

Hypertensive Emergency Checklist

Two severe BP values ($\geq 160/110$) taken 15-60 minutes apart. Values do not need to be consecutive.
May treat within 15 minutes if clinically indicated.

- ☐ Call for Assistance
- ☐ Designate:
 - ☐ Team leader
 - ☐ Checklist reader/recorder
 - ☐ Primary RN
- ☐ Ensure side rails up / padding if possible
- ☐ Institute fetal surveillance if viable
- ☐ Place IV / Draw preeclampsia labs
- ☐ Antihypertensive therapy within 1 hour for persistent severe range BP
- ☐ Administer seizure prophylaxis
- ☐ Antenatal corticosteroids (if indicated)
- ☐ Place indwelling urinary catheter
- ☐ If first line agents unsuccessful, emergency consult with specialist (MFM, internal medicine, OB anesthesiology, critical care) is recommended
- ☐ Brain imaging if unremitting headache or neurological symptoms
- ☐ Debrief patient, family, and obstetric team

Magnesium Sulfate
<i>Contraindications: myasthenia gravis; avoid with pulmonary edema, use caution with renal failure</i>
IV access: ☐ Load 4-6 grams 10% magnesium sulfate in 100 mL solution over 20 min ☐ Label magnesium sulfate ☐ Connect to labeled infusion pump ☐ Maintenance 1-2 grams/hour No IV access: ☐ 10 grams of 50% solution IM (5 g in each buttock)
If contra-indicated: Levetiracetam can be considered as a second line agent
Antihypertensive Medications (see table)
Labetalol
▪ Maximum cumulative IV dose in 24 hours : 300 mg ▪ Hold IV labetalol for maternal pulse under 60 ▪ Avoid parenteral labetalol with active asthma, heart disease, or congestive heart failure ▪ Use with caution with history of asthma Active asthma is defined as symptoms at least: - Once a week, or - Use of an inhaler, corticosteroids for asthma during the pregnancy, or - Any history of intubation or hospitalization for asthma.
Hydralazine
▪ Maximum cumulative IV dose in 24 hours: 20 mg ▪ May increase risk of maternal hypotension
Oral Nifedipine (immediate-release)
▪ Maximum daily dose: 180 mg ▪ Capsules should be administered orally, not punctured or otherwise administered sublingually
Guidance on Head Imaging
▪ Patients with seizures who do not fit the diagnosis of preeclampsia ▪ Persistent neurologic deficit ▪ Prolonged loss of consciousness ▪ Onset of seizures > 48 hours after giving birth ▪ Onset of seizures < 20 weeks ▪ Seizures despite magnesium therapy

PROTOCOLS FOR THE TREATMENT OF SEVERE HYPERTENSION <i>SBP ≥ 160 mm Hg or DBP ≥ 110 mm Hg and persistent for 15 minutes</i>							
Time (min)	0	10	20	30	40	50	60
LABETALOL (IV)	20 mg IV	SBP ≥ 160 or DBP ≥ 110 40 mg IV	SBP ≥ 160 or DBP ≥ 110 80 mg IV	SBP ≥ 160 or DBP ≥ 110 10 mg IV HYDRALAZINE		SBP ≥ 160 or DBP ≥ 110 CONSULT AND TREAT	

Time (min)	0	10	20	30	40	50	60
HYDRALAZINE (IV)	5-10 mg IV		SBP ≥ 160 or DBP ≥ 110 10 mg IV		SBP ≥ 160 or DBP ≥ 110 20 mg IV LABETALOL	SBP ≥ 160 or DBP ≥ 110 40 mg IV LABETALOL CONSULT AND TREAT	

Time (min)	0	10	20	30	40	50	60
NIFEDIPINE (PO)	10 mg PO		SBP ≥ 160 or DBP ≥ 110 20 mg PO		SBP ≥ 160 or DBP ≥ 110 20 mg PO		SBP ≥ 160 or DBP ≥ 110 20 mg IV LABETALOL CONSULT AND TREAT

Adapted from Fishel Bartal M, Sibai BM. Eclampsia in the 21st century. Am J Obstet Gynecol. 2022 Feb;226(2S):S1237-S1253.