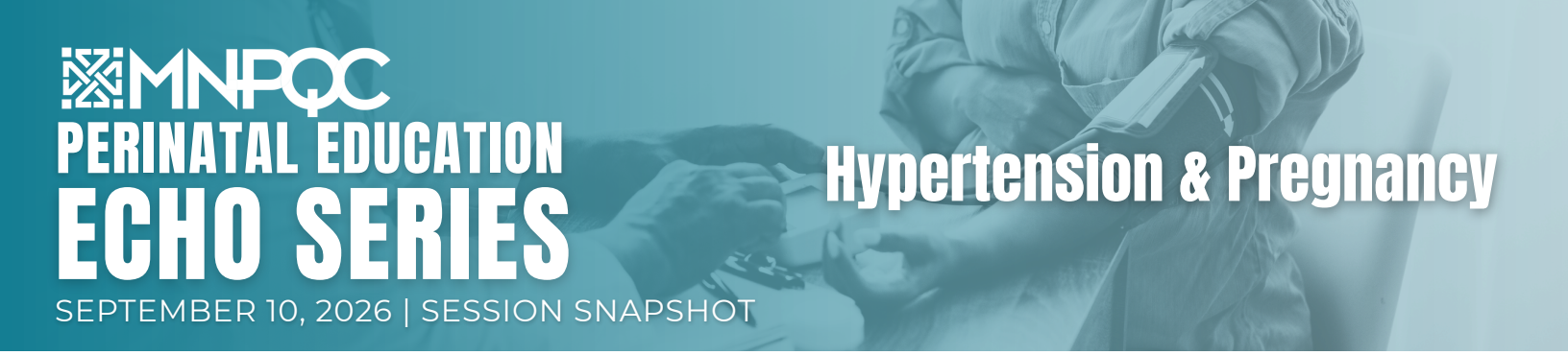

MNPQC

PERINATAL EDUCATION ECHO SERIES

SEPTEMBER 10, 2026 | SESSION SNAPSHOT

Hypertension & Pregnancy

SESSION SUMMARY

Hypertensive disorders of pregnancy (HDP) are a leading cause of maternal morbidity & mortality in the US. This webinar reviewed the physiology of HDP while highlighting suggested management strategies. Participants learned evidence-based approaches to the diagnosis & management of HDP, strategies to reduce postpartum readmission, and the long-term association between adverse pregnancy outcomes and future cardiovascular disease. This session equipped healthcare professionals with practical knowledge to improve recognition, response, and long-term management of cardiovascular health amongst birthing populations.

HYPERTENSION DEFINITIONS:

Hypertension looks different for non-pregnant and pregnant individuals.

- **For non-pregnant adults:** Hypertension = systolic ≥130 OR diastolic ≥80.
- **During Pregnancy:** Hypertension = systolic ≥140 OR diastolic ≥90, confirmed on 2 readings four or more hours apart.

PREECLAMPSIA:

Preeclampsia is a new-onset hypertension at ≥20 weeks of pregnancy with proteinuria OR new organ dysfunction.

Who is at Risk: Those with prior preeclampsia, chronic hypertension, pregestational diabetes, kidney disease, lupus/antiphospholipid syndrome, & multifetal pregnancy. Additional risk factors include first pregnancy, BMI >30, Age ≥ 35, family history, IPV, and prior adverse pregnancy outcomes.

Prevention to Reduce Risk: Trials have shown that low-dose aspirin, exercise, and nutrition (such as the Mediterranean & DASH diet) can lower the risk of preeclampsia. *Note: The amount of risk reduction is different per prevention method.*

SEVERE BP MANAGEMENT & TREATMENT:

Recognize	Confirm	Treat
SBP ≥160 OR DBP ≥110	Persistent over ~15 minutes	Start promptly, within 30-60 minutes

Follow your organization's emergency treatment pathway and evaluate for severe features.

DISCHARGE & READMISSION:

Although there is no universal discharge target established in the US, data show that higher discharge BP leads to higher readmission rates for postpartum patients. Research shows that BPs at:

- ≥130/80mm HG have 1.43x readmission odds
- ≥140/90mm HG have 2.03x readmission odds
- ≥150/100mm HG have 2.72x readmission odds
- ≥160/110mm HG have 2.90x readmission odds

Discharge does not end the risk of hypertension: continued monitoring, follow-up, and prompt assessment of warning symptoms are essential.

PREGNANCY HISTORY IS PART OF CARDIOVASCULAR RISK ASSESSMENT:

A history of HDP signals increased cardiovascular risk and should prompt ongoing blood pressure monitoring and cardiovascular risk assessment beyond the routine six-week postpartum visit.

KEY RECOMMENDATIONS:

1 Recognize and Treat HDP

Know the hypertension thresholds for pregnant patients, understand key risk factors, & initiate proper treatment promptly when HDP is identified.

2 Follow the Patient Beyond Delivery

Recognize that the effects of HDP can extend years beyond pregnancy. Establish clear postpartum follow-up and connect patients with ongoing care to monitor blood pressure and cardiovascular risk.

3 Use Pregnancy History to Guide Prevention

Treat a history of HDP as an opportunity to identify long-term cardiovascular risk, connect patients to appropriate providers, and close the referral loop.

Updated as of September 2026

RESOURCES:

- **ACOG has created guidance** related to hypertension and pregnancy that can be accessed below:
  - ACOG's Gestational Hypertension and Preeclampsia | Practice Bulletin | Number 222
  - ACOG's Chronic Hypertension In Pregnancy | Practice Bulletin Number 203

- **At- home blood pressure monitoring studies** are examining whether this intervention method can improve outcomes for pregnant and postpartum patients.
  - Long-Term Blood Pressure Control After Hypertensive Pregnancy Following Physician-Optimized Self-Management
  - Telehealth with Remote Blood Pressure Monitoring Compared with Standard Care for Postpartum Hypertension
  - Clinical Outcomes Associated With a Remote Postpartum Hypertension Monitoring Program

- **Research Articles:** These articles review current evidence on the diagnosis and management of hypertension during and after pregnancy, highlighting approaches to reduce maternal complications and long-term cardiovascular risk while identifying gaps in the evidence and areas for future research.
  - Hypertension in Pregnancy and Postpartum: Current Standards and Opportunities to Improve Care
  - Opportunities in the Postpartum Period to Reduce Cardiovascular Disease Risk After Adverse Pregnancy Outcomes: A Scientific Statement From the American Heart Association

- **Pregnancy-Induced Cardiovascular Risk Resource Guides:** The Minneapolis Heart Institute Foundation created these resource guides because women face unique risk factors in pregnancy that increase their risk of cardiovascular disease both in the short and long term.
  - Pregnancy Resources (PDF)
  - Postpartum Resources (PDF)
  - Provider Resources (PDF)

HYPERTENSIVE DISORDERS OF PREGNANCY (HDP):

- **Chronic Hypertension:** Present before pregnancy or before 20 weeks. Persistence beyond 12 weeks postpartum supports chronic hypertension.
- **Gestational Hypertension:** New hypertension that occurs at ≥ 20 weeks of pregnancy without proteinuria or preeclampsia features.
- **Preeclampsia:** New hypertension at ≥ 20 weeks of pregnancy with proteinuria OR new organ dysfunction.
- **Superimposed Preeclampsia:** Chronic hypertension with new preeclampsia features, such as new proteinuria or organ dysfunction after 20 weeks.
- **Severe range BP:** Systolic ≥160 OR diastolic ≥110 mm Hg.

PRESENTER CONTACT

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ADDITIONAL DETAILS

If you have questions about this session snapshot or would like to request access to the session slides, please contact the QI Team: QI@minnesotaperinatal.org.

Learn more about this ECHO Series. Visit our ECHO webpage.

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