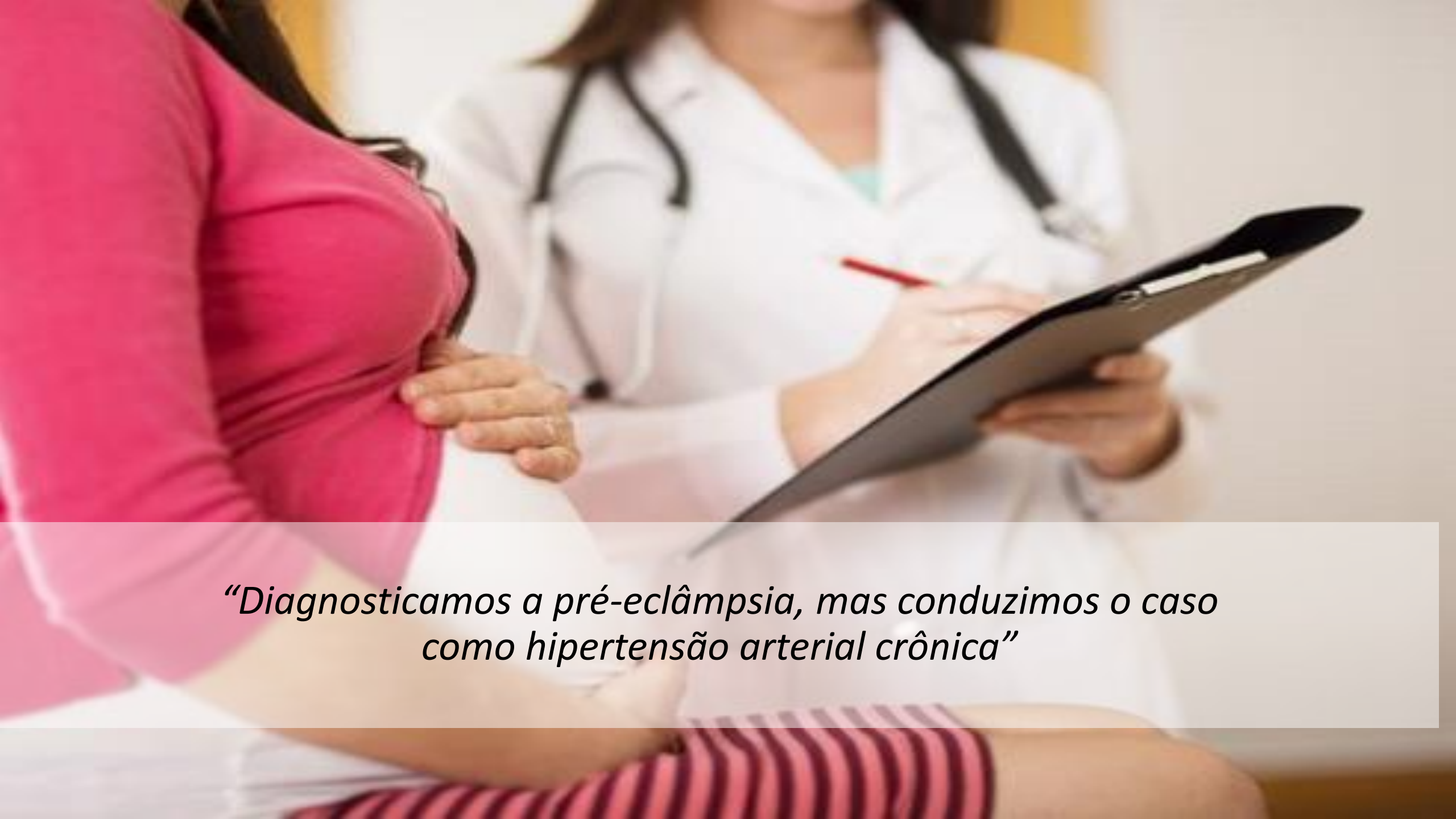
I Congresso Brasileiro sobre Hipertensão na Gravidez 2021

Classificação atual das síndromes hipertensivas na gravidez

Francisco Lázaro Pereira de Sousa
lazarosume@yahoo.com.br

DECLARAÇÃO DE CONFLITO DE INTERESSES

Atualmente não recebo qualquer forma de pagamento ou auxílio financeiro de entidade pública ou privada para pesquisa ou desenvolvimento de métodos diagnósticos e terapêuticos ou ainda, honorários como consultor de indústria farmacêutica.



“Diagnosticamos a pré-eclâmpsia, mas conduzimos o caso como hipertensão arterial crônica”

Dilema classificatório

1000 gestantes hipertensas, classificadas para Pré-eclâmpsia:

77% Australian Society for the Study of Hypertension in Pregnancy

16% National High Blood Pressure Education Program Working Group

International Society for the study of Hypertension in Pregnancy

Brown MA, Buddle ML. What´s it a name? Problems with the classification of Hypertension in pregnancy. J Hypertension 1997;15:1049-54.

Estado hipertensivo

PAS ≥ 140mmHg e/ou
≥ 90mmHg
(2 x ,intervalo de quatro horas)

Ou

PAS ≥ 160 mmHg e/ou
PAD ≥ 110 mmHg
(2 x ,intervalo de alguns minutos)
(ACOG,2020)

Técnica adequada

Tabela de correção da PA, segundo a circunferência do braço

Circunferência do braço (cm)	Correção PA Sistólica (mmHg)	Correção PA Diastólica (mmHg)
20	+11	+7
22	+9	+6
24	+7	+4
26	+5	+3
28	+3	+2
30	0	0
32	-2	-1
34	-4	-3
36	-6	-4
38	-8	-6
40	-10	-7
42	-12	-9
44	-14	-10
46	-16	-11
48	-18	-13
50	-21	-14

Maxwell et al, 1982.

Técnica de aferição da pressão arterial

Tal sistematização é imprescindível:

» Gestante sentada;

» Medir a PA no braço direito, e mantendo este elevado na altura do coração, livres de roupas, palma da mão para cima e cotovelo ligeiramente fletido.

» A paciente deve estar calma, bexiga vazia, não praticou exercícios há 60-90 minutos; não ingerir bebidas alcoólicas, café, se alimentou ou fumou até 30 minutos antes, e não está com as pernas cruzadas.

» O manguito deve medir 13cm, e ser colocado confortavelmente a 03 cm da artéria braquial.

» Palpar o pulso radial e inflar o manguito até o seu desaparecimento, para a estimativa do nível de pressão sistólica, desinflar novamente.

» Após aguardar 1 minuto, inflar rapidamente de 10 em 10 mmHg até ultrapassar 20 a 30 mmHg, o nível estimado da PAS, proceder a deflação com velocidade constante.

» Determinar a PA: - Sistólica: primeiro som (fase I de Korotkoff)

- Diastólica: desaparecimento do som (fase V de Korotkoff).
  Obs: Quando os batimentos persistirem até o nível zero, determinar a PAD no abafamento do som (fase IV de Korotkoff).

» Esperar 01 a 02 minutos antes de realizar novas aferições.

Peraçoli JC, Ramos JGL, Sass N, Martins-Costa SH, de Oliveira LG, Costa ML, Cunha Filho EV, Korkes HA, de Sousa FLP, Mesquita MRS, Borges VTM, Corrêa Jr MD, Araujo ACPF, Zaconeta AM, Freire CHE, Poli-de-Figueiredo CE, Rocha Filho EAP, Cavalli RC. Pré-eclâmpsia/eclâmpsia – Protocolo no. 01 - Rede Brasileira de Estudos sobre Hipertensão e Gravidez (RBEHG), 2020. Sociedade Brasileira de Hipertensão Arterial.

Diagnóstico preciso do estado hipertensivo

Revista Eletrônica de Enfermagem
ISSN 1518-1944 UFG

Artigo Original

Análise dos níveis pressóricos em gestantes no diagnóstico precoce da síndrome hipertensiva gestacional

Blood pressure analysis among pregnant women for an early diagnosis of gestational hypertensive syndrome

Análisis de los niveles presóricos en gestantes en el diagnóstico precoz del síndrome hipertensivo gestacional

Andreza de Sá Gomes[1], Anne Fayma Lopes Chaves[2], Rebeca Barros da Silva[3], Ana Kelve de Castro Damasceno[4], Rosana Gomes de Freitas Menezes Franco[5], Mônica Oliveira [6]

[1] Enfermeira. São Paulo, SP, Brasil. E-mail: andreza.anastasis@yahoo.com.br.
[2] Enfermeira. Discente do Programa de Pós-Graduação em Enfermagem, nível Mestrado, da Universidade [illegible] mail: faymalopes@bol.com.br.
[3] Enfermeira. Fortaleza, CE, Brasil. E-mail: rebecasuez@hotmail.com.
[4] Enfermeira, Doutora em Enfermagem. Professora Adjunta da UFC. Fortaleza, CE, Brasil. E-mail: anakelve[illegible]
[5] Enfermeira, Mestre em Enfermagem. Fortaleza, CE, Brasil. E-mail: rosanagomesfranco@hotmail.com.
[6] Enfermeira, Doutora em Enfermagem. Professora Adjunta da UFC. Fortaleza, CE, Brasil. E-mail: oriaremo[illegible]

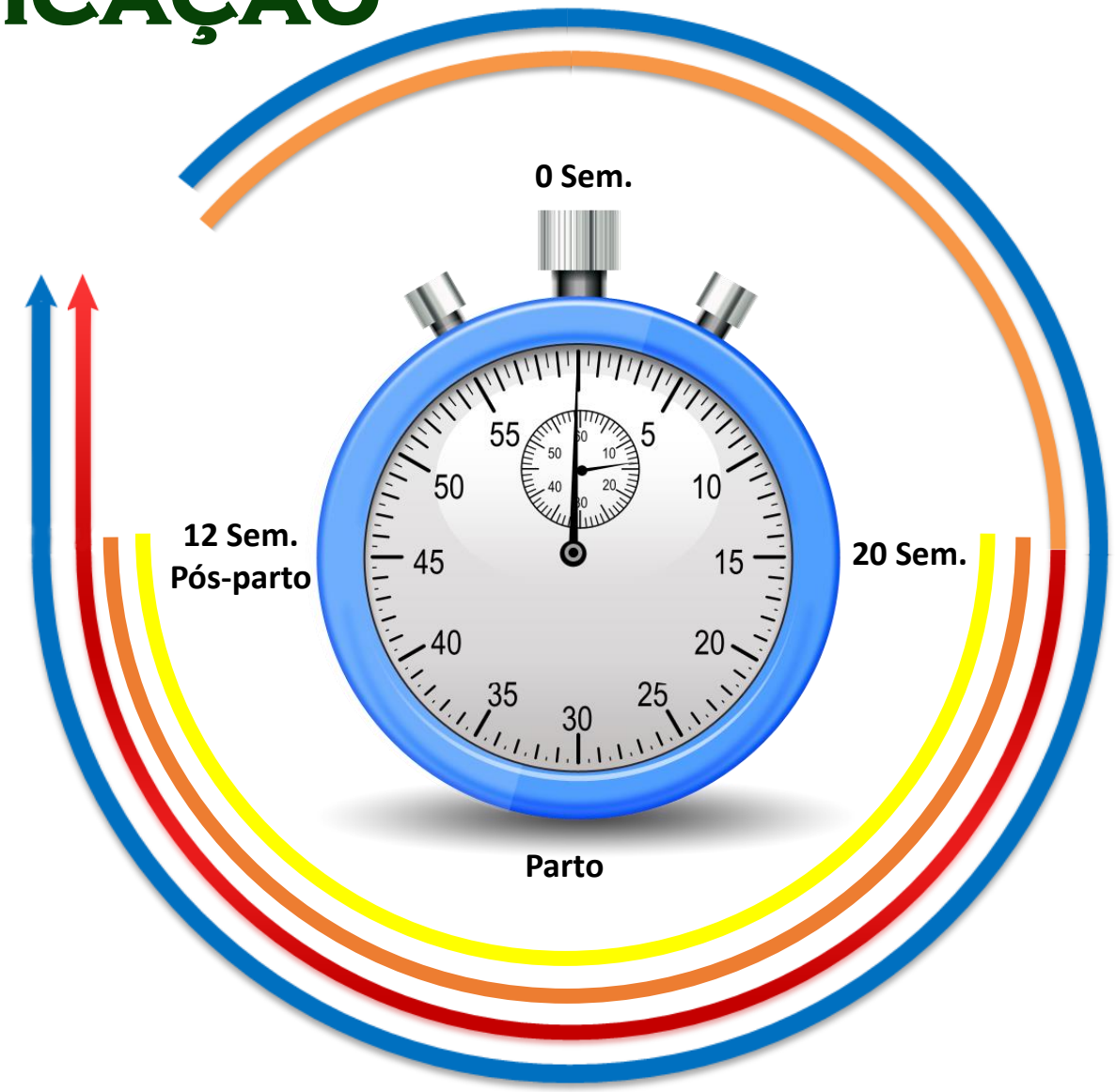
RESUMO

O objetivo foi comparar os níveis pressóricos em gestantes aferidos na sala de preparo [illegible] as medidas verificadas no consultório seguindo as Diretrizes Brasileiras de Hipertensã[illegible] tendo como amostra 94 gestantes. A coleta de dados ocorreu no período de setembro a novembro de 2011 em duas etapas: a primeira se consistiu da coleta dos valores da PA aferidos rotineiramente pelos funcionários da sala de preparo, nesta foi realizada observação da técnica de aferição da PA. A segunda etapa ocorreu no consultório no qual foi realizada aferição da PA seguindo a VI Diretrizes Brasileiras de Hipertensão. Foram encontradas disparidades em 87% das aferições variando de -38 a 28mmHg para pressão sistólica e -26 a 20mmHg para pressão diastólica. Conclui-se que existe diferença significativa entre as medidas de pressões arteriais verificadas rotineiramente na sala de preparo e as medidas realizadas no consultório.

Descritores: Hipertensão Induzida pela Gravidez; Pressão Arterial; Cuidado Pré-Natal; Atenção Primária à Saúde; Cuidados de Enfermagem.

Identificou-se disparidade em 87% das aferições de PA entre avaliação rotineira e da VI Diretriz Brasileira de Hipertensão (2011).

Classificação



Hipert. Art. Crônica

Hipert. Gest. Tardia

Pré Eclâmpsia

PE Sobreposta a HAC

NATIONAL HIGH BLOOD PRESSURE EDUCATION PROGRAM.
Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. Am J Obstet Gynecol 2000; 183(1):S1-S22.

Diagnóstico baseado em Proteinúria

Positivo: +/4+

Positivo: 300 mg/24 horas

NATIONAL HIGH BLOOD PRESSURE EDUCATION PROGRAM.
Report of the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy. Am J Obstet Gynecol 2000; 183(1):S1-S22.

Relação proteinúria/creatinúria ≥ 0,3

RESEARCH www.AJOG.org

OBSTETRICS

Usage of spot urine protein to creatinine ratios in the evaluation of preeclampsia

Thomas L. Wheeler II, MD; Dawn W. Blackhurst, DrPH; Eric H. Dellinger, MD; Patrick S. Ramsey, MD, MSPH

OBJECTIVE: The objective of the study was to prospectively compare spot urine protein to creatinine (P:C) ratios with 24 hour urine collections for protein in women being evaluated for preeclampsia.

STUDY DESIGN: A spot urine P:C ratio was obtained at the beginning of 24 hour urine collections from 126 patients admitted to evaluate for preeclampsia. Correlation between the spot P:C ratio with the 24 hour urine collections was calculated. Receiver operator characteristic curves were constructed to determine best P:C cut-offs for 300 mg and 5000 mg protein per 24 hours.

RESULTS: Random spot P:C ratios were strongly correlated with 24 hour urine protein levels (Pearson $r = 0.88$). The optimal P:C cut-offs were 0.21 (300 mg per 24 hours) and 3.0 (5000 mg per 24 hours). A P:C ratio of less than 0.21 (300 mg per 24 hours) had a negative predictive value (NPV) of 83.3% and a P:C ratio of less than 3.0 (5000 mg per 24 hours) had 100% NPV.

CONCLUSION: Urine spot P:C ratio correlated well with 24 hour urine collections for protein but was not justified as a substitute for timed collections.

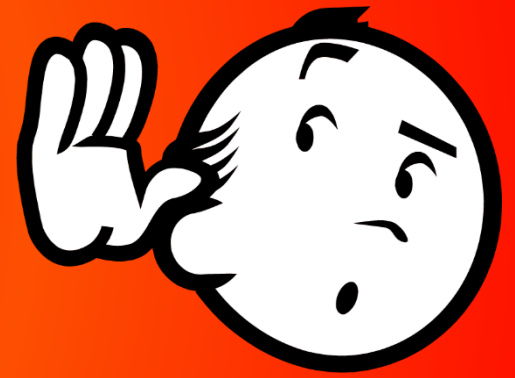
Key words: creatinine, measurement, preeclampsia, protein

Cite this article as: Wheeler TL, Blackhurst DW, Dellinger EH, et al. Usage of spot urine protein to creatinine ratios in the evaluation of preeclampsia. Am J Obstet Gynecol 2007;196;465.e1-465.e4.

Conceito de pré-eclâmpsia sem proteinúria (ACOG, 2013)

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Estar atento e ouvir com atenção



States. Preeclampsia, either alone or superimposed on pre-existing (chronic) hypertension, presents the major risk. Although appropriate prenatal care, with observation of women for signs of preeclampsia and then delivery to terminate the disorder, has reduced the number and extent of poor outcomes, serious maternal–fetal morbidity and mortality still occur. Some of these adverse outcomes are avoidable, whereas others can be ameliorated. Also, although some of the problems that face neonates are related directly to preeclampsia, a large proportion are secondary to prematurity that results from the appropriate induced delivery of the fetuses of women who are ill. Optimal management requires close observation for signs and premonitory findings and, after establishing the diagnosis, delivery at the optimal time for both maternal and fetal well-being. More recent clinical evidence to guide this timing is now avail-

is now clear that preeclampsia is associated with later-life cardiovascular (CV) disease; however, further research is needed to determine how best to use this information to help patients. The task force also has identified issues in the management of preeclampsia that warrant special attention. First, is the failure by health care providers to appreciate the multisystemic nature of preeclampsia. This is in part due to attempts at rigid diagnosis, which is addressed in the report. Second, preeclampsia is a dynamic process, and a diagnosis such as "mild preeclampsia" (which is discouraged) applies only at the moment the diagnosis is established because preeclampsia by nature is progressive, although at different rates. Appropriate management mandates frequent reevaluation for severe features that indicate the actions outlined in the recommendations (which are listed after the chapter summaries). It has been known

TABLE E-1. **Diagnostic Criteria for Preeclampsia**

Insuficiência renal	• Serum creatinine concentrations greater than 1.1 mg/dL or a doubling of the serum creatinine concentration in the absence of other renal disease
Insuficiência hepática	• Elevated blood concentrations of liver transaminases to twice normal concentration
Edema pulmonar	

Portanto, o diagnóstico de PE não é estático, ele é dinâmico e heterogêneo

Conceito de pré-eclâmpsia sem proteinúria (ISSHP, 2014)

Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health 4 (2014) 97–104

Contents lists available at ScienceDirect

Pregnancy Hypertension: An International Journal of Women's Cardiovascular Health

journal homepage: www.elsevier.com/locate/preghy

The classification, diagnosis and management of the hypertensive disorders of pregnancy: A revised statement from the ISSHP

Introduction

There has never been a definite consensus on the classification and diagnostic criteria for the hypertensive disorders of pregnancy. This uncertainty is likely to have led to between-centre differences in rates of adverse maternal and foetal outcomes for the various hypertensive disorders in pregnancy, particularly pre-eclampsia.

In 2000, the International Society for the Study of Hypertension in Pregnancy (ISSHP) recognised that this lack of consensus was one reason for controversies concerning counselling, management and documentation of immediate and remote pregnancy outcomes. Accordingly, the Society appointed a committee that reviewed available classifications and endorsed and published an international recommendation for how these disorders should be classified and diagnosed in pregnancy [1]. The major stumbling block remained whether or not proteinuria should be retained as a *sine qua non* for the diagnosis of pre-eclampsia; the Society recommended that a broad definition, at times not including proteinuria, could be applied for the ***clinical definition*** of pre-eclampsia whilst the inclusion of proteinuria would ensure more specificity around the diagnosis when reporting clinical criteria for patients enrolled in ***scientific research***. The purpose of this document is to update ISSHP thinking on this subject.

Why is there a need for an updated statement?

In the years since this report, there have been a number of developments relevant to diagnosis, classification and management of the hypertensive disorders in pregnancy. One problem is the emerging concept that pre-eclampsia may indeed have several subtypes, the final clinical manifestation being the result of a maternal constitutive response to either abnormal placental function or abnormal placentation [2]. Several clinical issues need be considered.

Firstly, there has been an international move away from the use of mercury sphygmomanometry, largely for occupational health and safety reasons. This has led to the widespread use of automated blood pressure devices, many of which have not been validated for use in pregnancy, or specifically in pre-eclampsia. Secondly, there has been growing recognition of the potential inaccuracies in the measurement of proteinuria and of the potential for severe maternal complications in pregnancies complicated by de novo hypertension without proteinuria [3]. Thirdly, there has been an explosion of research in general hypertension into the disorder of white coat hypertension, such that it is imperative to distinguish between this and true chronic hypertension. Fourth, the research into the cause(s) of pre-eclampsia has led to considerations that a diagnosis might move away from the traditional clinical diagnosis to one that utilises biomarkers, particularly angiogenic factors [4]. ISSHP considers that this may be a fruitful area for diagnostic criteria in the future but for now a clinical definition remains the most appropriate. Finally, a number of scholarly guidelines have been produced in recent years by the World Health Organisation (http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/9789241548335/en/index.html) and others [5–10] to assist in the management of the hypertensive disorders of pregnancy; these guidelines differ at times, including in areas such as at what level of blood pressure is therapy required to treat hypertension and when should convulsion prophylaxis be given, but there is suggestive evidence that such guidelines do make a difference to improving pregnancy outcome [9]. Many countries do not have national guidelines for the management of hypertensive pregnancies, and it is hoped that this guideline might assist in drafting of local protocols.

ISSHP charged a small group of clinician researchers to provide recommendations about the appropriate classification, definitions, and management of the hypertensive disorders of pregnancy.

The revised classification for hypertensive disorders in pregnancy is as follows (Table 1):

1. Chronic hypertension.
2. Gestational hypertension.
3. Pre-eclampsia – de novo or superimposed on chronic hypertension.
4. White coat hypertension.

http://dx.doi.org/10.1016/j.preghy.2014.02.001
2210-7789/© 2014 Published by Elsevier B.V. on behalf of International Society for the Study of Hypertension in Pregnancy.

Table 2
The revised ISSHP definition of pre-eclampsia (2014) is.

Hypertension developing after 20 weeks gestation and the coexistence of one or more of the following new onset conditions:
1. Proteinuria
2. Other maternal organ dysfunction:
• renal insufficiency (creatinine ≥90 umol/L)
• liver involvement (elevated transaminases and/or severe right upper quadrant or epigastric pain)
• neurological complications (examples include eclampsia, altered mental status, blindness, stroke, or more commonly hyperreflexia when accompanied by clonus, severe headaches when accompanied by hyperreflexia, persistent visual scotomata)
• haematological complications (thrombocytopenia, DIC, haemolysis)
3. Uteroplacental dysfunction
• foetal growth restriction

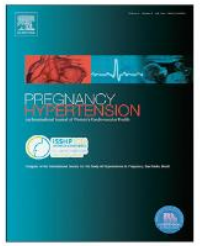
ARTICLE IN PRESS

Pregnancy Hypertension xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Pregnancy Hypertension

journal homepage: www.elsevier.com/locate/preghy



The hypertensive disorders of pregnancy: ISSHP classification, diagnosis & management recommendations for international practice

Mark A. Brown[a,b,*], Laura A. Magee[c], Louise C. Kenny[d], S. Ananth Karumanchi[e], Fergus P McCarthy[f], Shigeru Saito[g], David R. Hall[h], Charlotte E. Warren[i], Gloria Adoyi[j], Salisu Ishaku[j], on behalf of the International Society for the Study of Hypertension in Pregnancy (ISSHP)

[a] *Dept. of Renal Medicine, St. George Hospital, Sydney, Australia*
[b] *Dept. of Medicine, St. George Hospital Clinical School, University of NSW, Sydney, Australia*
[c] *King's College London, Faculty of Life Sciences and Medicine, London, UK*
[d] *Faculty of Health & Life Sciences, University of Liverpool and INFANT Centre, Cork University Maternity Hospital, Cork, Ireland*
[e] *Department of Medicine, Beth Israel Deaconess Medical Center and Harvard Medical School, Boston, MA, USA*
[f] *INFANT Centre, Cork University Maternity Hospital, Cork, Ireland*
[g] *Department of Obstetrics and Gynecology, Graduate School of Medicine and Pharmaceutical Science for Research, University of Toyama, Japan*
[h] *Dept. of Obstetrics & Gynaecology, Stellenbosch University and Tygerberg Hospital, Tygerberg, South Africa*
[i] *Reproductive Health Program, Population Council-Washington DC, USA*
[j] *Reproductive Health Program, Population Council-Nigeria, West Africa, Nigeria*

ARTICLE IN PRESS

Pregnancy Hypertension xxx (xxxx) xxx–xxx

Contents lists available at ScienceDirect

Pregnancy Hypertension

journal homepage: www.elsevier.com/locate/preghy

The hypertensive disorders of pregnancy: ISSHP classification, diagnosis & management recommendations for international practice

Mark A. Brown, Laura A. Magee, Louise C. Kenny, S. Ananth Karumanchi, Fergus P McCarthy, Shigeru Saito, David R. Hall, Charlotte E. Warren, Gloria Adoyi, Salisu Ishaku, on behalf of the International Society for the Study of Hypertension in Pregnancy (ISSHP)

These recommendations from the ISSHP are based upon available literature and expert opinion. It is intended that this be a 'living' document, to be updated when needed as more research becomes available to influence good clinical practice. Unfortunately there is a relative lack of high quality randomised trials in the field of Hypertension in Pregnancy compared with studies in essential hypertension outside of pregnancy and ISSHP encourages greater funding and uptake of collaborative research in this field. Accordingly, the quality of evidence for the recommendations in this document has not been graded, though relevant references and explanations are provided for each recommendation. The document will be a 'living' guideline and we hope to be able to grade recommendations in the future.

Guidelines and recommendations for management of hypertension in pregnancy are typically written for implementation in an ideal setting. It is acknowledged that in many parts of the world, it will not be possible to adopt all of these recommendations; for this reason, options for management in less-resourced settings are discussed separately in relation to diagnosis, evaluation, and treatment.

This document has been endorsed by the International Society of Obstetric Medicine (ISOM) and The Japanese Society for the Study of Hypertension in Pregnancy (JSSHP).

1. Key points

All units managing hypertensive pregnant women should maintain and review uniform departmental management protocols and conduct regular audits of maternal & fetal outcomes.

The cause(s) of pre-eclampsia and the optimal clinical management of the hypertensive disorders of pregnancy remain uncertain; therefore, we recommend that every hypertensive pregnant woman be offered an opportunity to participate in research, clinical trials and follow-up studies.

1.1. Classification

1. Hypertension in pregnancy may be chronic (pre-dating pregnancy or diagnosed before 20 weeks of pregnancy) or de novo (either pre-eclampsia or gestational hypertension).
2. Chronic hypertension is associated with adverse maternal and fetal outcomes and is best managed by tightly controlling maternal blood pressure (BP 110-140/85 mmHg), monitoring fetal growth and repeatedly assessing for the development of pre-eclampsia and maternal complications. This can be done in an outpatient setting.
3. White-coat hypertension refers to elevated office/clinic (≥140/90 mmHg) blood pressure but normal blood pressure measured at home or work (< 135/85 mmHg); it is not an entirely benign condition and conveys an increased risk for pre-eclampsia.
4. Masked hypertension is another form of hypertension, more difficult to diagnose, characterised by blood pressure that is normal at a clinic or office visit but elevated at other times, most typically diagnosed by 24 h ambulatory BP monitoring (ABPM) or automated home blood pressure monitoring (HBPM).
5. Gestational hypertension is hypertension arising de novo after 20 weeks' gestation in the absence of proteinuria and without

* Corresponding author at: Dept. of Renal Medicine, St. George Hospital, Kogarah, Sydney, NSW 2217, Australia.
E-mail address: m.brown@unsw.edu.au (M.A. Brown).

https://doi.org/10.1016/j.preghy.2018.05.004

2210-7789/ © 2018 International Society for the Study of Hypertension in Pregnancy. Published by Elsevier B.V. All rights reserved.

Please cite this article as: Brown, M., Pregnancy Hypertension (2018), https://doi.org/10.1016/j.preghy.2018.05.004

Hipertensão do “jaleco branco”

PA ≥ 140/90 mmHg (consultório)

PA < 135/85 mmHg (residência/trabalho)

Condição não benigna

Associado a risco de pré-eclâmpsia

Latente e transitória

“Monitoramento ambulatorial em 24 horas (ou automático domiciliar)”

Brown MA, Magee LA, Kenny LC, Karumanchi SA, McCarthy FP, Saito S, Hall DR, Warren CE, Adoyi G, Ishaku S; International Society for the Study of Hypertension in Pregnancy (ISSHP). Hypertensive Disorders of Pregnancy: ISSHP Classification, Diagnosis, and Management Recommendations for International Practice. Hypertension. 2018;72(1):24-43.

Hipertensão oculta/latente (*masked hypertension*)

- Hipertensão transitória
- Mais difícil diagnóstico
- PA normal na consulta
- PA elevada em outras situações

Brown MA, Magee LA, Kenny LC, Karumanchi SA, McCarthy FP, Saito S, Hall DR, Warren CE, Adoyi G, Ishaku S; International Society for the Study of Hypertension in Pregnancy (ISSHP). Hypertensive Disorders of Pregnancy: ISSHP Classification, Diagnosis, and Management Recommendations for International Practice. Hypertension. 2018;72(1):24-43.

Posição da RBEHG

Hipertensão do Jaleco Branco
e
Hipertensão oculta

- Difícil caracterização clínica;
- Só podem ser consideradas quando pacientes na primeira metade da gestação;
- Não devem ser considerados diagnósticos diferenciais com pré-eclâmpsia;
- São fatores de risco para pré- eclâmpsia.

Peraçoli JC, Ramos JGL, Sass N, Martins-Costa SH, de Oliveira LG, Costa ML, Cunha Filho EV, Korkes HA, de Sousa FLP, Mesquita MRS, Borges VTM, Corrêa Jr MD, Araujo ACPF, Zaconeta AM, Freire CHE, Poli-de-Figueiredo CE, Rocha Filho EAP, Cavalli RC. Pré-eclâmpsia/eclâmpsia – Protocolo no. 01 - Rede Brasileira de Estudos sobre Hipertensão e Gravidez (RBEHG), 2020.

Pré-eclâmpsia: época de instalação

Etiologia diferente? Adaptações hemodinâmicas diversas?

Precoce

Dano da circulação uteroplacentária e placenta

34 SEMANAS

Tardia

Associação com síndromes metabólicas e distúrbios endoteliais crônicos

von Dadelszen P, Magee LA, Roberts JM. Subclassification of preeclampsia. Hypertens Pregnancy. 2003;22(2):143-8.
Huppertz B. Placental origins of preeclampsia: challenging the current hypothesis. Hypertension. 2008;51(4):970-5.

Tendências de conceitos

Pré-eclâmpsia ~~leve~~

A pré-eclâmpsia não é só o aumento da PA

A diferença entre uma doença hipertensiva gestacional grave ou leve pode nos confundir, porque o que é aparentemente leve pode progredir rapidamente para uma doença grave.

Gestational Hypertension and Preeclampsia: ACOG Practice Bulletin, Number 222. Obstet Gynecol. 2020 Jun;135(6):e237-e260.

Pré-eclâmpsia com sinais de gravidade

(Deterioração clínica e/ou laboratorial, pelo menos 01 critério)

- Eclâmpsia;
- PAS ≥ 160 mmHg e/ou PAD ≥ 110 mmHg confirmada após 15’ (repouso sentada)
- Síndrome HELLP;
- Insuficiência renal aguda: creatinina ≥ 1,2mg/dL;
- Dor torácica;
- Edema pulmonar;

Sinais/Sintomas

Ausentes (crise)

Presentes (emergência)

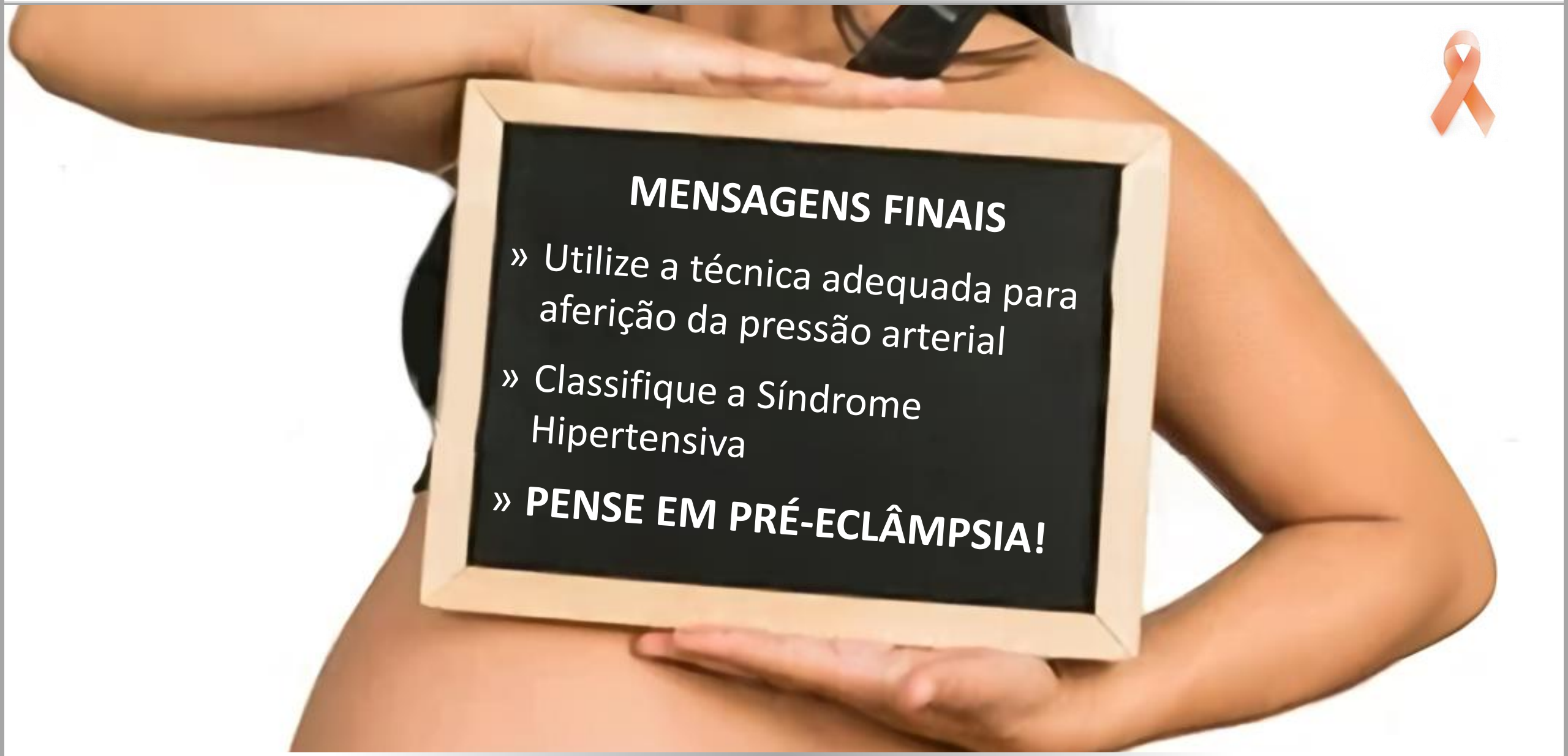
“Iminência” de eclâmpsia:

- Nível de proteinúria (≥ 05g/24hrs)
- Distúrbio do sistema nervoso: cefaleia, fotofobia, fosfenas, escotomas, hiperreflexia
- Comprometimento hepático: epigastralgia, náuseas, vômitos e dor no hipocôndrio direito

- Valorizar contexto clínico (≥ 10g/24hrs)
- Não é critério único para antecipação do parto

American College of Obstetricians and Gynecologists; Task Force on Hypertension in Pregnancy. Hypertension in pregnancy. Report of the American College of Obstetricians and Gynecologists’ Task Force on Hypertension in Pregnancy. Obstet Gynecol. 2013;122(5):1122-31.

Peraçoli JC, Ramos JGL, Sass N, Martins-Costa SH, de Oliveira LG, Costa ML, Cunha Filho EV, Korkes HA, de Sousa FLP, Mesquita MRS, Borges VTM, Corrêa Jr MD, Araujo ACPF, Zaconeta AM, Freire CHE, Poli-de-Figueiredo CE, Rocha Filho EAP, Cavalli RC. Pré-eclâmpsia/eclâmpsia – Protocolo no. 01 - Rede Brasileira de Estudos sobre Hipertensão e Gravidez (RBEHG), 2020.


MENSAGENS FINAIS
» Utilize a técnica adequada para aferição da pressão arterial
» Classifique a Síndrome Hipertensiva
» PENSE EM PRÉ-ECLÂMPSIA!

Obrigado!

DEPARTAMENTO DE OBSTETRÍCIA
UNIFESP
UNICAMP
Sociedade Brasileira de Nefrologia
SOCIEDADE BRASILEIRA DE CARDIOLOGIA
SBC
1943
febrasgo
Federação Brasileira das Associações de Ginecologia e Obstetrícia
Associação Amazonense de Ginecologia e Obstetrícia
ASSAGO
FACULDADE DE MEDICINA DE RIBEIRÃO PRETO
CEMICAMP
SBH
APM
ASSOCIAÇÃO PAULISTA DE MEDICINA
Ministério da Saúde
FIOCRUZ
Fundação Oswaldo Cruz
SOGESP
ASSOCIAÇÃO DE OBSTETRÍCIA E GINECOLOGIA DO ESTADO DE SÃO PAULO
FACULDADE DE MEDICINA
FMB
1963
BOTUCATU
unesp
SOGOMAT-SUL
HOSPITAL
SANTA MARCELINA
ENTIDADE FILANTRÓPICA
HOSPITAL
MOINHOS DE VENTO
Faculdade de Ciências da Saúde
IFF
INSTITUTO NACIONAL
DE SAÚDE DA MULHER, DA CRIANÇA E DO ADOLESCENTE
FERNANDES FIGUEIRA
Sogirgs
Associação de Obstetrícia e Ginecologia do Rio Grande do Sul
SOGIBA
IEP
AMB
Associação Médica Brasileira
ASSOCIAÇÃO MATO GROSSENSE DE GINECOLOGIA E OBSTETRÍCIA
SOMAGO
SOCIEDADE DE GINECOLOGIA E OBSTETRICIA DA PARAIBA
CRM-PB
sbhci
SOCIEDADE BRASILEIRA DE HEMODINÂMICA E CARDIOLOGIA INTERVENCIONISTA
VIRTUS IMPAVIDA
UFPE
FCMS UNILUS
ASSOGIRO
Claretiano
CENTRO UNIVERSITÁRIO
SOGISE
ASSOCIAÇÃO DE OBSTETRÍCIA E GINECOLOGIA DE SERGIPE
SOGOPE
SGOB
Associação de Ginecologia e Obstetrícia do Distrito Federal
Faculdade de Medicina
Universidade de Brasília
UFMG
UFU
Universidade Federal de Uberlândia
USCS
Faculdade de Medicina
Universidade Federal do Rio Grande do Sul
120 anos
sogima
BAYER
Roche
UMC
UNIVERSIDADE
sogorn
Associação de Ginecologia e Obstetrícia do Rio Grande do Norte