

When Diagnosing Preeclampsia, Think Widely, Be Alert

Lara C. Pullen, PhD | November 18, 2013

The presence of proteinuria is no longer required to diagnose preeclampsia. In the absence of proteinuria, preeclampsia can be diagnosed when a pregnant woman presents with any of the following:

- hypertension,
- thrombocytopenia,
- impaired liver function,
- progressive renal insufficiency,
- pulmonary edema, or
- new-onset cerebral or visual disturbances.

The new diagnosis criteria are described in the American College of Obstetricians and Gynecologists (ACOG) [task force report](#) on hypertension in pregnancy. The report reflects the last 10 years of research on preeclampsia and therapy. In particular, it reflects a growing understanding that preeclampsia is a multisystem disease that extends beyond high blood pressure and renal dysfunction.

Evidence-Based Guidelines

James N. Martin Jr, MD, professor of obstetrics and gynecology at the University of Mississippi Medical Center in Jackson and ACOG past president, created the task force and spoke with *Medscape Medical News* about the report. "The biggest new thing, I think, is the requirement to no longer document proteinuria in order to make the diagnosis of preeclampsia," he explained.

Dr. Martin also described the novel approach used by the task force. They approached the issue, using the [strategy recommended](#) by the Grading of Recommendations Assessment, Development, and Evaluation (GRADE) Working Group. The task force then recommended the most appropriate course of action. "It is the first time that we have done recommendations like this using the GRADE approach, which is evidence-based," Dr. Martin elaborated.

The task force decided to continue with the classification of hypertensive disorders that was first adopted by ACOG in 1972. They have also maintained the blood pressure criteria from prior recommendations.

The new guidelines, however, acknowledge that the old requirements for proteinuria were missing some patients with preeclampsia. The new guidelines should encourage physicians to think more widely and be alert for other symptoms and signs of preeclampsia. The report does not recommend any screening to predict preeclampsia beyond obtaining an appropriate medical history.

The task force does recommend daily low-dose (60 - 80 mg) aspirin beginning in the late first trimester for women with a medical history of early-onset preeclampsia. In addition, the report concluded that vitamins C and E do not prevent preeclampsia.

The task force also recommends close monitoring of women with gestational hypertension or preeclampsia who do not

have severe features. This includes monitoring blood pressure and proteinuria at least once a week.

The report suggests that women with preeclampsia in a previous pregnancy receive preconception counseling and assessment. In addition, patients with secondary hypertension should be referred to a physician with expertise in treating hypertension. Treatment should include home blood pressure monitoring for pregnant women with poorly controlled chronic hypertension.

Women with a medical history of preeclampsia and preterm delivery should have a yearly assessment of blood pressure, lipids, fasting blood glucose, and body mass index.

The report emphasizes that hypertensive disorders during pregnancy are a major health issue for women and their infants. The task force recommends that healthcare providers educate women about preeclampsia in the context of prenatal care.

Dr. Martin has disclosed no relevant financial relationships.

Hypertension in Pregnancy. November 2013. [Full text](#)

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