> 00:10:02,480

that should be being provided

159

00:10:02,480 --> 00:10:03,800

during the pregnancy,

160

00:10:03,800 --> 00:10:06,280

during the birth and postpartum as well.

161

00:10:07,040 --> 00:10:10,360

The aim of monitoring is to identify

a worsening condition

162

00:10:10,600 --> 00:10:14,520

and then intervene to support

the woman's health and the baby's health.

163

00:10:15,200 --> 00:10:18,680

The parameters for the monitoring

relate to the woman's blood pressure,

164

00:10:19,080 --> 00:10:22,520

to proteinuria, to preeclampsic symptoms,

165

00:10:22,680 --> 00:10:26,720

and also to any systemic issues that may

be occurring because of the hypertension.

166

00:10:27,360 --> 00:10:30,040

Clearly, when a woman

has developed

167

00:10:30,040 --> 00:10:32,880

hypertensive symptoms

or hypertensive disorder,

168

00:10:32,880 --> 00:10:34,760

she will need a referral through

169

00:10:34,760 --> 00:10:36,880

to the obstetric team

170

00:10:36,880 --> 00:10:41,280

and during that time there should be some

there should be individualised care planning,

171

00:10:41,280 --> 00:10:44,640

which will involve which

will identify what monitoring

172

00:10:44,640 --> 00:10:47,360

the woman should have

ongoing for her care.

173

00:10:48,200 --> 00:10:50,240

Whilst we have a table within the Guideline

174

00:10:50,240 --> 00:10:52,360

which gives the parameters

for this monitoring,

175

00:10:52,360 --> 00:10:55,080

this should be individualised

for each woman dependent

176

00:10:55,080 --> 00:10:59,480

on her context, her situation

and what's feasible in her in

177

00:10:59,480 --> 00:11:03,360

for her situation to ensure that both her

and her baby are kept safe.

178

00:11:04,080 --> 00:11:07,320

The last set of recommendations

is around magnesium sulphate.

179

00:11:07,320 --> 00:11:10,200

This also has not been updated since 2018.

180

00:11:10,560 --> 00:11:13,200

It is one of the few areas

of the Guideline that has high-

181

00:11:13,200 --> 00:11:16,680

quality evidence

to underscore the strength

182

00:11:16,680 --> 00:11:20,120

of these recommendations,

and that is that we recommend

183

00:11:20,400 --> 00:11:23,960

magnesium sulphate be used in women

with pre-eclampsia

184

00:11:24,240 --> 00:11:28,440

to reduce the risk of having a seizure

or developing eclampsia.

185

00:11:36,760 --> 00:11:41,920

Welcome to this section of the

webinar on the intrapartum management

186

00:11:41,920 --> 00:11:45,280

of women with hypertension

disorders of pregnancy

187

00:11:45,280 --> 00:11:48,120

and specifically focusing

on the timing of birth.

188

00:11:48,600 --> 00:11:51,520

This was the one area

where we did do an

189

00:11:51,520 --> 00:11:55,960

evidence review of women

with pre-eclampsia.

190

00:11:55,960 --> 00:12:00,840

The other conditions

such as pre-existing hypertension,

191

00:12:00,840 --> 00:12:05,000

gestational hypertension and women

with severe pre-eclampsia or eclampsia

192

00:12:05,680 --> 00:12:08,280

essentially is unchanged

from the previous version.

193

00:12:09,800 --> 00:12:12,120

For the Steering Group,

it was really important that we were able

194

00:12:12,120 --> 00:12:17,520

to balance the or considered balancing

the maternal health and the baby's health.

195

00:12:18,120 --> 00:12:21,000

Essentially,

what we what we were seeing was if,

196

00:12:21,000 --> 00:12:23,680

one would be affected, then

we didn't want the other to be affected.

197

00:12:23,680 --> 00:12:26,640

So we didn't want the mother's health

to be affected more than the baby's health

198

00:12:26,840 --> 00:12:29,280

or the baby's health to be affected

more than the mother's health.

199

00:12:30,000 --> 00:12:34,520

So it's a real balancing act to try

and identify the optimal time of birth

200

00:12:34,800 --> 00:12:37,920

for that particular woman

dependent on her particular condition

201

00:12:38,640 --> 00:12:40,880

and also how the baby's faring as well.

202

00:12:41,600 --> 00:12:45,640

And so the clinician has quite

a difficult decision to make at that point in time,

203

00:12:45,640 --> 00:12:48,240

and clearly the woman's wishes

have to come into that as well.

204

00:12:48,720 --> 00:12:52,520

However,

I also always talk to my registrars

205

00:12:52,520 --> 00:12:55,680

about the importance

of a 3-way conversation,

206

00:12:55,680 --> 00:12:58,320

but also knowing for yourself

what the evidence shows.

207

00:12:58,760 --> 00:13:03,040

So I guess what was good about this

evidence review

208

00:13:03,040 --> 00:13:06,360

is that we did find a meta-analysis

that was published in 2021

209

00:13:06,360 --> 00:13:10,160

that summarised three randomised trials,

specifically looking

210

00:13:10,160 --> 00:13:13,720

at timing of birth in women

between 34 and 37 weeks

211

00:13:13,720 --> 00:13:18,720

and asking the question of what maternal

and fetal outcomes were improved

212

00:13:18,720 --> 00:13:22,280

or worsened by planning birth,

213

00:13:22,280 --> 00:13:24,400

versus planning expectant management.

214

00:13:24,880 --> 00:13:26,760

And it's exactly what you said:

215

00:13:26,760 --> 00:13:29,200

you're always balancing the two.

216

00:13:29,200 --> 00:13:34,520

The moderate quality evidence did suggest

that if you planned expectant management,

217

00:13:34,520 --> 00:13:38,960

you would increase the risk

of the composite maternal adverse outcome

218

00:13:39,280 --> 00:13:40,720

whilst if you

219

00:13:41,800 --> 00:13:43,360

planned expectant management,

220

00:13:43,360 --> 00:13:46,720

then then the baby outcomes

were better in terms of being

221

00:13:46,720 --> 00:13:50,880

admitted to the nursery or developing RDS

or other complications of prematurity.

222

00:13:51,960 --> 00:13:54,000

Yes. , which is why it's

such a difficult decision

223

00:13:54,000 --> 00:13:58,800

but the recommendation is to plan

expectant management, if at all possible.

224

00:13:58,840 --> 00:13:59,200

Yeah.

225

00:13:59,200 --> 00:14:02,520

And then there's a very clear table

in the Guideline

226

00:14:02,520 --> 00:14:06,520

that delineate the different conditions,

both for the mum or the baby

227

00:14:06,520 --> 00:14:11,280

that would warrant offering

induction of labour or a caesarean section.

228

00:14:11,280 --> 00:14:12,000

Yeah.

229

00:14:12,000 --> 00:14:14,880

And it was really an interesting

discussion.

230

00:14:14,880 --> 00:14:16,760

It took an entire meeting

of the Steering Group

231

00:14:16,760 --> 00:14:19,920

to really grapple with this

between the midwives, the doctors,

232

00:14:19,920 --> 00:14:23,040

the MFM specialists,

the neonatal specialists in the room,

233

00:14:23,040 --> 00:14:27,360

all trying to work through

how to frame our recommendations.

234

00:14:28,080 --> 00:14:30,400

And again, it's it comes back to

235

00:14:30,400 --> 00:14:33,240

putting the mother's

health first or the baby's health first,

236

00:14:33,520 --> 00:14:37,080

when actually what we want to do

is put both of those those health first.

237

00:14:37,080 --> 00:14:40,040

Yeah. Which underlines the importance

of having a 3-way conversation.

238

00:14:40,040 --> 00:14:42,560

It will be different in any one

239

00:14:43,200 --> 00:14:46,120

individualised situation

with that clinician, with the woman

240

00:14:46,120 --> 00:14:49,480

in front of them, and trying to make

the best decision possible for both.

241

00:14:49,720 --> 00:14:52,720

And it's important that midwives are aware

of those conversations and able

242

00:14:52,720 --> 00:14:56,520

to support the woman and her partner

and her whānau,

243

00:14:56,520 --> 00:14:59,480

as well as actually support

the recommendations in the Guidelines.

244

00:14:59,920 --> 00:15:05,520

And we did agree for women after 37 weeks

that we would recommend offering birth,

245

00:15:05,520 --> 00:15:09,040

whether induction of labour

or a caesarean section over 37 weeks.

246

00:15:09,880 --> 00:15:13,120

So the recommendations around the mode

of birth actually have not changed.

247

00:15:13,800 --> 00:15:17,040

Essentially, it's the preferred mode of

Birth is a vaginal birth

248

00:15:18,560 --> 00:15:22,360

and eclampsia is not an indication

for caesarean section.

249

00:15:22,360 --> 00:15:25,400

So induction of labour is a safe option

250

00:15:25,400 --> 00:15:27,960

in cases of hypertension, essentially.

251

00:15:29,200 --> 00:15:32,920

But clearly the mode of birth

also needs to be discussed with the woman

252

00:15:33,520 --> 00:15:37,840

and her preferences

should also be acknowledged and discussed.

253

00:15:38,400 --> 00:15:42,360

The Guidelines make a special note of

women who are less than 28 weeks pregnant

254

00:15:43,080 --> 00:15:47,400

in that the induction of labour is less

successful for this group of women.

255

00:15:47,760 --> 00:15:51,600

Therefore, a caesarean section

should be offered to these women;

256

00:15:51,600 --> 00:15:57,000

to women who are less than 28 weeks

to as a as a preferred mode of birth.

257

00:15:57,600 --> 00:16:00,160

So the final piece is on anaesthesia.

258

00:16:00,160 --> 00:16:02,760

When I was training,

it used to be that everyone with

259

00:16:02,760 --> 00:16:05,480

pre-eclampsia had a

general anaesthetic if needed

260

00:16:05,840 --> 00:16:10,320

and I'm happy to say that practice

has changed over the last few decades

261

00:16:10,320 --> 00:16:15,640

and the recommendation is unchanged

from 2018, where women should be offered

262

00:16:15,640 --> 00:16:21,080

an epidural or a spinal or CSE

if they need an operative birth

263

00:16:21,080 --> 00:16:24,960

and this is thought to be safe

even in the setting of low platelets.

264

00:16:25,640 --> 00:16:29,680

That being said, there's a suggestion

that a platelet count of under 80

265

00:16:29,680 --> 00:16:33,480

probably is a contraindication

to a regional anaesthetic.

266

00:16:41,120 --> 00:16:45,160

Kia ora welcome to the postpartum

section of the webinar.

267

00:16:45,560 --> 00:16:47,040

This section will cover

268

00:16:47,040 --> 00:16:50,600

the immediate postpartum

monitoring of the woman's blood pressure

269

00:16:50,920 --> 00:16:55,040

and also the long term implications

of hypertension during pregnancy.

270

00:16:55,720 --> 00:16:59,640

We know that for most women

who have hypertensive disorder,

271

00:16:59,640 --> 00:17:03,240

the blood pressure will return to normal

within a few days of giving birth

272

00:17:03,600 --> 00:17:05,240

although for some for some women,

273

00:17:05,240 --> 00:17:08,360

it may take up to three months

to return to normal postpartum.

274

00:17:09,000 --> 00:17:12,320

The Guideline recommends

that women remain in hospital for 72 hours

275

00:17:12,320 --> 00:17:13,680

following the birth.

276

00:17:13,680 --> 00:17:17,520

This allows the woman's blood

pressure to be monitored closely

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00:17:17,520 --> 00:17:19,320

for those for those three days

278

00:17:19,320 --> 00:17:23,320

and also allows for a review

of her blood pressure medication

279

00:17:23,320 --> 00:17:25,640

to ensure that she's on the right medication

280

00:17:25,640 --> 00:17:26,560

before she goes home.

281

00:17:26,560 --> 00:17:30,400

Once the woman is home,

there is an expectation that the midwife

282

00:17:30,400 --> 00:17:33,680

will visit within 24 hours

and repeat the blood pressure check.

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00:17:33,960 --> 00:17:35,160

At this point, she's again

284

00:17:35,160 --> 00:17:37,800

checking that the woman's blood

pressure is remaining stable.

285

00:17:38,520 --> 00:17:43,200

And if there are any concerns, then

clearly she would make plans to undertake

286

00:17:43,200 --> 00:17:48,280

further assessment of that blood pressure

and connecting with the hospital team again.

287

00:17:49,040 --> 00:17:52,400

If the woman's blood pressure is stable,

then the expectation

288

00:17:52,400 --> 00:17:55,440

is that the blood pressures

checked on a weekly basis

289

00:17:56,160 --> 00:17:58,360

with any concerns clearly raised with

290

00:17:58,760 --> 00:18:00,760

either the hospital team or the GP.

291

00:18:01,400 --> 00:18:04,720

There is an expectation

that the discharge summary

292

00:18:04,720 --> 00:18:08,680

will include a care plan

which identifies the woman's medication

293

00:18:08,880 --> 00:18:11,840

and the expectation around

how that medication is managed

294

00:18:12,120 --> 00:18:15,960

through the postpartum period

and into the GP care.

295

00:18:16,680 --> 00:18:19,680

The postpartum management

and blood pressure monitoring

296

00:18:19,680 --> 00:18:22,520

has changed in this Guideline

from the previous Guideline.

297

00:18:23,240 --> 00:18:26,960

The previous Guideline identified

blood pressure monitoring for seven days

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00:18:26,960 --> 00:18:28,320

following the birth.

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00:18:28,320 --> 00:18:31,560

Our evidence review did not uncover

any evidence to support

300

00:18:31,560 --> 00:18:33,120

seven days of monitoring;

301

00:18:33,120 --> 00:18:36,920

however, we did identify

that women's blood pressure

302

00:18:36,920 --> 00:18:39,840

can be mobile for

up to five days postpartum.

303

00:18:39,840 --> 00:18:41,760

Therefore, it's important

that we actually monitor

304

00:18:41,760 --> 00:18:45,600

the blood pressure for those five days

and then obviously, if stable,

305

00:18:45,600 --> 00:18:48,280

continue to monitor weekly after that.

306

00:19:05,360 --> 00:19:10,040

The important thing after that

first six weeks of the postpartum period,

307

00:19:10,040 --> 00:19:14,120

once women and their babies are handed

over to the GP,

308

00:19:14,400 --> 00:19:19,080

is to educate women and the GPs about

the long-term health implications

309

00:19:19,080 --> 00:19:23,040

of having had gestational hypertension

or pre-eclampsia during pregnancy.

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00:19:23,520 --> 00:19:26,440

It also underscores

the importance of a healthy lifestyle

311

00:19:26,480 --> 00:19:29,360

to try to reduce

some of those risks in the long-term.

312

00:19:29,880 --> 00:19:33,400

So for example, in the Guideline Table 3

313

00:19:33,400 --> 00:19:37,680

outlines the risks to future health

for these women.

314

00:19:38,160 --> 00:19:42,240

I think most women

and their caregivers know that the risk

315

00:19:42,240 --> 00:19:46,200

of having pre-eclampsia again

in a subsequent pregnancy is quite high.

316

00:19:46,200 --> 00:19:48,960

It's that six times

higher than the general population

317

00:19:49,920 --> 00:19:52,400

but I think it's really important to also talk

318

00:19:52,400 --> 00:19:54,240

about and inform women

319

00:19:54,240 --> 00:19:58,360

about their lifetime risk of developing

chronic hypertension,

320

00:19:59,480 --> 00:20:02,640

cardiovascular disease

or cerebrovascular disease,

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00:20:02,840 --> 00:20:07,760

and also things like venous

thromboembolism and kidney disease.

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00:20:07,760 --> 00:20:14,360

So these are all really important health

outcomes that are potentially modifiable

323

00:20:14,360 --> 00:20:19,640

by screening for and changing things

that could help improve those risks.

324

00:20:20,360 --> 00:20:23,080

We also don't want to forget

general postpartum care,

325

00:20:23,080 --> 00:20:26,920

such as contraception

and looking for any mental health issues.

326

00:20:27,400 --> 00:20:30,880

It's especially important in these women

who have had a really complex pregnancy

327

00:20:30,880 --> 00:20:34,520

with lots of extra monitoring

and more interventions

328

00:20:34,520 --> 00:20:39,720

and potentially a difficult birth to offer them

a debrief to discuss these issues.

329

00:20:40,320 --> 00:20:45,560

So although the audience for this webinar

is primarily midwives and obstetricians,

330

00:20:46,040 --> 00:20:49,520

I think it's really important that women

get as much information as they can

331

00:20:49,520 --> 00:20:54,240

and that we signal to GPs

that this is a lifetime consideration.

332

00:21:02,720 --> 00:21:05,040

We'd like to say thank you

for watching this webinar

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00:21:05,040 --> 00:21:07,160

on the Hypertensive Guidelines.

334

00:21:07,320 --> 00:21:10,240

We hope you find them helpful

and interesting and hope that you will

335

00:21:11,360 --> 00:21:14,360

carefully read them and

take them into your practice.

336

00:21:14,880 --> 00:21:18,120

The review itself

raised a number of questions

337

00:21:18,120 --> 00:21:21,280

that have not been answered

within the evidence review

338

00:21:21,280 --> 00:21:25,400

and which actually provide or demonstrate

gaps in our knowledge base at the moment,

339

00:21:26,000 --> 00:21:28,400

which obviously will need to be filled.

340

00:21:28,400 --> 00:21:32,240

One of those knowledge gaps

was about equitable outcomes for women,

341

00:21:32,240 --> 00:21:33,720

and the question was asked

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00:21:33,720 --> 00:21:37,640

should some of the recommendations

be tailored for specific groups of women?

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00:21:37,640 --> 00:21:41,560

Unfortunately, we were unable

to find any strong evidence to support

344

00:21:41,560 --> 00:21:45,320

any changes in the recommendations

as they are at the moment

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00:21:45,320 --> 00:21:48,960

but clearly this is something that does

need to be reviewed in future to ensure

346

00:21:48,960 --> 00:21:52,520

that we have equitable outcomes

for our context in future.

347

00:21:52,920 --> 00:21:56,600

So I would like to briefly thank

all the people that made this happen,

348

00:21:56,600 --> 00:21:59,480

specifically Allen and Clarke

and the project team

349

00:21:59,480 --> 00:22:02,760

that provided expertise

to the development of the Guideline,

350

00:22:02,760 --> 00:22:06,280

including Norma Campbell and Professor Bloomfield,

351

00:22:06,280 --> 00:22:08,240

also the Steering Group

352

00:22:08,240 --> 00:22:10,840

for all the hours spent reading documents

353

00:22:10,840 --> 00:22:12,640

and coming together to discuss

354

00:22:12,640 --> 00:22:15,160

the recommendations under the guidance

355

00:22:15,160 --> 00:22:17,960

of co-chairs Angela and Sue.

356

00:22:18,680 --> 00:22:22,080

After the group had our initial

357

00:22:22,080 --> 00:22:23,320

set of recommendations,

358

00:22:23,320 --> 00:22:26,680

these were sent out for formal external stakeholder

359

00:22:27,640 --> 00:22:29,760

consultation and all of that feedback

360

00:22:29,760 --> 00:22:31,520

was taken and analysed

361

00:22:31,520 --> 00:22:33,480

and provided back to the Steering Group

362

00:22:33,480 --> 00:22:34,880

who made a final version,

363

00:22:35,280 --> 00:22:38,360

and that went back to the Ministry

of Health and for endorsement

364

00:22:38,640 --> 00:22:42,880

by the New Zealand Committee of RANZCOG,

the New Zealand College of Midwives

365

00:22:42,880 --> 00:22:46,720

and the New Zealand College of GPs,

all of whom have endorsed the Guideline

366

00:22:46,720 --> 00:22:48,000

and it's now published

367

00:22:48,000 --> 00:22:50,960

on the Te Whatu Ora website,

and I would encourage

368

00:22:50,960 --> 00:22:52,200

everyone to have a look at it.

369

00:22:53,240 --> 00:22:55,840

A Guideline is only as good as the people

that are using it.

370

00:22:55,840 --> 00:22:56,960

So essentially

371

00:22:56,960 --> 00:23:00,040

we hope this Guideline will be something

that you will use in practice.

372

00:23:00,040 --> 00:23:03,800

For women who experience hypertension,

during pregnancy,

373

00:23:04,360 --> 00:23:05,760

it can be very challenging

374

00:23:05,760 --> 00:23:09,200

so having a Guideline that sets out

how they should be treated

375

00:23:09,200 --> 00:23:12,520

and what options there are for

them is important

376

00:23:12,760 --> 00:23:15,680

but this is also important

for the practitioners themselves,

377

00:23:15,920 --> 00:23:18,440

so that they are also providing

consistent care

378

00:23:18,440 --> 00:23:23,920

and able to be clear on the expectations

that the women should have.