OUTPATIENT MANAGEMENT OF PREECLAMPSIA

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BACKGROUND

Once a diagnosis of preeclampsia has been made based on new onset systolic blood pressure ≥ 140 mm Hg and or diastolic blood pressure ≥ 90 mm Hg, and new onset significant proteinuria, or signs and symptoms of preeclampsia as seen in the Chapter: Classification and Diagnosis or Hypertensive Disorders of Pregnancy, (Table 1, pg. 20), the provider must decide if the woman has preeclampsia without severe features (mild) or severe preeclampsia. Outpatient treatment should only be considered for women with preeclampsia without severe features (mild) at less than 37 weeks and only after confirming fetal wellbeing and maternal stability.[1] It is imperative in the initial evaluation to document the severity of preeclampsia and the following evaluation is recommended: blood pressure, proteinuria assessment, CBC (complete blood count) with platelet count, AST (Aspartate Aminotransferase), ALT (Alanine Aminotransferase), Cr (Creatinine), bilirubin, and LDH (Lactate dehydrogenase).[2] The symptoms that should be assessed and documented as present or absent include headache, abdominal pain, and significant visual disturbances.

Fetal assessment should include NST (Non-stress Test) or BPP (Biophysical Profile), which includes NST plus fetal movement, tone, breathing, and heart rate and amniotic fluid volume, and ultrasound assessment of fetal growth. The goal of outpatient management in women with preeclampsia without severe features (mild) is early identification of the development of severe preeclampsia so that the woman is hospitalized and delivered if necessary, before significant maternal or fetal morbidity ensues.

If any abnormalities in either maternal or fetal assessments are consistent with severe preeclampsia, further management should occur in the hospital (see Chapter: Special Circumstances: Severe Preeclampsia At < 34 weeks, pg. 76). If preeclampsia without severe features (mild) is documented and outpatient management is considered then there should be a clear documented follow-up plan that is understood by the patient. Heightened surveillance is recommended to diagnose signs of worsening disease, which would prompt hospitalization and/or delivery. This generally includes twice-weekly maternal and fetal assessment. Maternal blood pressure, urine protein assessment and a verbal review of signs and symptoms should be performed twice per week. The fetus should have an NST and AFI (Amniotic Fluid Index) or BPP twice per week during outpatient observation. Additional maternal laboratory tests should be done as indicated if there is a suspicion of worsening disease. Once the patient develops any sign of severe preeclampsia *she should be admitted to the hospital and* her plan should change accordingly. If the patient continues to have only preeclampsia without severe features (mild) but reaches 37 weeks, the plan of treatment should include delivery. If the patient is diagnosed with severe preeclampsia, she should be admitted to the hospital and—if

gestational age is 34 weeks or greater—delivered.[3] If she is less than 34 weeks with severe preeclampsia, she should be admitted and managed at a tertiary care facility with close observation for worsening disease or complications that necessitate delivery.

EVIDENCE GRADING
Level of Evidence: C

REFERENCES

1. ACOG. Diagnosis and Management of Preeclampsia and Eclampsia #33. *American Congress of Obstetricians and Gynecologists Practice Bulletin Number 33.* 2002 (Reaffirmed 2012).
2. Sibai BM. Diagnosis and management of gestational hypertension and preeclampsia. *Obstet Gynecol.* Jul 2003;102(1):181-192.
3. Sibai BM. Evaluation and management of severe preeclampsia before 34 weeks' gestation. *Am J Obstet Gynecol.* Sep 2011;205(3):191-198.