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

Transcript of the webinar for health practitioners

Te Kāwanatanga o Aotearoa
New Zealand Government

Te Whatu Ora
Health New Zealand

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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

277
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.

283
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

298
00:18:26,960 --> 00:18:28,320
following the birth.

299
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.

310
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,

321
00:20:02,840 --> 00:20:07,760
and also things like venous
thromboembolism and kidney disease.

322
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

333
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

342
00:21:33,720 --> 00:21:37,640
should some of the recommendations
be tailored for specific groups of women?

343
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

345
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.