Table 3. Treatment of severe hypertension (Modified by SOGC Clinical Practice Guideline 2014) 148

<table>
<thead>
<tr>
<th>Anti-hypertensive agent</th>
<th>Dosage</th>
<th>Onset</th>
<th>Duration</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labetalol</td>
<td>20 mg IV, repeat 20 to 80 mg IV q 30 min, or 1 to 2 mg/min, max 300 mg (then switch to oral)</td>
<td>5 min</td>
<td>4 h</td>
<td>Contraindications: asthma, cardiac failure</td>
</tr>
<tr>
<td>Nifedipine</td>
<td>5 to 10 mg capsule to be swallowed or bitten, every 30 min</td>
<td>5-10 min</td>
<td>6 h</td>
<td></td>
</tr>
<tr>
<td>Hydralazine</td>
<td>5 mg IV, repeat 5 to 10 mg IV every 30 min, or 0.5 to 10 mg/hr IV, to a maximum of 20 mg IV (or 30 mg IM)</td>
<td>5 min</td>
<td></td>
<td>Increased risk of maternal hypotension</td>
</tr>
</tbody>
</table>

for the prophylaxis of seizures in cases of severe preeclampsia or eclampsia.150

Therapeutic options for severe hypertension are shown in Table 3.148

CONCLUSIONS

In conclusion, PIH is a common health problem with adverse effects for both mother and fetus/neonate. It is believed to be a multifactorial health condition the pathogenetic mechanism of which is not as yet fully understood. More studies clarifying the latter will also contribute to more effective medical treatment and optimization of pregnancy outcome. The use of antihypertensive treatment, especially in cases of mild hypertension, is meanwhile of great concern. More randomized controlled studies are necessary for further evaluation of the ratio of maternal-fetal benefit to risk for fetal adverse effects.

CONFLICT OF INTERESTS

All authors declare no potential conflicts of interest.

REFERENCES