# 'Do the Logical Thing' in Managing Preeclampsia

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KAILUA KONA, HAWAII — Consider the worst thing that can happen when managing preeclampsia and then do the logical thing to avoid that outcome, Dr. Michael A. Belfort said at a conference on obstetrics, gynecology, perinatal medicine, neonatology, and the law.

He highlighted some confusing aspects in current practice and gave his "logical" alternatives for managing mild and severe preeclampsia.

▶ **Mild preeclampsia.** Dr. Belfort challenged those who say that it is appropriate to delay delivery in a mildly preeclamptic patient with a preterm fetus (35-37 weeks' gestation). "We've got to get out of the mind-set that it's terrible to deliver somebody earlier than 37 weeks" in the face of a potentially disastrous disease process, he said at the conference sponsored by Boston University. At 35-37 weeks' gestation, deliver the baby if the benefits outweigh the risks to both mother and baby, he said.

He reminded the audience of the American College of Obstetricians and Gynecologists' recommendation to manage mild preeclampsia in the hospital initially, and he supported subsequent outpatient management under certain conditions. Ideally, patients managed on an outpatient basis should have a blood pressure monitor at home so that they can take measurements up to four times daily. The patient also needs clearly defined, written instructions for when to call the physician, he said. The frequency and type of prenatal surveillance in preeclamptic patients are areas open to clinical judgment. Weekly nonstress tests, biophysical profiles, or both, are recommended by ACOG, said Dr. Belfort, professor of obstetrics and gynecology at the University of Utah, Salt Lake City.

He suggested increasing the frequency of these tests in hospitalized patients. Dr. Belfort orders a nonstress test, amniotic fluid index, and lab tests every 3-4 days or more often depending on the clinical circumstances. If intrauterine growth restriction (IUGR) is identified in someone with preeclampsia beyond 32 weeks, ACOG guidelines say that the baby should be delivered because the mother is now in the realm of severe preeclampsia. He recommends doing daily fetal movement counting in these patients; fetal movement counting is important not only in preeclampsia, but also in every pregnancy, he added.

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**DR. BELFORT**

When managing mild preeclampsia on an outpatient basis, Dr. Belfort prefers to do twice weekly nonstress testing with amniotic fluid index, the so-called modified biophysical profile. This gives him frequent opportunities not only to check the fetus but also to question patients about headache, abdominal pain, visual disturbances, or other complications.

In women with mild preeclampsia and the potential for developing IUGR, a growth ultrasound should be done every 2-3 weeks. Consider getting a weekly Doppler ultrasound, he added. Dr. Belfort repeats lab tests weekly as long as there's no progression and admits the patient if he suspects progression of disease.

▶ **Severe preeclampsia.** Beyond 32 weeks' gestation, delivery of the baby, as recommended by ACOG, is usually the safest option, Dr. Belfort said. ACOG guidelines say it's reasonable to deliver the babies of women with hemolysis, elevated liver enzymes, and low platelet count (HELPP) syndrome regardless of gestational age.

"The outcomes for 32-week babies are good in the average level 2 or level 3 neonatal unit. The outcomes for women with progressive, severe HELPP syndrome who have delayed delivery are usually not good," he explained.

Do an elective cesarean if the cervix is unripe because 80% of women with severe preeclampsia and an unripe cervix will end up having a C-section anyway, he added. Attempting a vaginal delivery may deplete the baby's reserves and result in an emergency C-section. In women with severe preeclampsia, Dr. Belfort orders continuous electronic fetal monitoring and gets lab tests every 6-8 hours to watch for worsening condition. ■