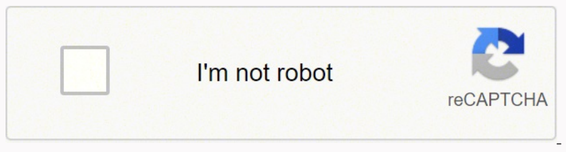

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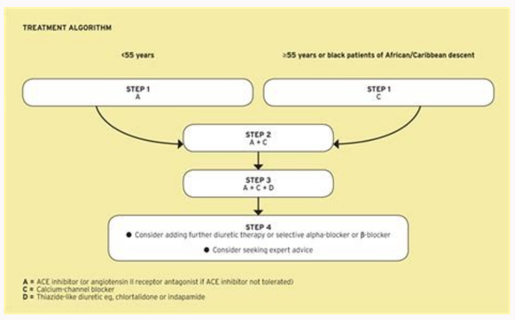


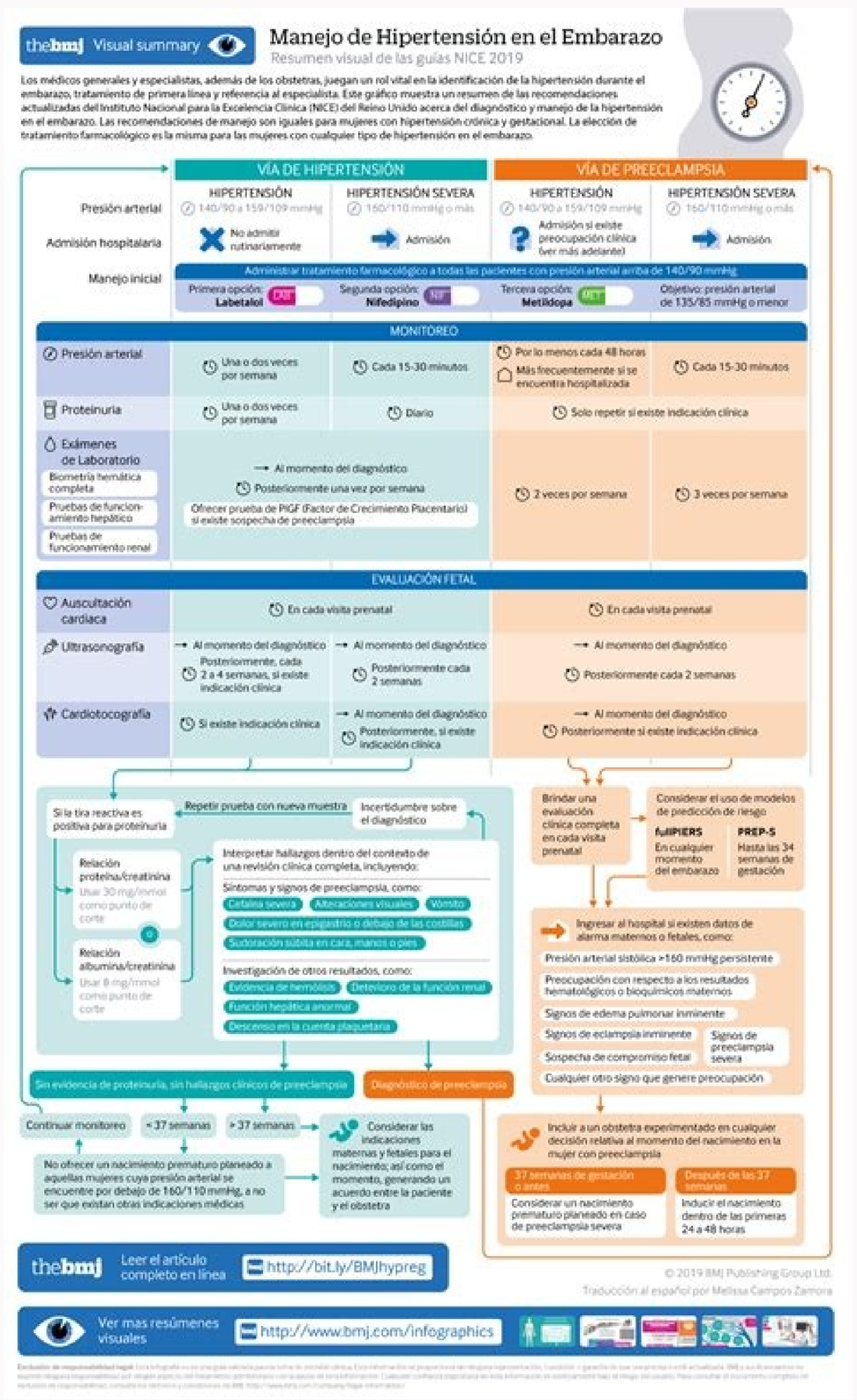
MANAGEMENT OF HYPERTENSIVE DISORDERS IN PREGNANCY

- An evidence based approach

Dr. Mohammed Sadiq Azam M.D. (Int Med)

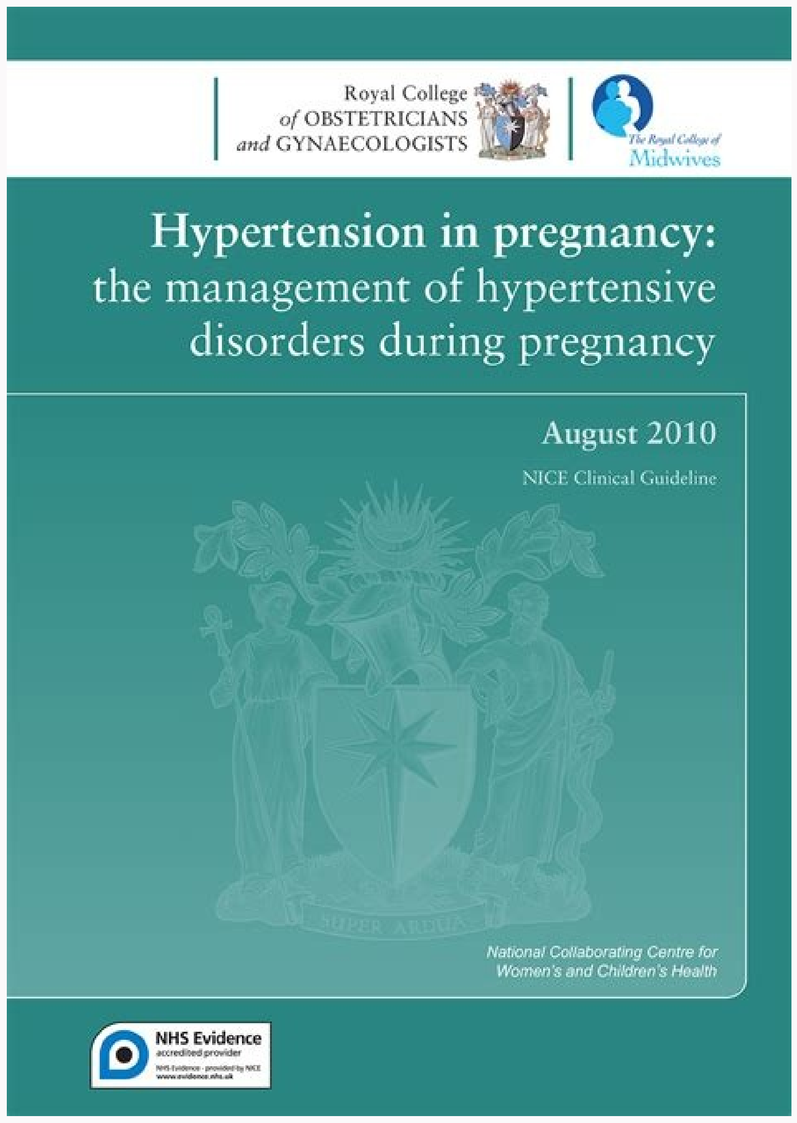
Senior Resident, Department of Medicine, Osmania General Hospital

Physician, Princess Esra Hospital



18.85 Definition of hypertension

Category	Systolic BP (mmHg)	Diastolic BP (mmHg)
BP		
Optimal	< 120	< 80
Normal	< 130	85
High normal	130–139	85–89
Hypertension		
Grade 1 (mild)	140–159	90–99
Grade 2 (moderate)	160–179	100–109
Grade 3 (severe)	≥ 180	> 110
Isolated systolic hypertension		
Grade 1	140–159	< 90
Grade 2	≥ 160	< 90



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Both for the mother and the baby, the prospects are better than they were, at least in the developed world. The new Nice guidelines for the management of hypertension during pregnancy (available online at HTTP: //www.nice.org.uk/Guidance/CG1), including more than 1000 pages, including apães, ambitiously re-examine all aspects of management and the evidence in which the recommendations are based. [2010, changed in 2019] 1.5.25 in women with parlém mpsia that have given birth, perform a test of urinary reagent strip 6 Ã € "8 weeks after birth. These information must be presented in such a way that it has individual risk and benefit scenarios and presents the absolute risk of numerically events and uses appropriate diagrams and texts. [2010] 1.5.14 In women with prested - mpsia who did not give antihypertensive treatment and they gave birth, start antihypertensive treatment if arterial pressure is 150 / 100ã, mmHG or higher . [2010, changed in 2019] 1.5.20 Develop a Care Plan for women with parliamentary women who have taken and are being transferred to Community care that includes all of the following: which will provide care for Follow-up, including medical revision, if necessary frequency of the arterial pressure monitoring thresholds to reduce or stop the indication of treatment for referral for primary care for analysis of the Arterial pressure, self-monitoring for symptoms. Ã € â € œ BMC pregnancy delivery. [2008, changed in 2014] 1.1.28 If the person's DVC risk is on a level in which the intervention is recommended, but this refuses to provide treatment, advise it to re-evaluate their risk DVC in the future. [2008] 1.1.3 People over 40 should have their risk estimate of DCV revised on a continuing basis. [2008, altered 2014] 1.1.18 Recognize that standard CVD risk classifications µ underestimate the risk in people who present an additional risk due to µ condition or underlying medical treatments. two: two: [2008, [2008, amended 2014] 1.1.21 Consider people aged 85Ã or older to be at increased risk of CVD because of age alone, particularly people who smoke or have raised blood pressure. Use clinical judgement to decide on further treatment of risk factors in people who are below the CVD risk threshold for treatment. See recommendations 1.3.23, 1.3.24 and 1.3.25 for advice on treatment with statins for people with typeÃ 1 diabetes. [2008] 1.1.27 To encourage the person to participate in reducing their CVD risk: find out what, if anything, the person has already been told about their CVD risk and how they feel about it explore the person's beliefs about what determines future health (this may affect their attitude to changing risk) assess their readiness to make changes to their lifestyle (diet, physical activity, smoking and alcohol consumption), to undergo investigations and to take long¢ÂÂterm medication assess their confidence in making changes to their lifestyle, undergoing investigations and taking medication inform them of potential future management based on current evidence and best practice involve them in developing a shared management plan check with them that they have understood what has been discussed. The breadth of the guidelines reflects the complexities of their subject. [2008, amended 2014] 1.1.16 Do not use a risk assessment tool for people who are at high risk of developing CVD because of familial hypercholesterolaemia (see NICE's guideline on familial hypercholesterolaemia) or other inherited disorders of lipid metabolism. [2008, amended 2014] 1.1.19 Recognise that CVD risk will be underestimated in people who are already taking antihypertensive or lipid modification therapy, or who have recently stopped smoking. [2008, amended 2014] 1.1.23 Use everyday, jargon¢ÂÂfree language to communicate information on risk. Previously the first cause of maternal death in the UK, it is now the second.1 Maternal deaths PrÃ©-eclÃomsia Not recently and, more disturbing, are associated with the highest rates of care below the standard, of all causes of maternal deaths.1 They also the most important reason for the iatrogenic prematurity, one of the main contributors to perinatal mortality and The cause of fetal growth restriction, especially with prÃ©-term disease.2 Amplification cannot be reliably avoided or reversed once established, except by delivery, which removes the cause - that is, the placenta. [2008] 1.1.25 Document the discussion related to the consultation on risk assessment and the person's decision. [2010] 1.5.21 Offer to women who have had pr³eclÃmpsia and who remain in antihypertensive treatment, a medical review with their GP or specialist in 2 years after the transfer to the care of the community. Langenveld J, et al. Gestational hypertens are often benign, but also ©m may be an early stage in the development of prA©-eclÃampsia.Pre-eclampsia is not benign. [2010] 1.5.16 In women with prÃ©-eclÃampsia who took antihypertensive treatment and gave it to light, measure blood pressure: at least 4 times a day, while the woman A hospital every 1 "days ³ the transfer. for the care of the community until the woman is out of treatment and does not have hyperitems. They deal with many specific quests µs not a ©tricas, but it is clear that the management of ³ hypertens is a primary focus. If you use the term tapicnics, explain them clearly. [New 2014] 1.1.9 Do not use a risk assessment tool to assess the risk of CVD in people with diabetes type. Hyperitems in pregnancy may indicate a medical chronic problem, gestational hypertens (new hyper-items without protein) or pr-eclLampsia (new hyper-items with new protein). [2008, amended 2014] [2010, amended 2019] 1.5.22 Offer all women who have had prA©-eclÃmpitas Membership review with your GP or specialist 6 - 8 hours after birth. [2008] 1.1.26 Offer information about people about your DCV risk and the benefits and absolute damage of an intervention â € a 10 year period. [2010, altered in 2019] 1.5.27 Consider women with an assessment of abnormal renal function at 3 months for a renal evaluation specialized in accordance with NICA NICE on disease renal criant in adults. Clinical assay. 2011 Jul 7; 11: 50. Intended for health professionals BMJ 2019; 366 Doi: (Published on September 9, 2019) Cite it as: BMJ 2019; 366: L5119 Spanish Version: VersiÃƒÂ³n EN EspaÃƒÂ ± OL Induction of labor versus expectant monitoring for gestational hypertension or light-mpsia-mps between 34 and 37 weeks of gestation (Hypitat-II): an essay Multicted, open, randomized and controlled. [2008] 1.1.14 Consider socioeconal status as an additional factor contributing to the risk of DVC. Langenveld J, Broekhuijsen K, Van Baaren GJ, Van Pampus MG, Van Kaam Ah, Groen H, Poreath M, Oudijk Ma, Bloemenkamp KW, Groot CJ, Van Beek and, Van Huizen Me, Oosterbaan HP, Willekes C, Wijnen-Duvekot EJ, Franssen Mt, Perquy, Sporken JM, Woiski MD, Bremer Ha, Papatsonis DN, Brons JT, Kaplan M, Nij Bijvanck BW Mol BW; Hypitat-II study group. [2008, changed in 2014] 1.1.5 Discuss the risk assessment process with the person identified as being at risk, including the option to refuse any formal risk assessment. The interpretation of DCV risk punctions should always reflect a clinical evaluation informed. Cardiovascular, obstacular or intensive care machines will participate, or may be involved at some point, and these guidelines are also directed to them.HiPertension is defined as in the table 1. [2010, altered in 2019] 1.5.23 In women who have pronate-earmsia with light or moderate hypertension, or after the uncomfortable of chronic care: measuring platelet count, acir©Ās acir©Ās aninitaerc a uo sesanimasnart sa ,sateuqalp ed megatnoc a matiper o£Ān o£Ã§Āuder a uo otnemicsan o s³Āpa saroh Ã27Â Â¢Ã84 acir©Ās aninitaerc a e .oir¡Āssecen .lanoicida atlusnoc amu air¡Āssecen res edoP .CVD ed ocsir o arap odamixorpa rolav mu sanepa recenrof medop CVD ed socsir ed o£Ã§Āailava ed sotnemurtsni so sodot euq ed etneic ajetsE 7.1.1]8002[.odnarohlem o£Âtse uo siev¡Âtse o£Ās soenÃugnas setset sod sodatluser so sonem uo gHmm Ã001/051 ed ©Ā ,otnematart mes uo moc ,aispm¢Ālce-©Ārp lairetra o£Ãsserp ed samotnis ¡Ãh o£Ān :sodidneta odis merevit soir©Ātirc setniuges so sodot es soir¡Ātinumoc sodadiuc arap aicnªĀrefsnart zul Ā odad mahnet euq aispm¢Ālce-©Ārp moc serehlum s Ā recerefO 91.5.1]9102 me odaretla ,0102[.sacid©Ām saton saus me ahlocse aus ertsigeR .saroh Ã27Â Â¢Ã84 a siamron merevitse sodatluser so es

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