Update on the Use of Antihypertensive Drugs in Pregnancy

Tiina Podymow, Phyllis August

As the most common medical disorder of pregnancy, hypertension is reported to complicate 1 in 10 pregnancies and affects an estimated 240,000 women in the United States each year. Antihypertensive treatment rationale in this group represents a departure from the nonpregnant adult Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure guidelines. First, during pregnancy, the priority regarding hypertension is in making the correct diagnosis, with the emphasis on distinguishing preexisting (chronic) from pregnancy induced (gestational hypertension and the syndrome of preeclampsia). Second, much of the obstetric literature distinguishes blood pressure (BP) levels as either mild (140 to 159/90 to 109 mm Hg) or severe (≥160/110 mm Hg), rather than as stages (as in Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure; Table 1). Third, in contrast to hypertension guidelines in adults, which emphasize the importance of systolic BP, much of the obstetric literature focuses on diastolic rather than systolic BP, in part because of the lack of clinical trials to support one approach versus another. The focus of treatment is the 9 months of pregnancy, during which untreated mild-to-moderate hypertension is unlikely to lead to unfavorable long-term maternal outcomes. In this setting, antihypertensive agents are mainly used to prevent and treat severe hypertension; to prolong pregnancy for as long as safely possible, thereby maximizing the gestational age of the infant; and to minimize fetal exposure to medications that may have adverse effects. During pregnancy, the challenge is in deciding when to use antihypertensive medications and what level of BP to target. The choice of antihypertensive agents is less complex, because only a small proportion of currently available drugs have been adequately evaluated in pregnant women, and many others are contraindicated. Appropriate use of antihypertensive drugs in specific pregnancy-associated hypertensive disorders, including therapeutic BP goals and criteria for selecting specific antihypertensive drugs, are discussed in this review.

Principles of Treatment of Specific Hypertensive Disorders

There are 4 major hypertensive disorders in pregnancy, each with unique pathophysiologic features that have implications for antihypertensive therapy, as described below.

Chronic hypertension, defined as BP >140/90 mm Hg either predating pregnancy or developing before 20 weeks’ gestation, complicates ≈3% of pregnancies. Because the cause is largely essential hypertension, it is more frequent in African American patients and women who are of advanced maternal age or who are obese. Women of childbearing age with stage 1 essential hypertension (Table 1) who are free of target organ damage and are in good health have an excellent prognosis for pregnancy. Although at increased risk for superimposed preeclampsia (see below), many will experience a physiological lowering of BP during pregnancy and a reduction in the requirement for antihypertensive medication. The goal of treatment is to maintain BP at a level that minimizes maternal cardiovascular and cerebrovascular risk. Prevention of preeclampsia is desirable; however, current evidence has not shown that either specific BP targets in pregnancy or specific antihypertensive agents modify the risk of superimposed preeclampsia in women with preexisting hypertension.

Preeclampsia-eclampsia is a syndrome that manifests clinically as new-onset hypertension in later pregnancy (any time after 20 weeks, but usually closer to term), with associated proteinuria: 1+ on dipstick and, officially, ≥300 mg per 24-hour urine collection. This syndrome occurs in 5% to 8% of all pregnancies and is thought to be a consequence of abnormalities in the maternal vessels supplying the placenta, leading to poor placental perfusion and release of factors causing widespread endothelial dysfunction with multigorgan system clinical features, such as hypertension, proteinuria, and cerebral (edema, occipital headaches, or seizures) and hepatic dysfunction (extension to hemolysis elevation of liver enzymes, low platelets). As currently understood, the hypertension of preeclampsia is secondary to placental underperfusion, thus, lowering systemic BP is not believed to reverse the primary pathogenic process, and antihypertensive medication has never been demonstrated to “cure” or reverse preeclampsia. Nevertheless, because preeclampsia may develop suddenly in young, previously normotensive women, prevention of cardiovascular and cerebrovascular consequences of severe and rapid elevations of BP is an important goal of clinical management, often requiring judicious use of antihypertensive medication.
Principles for Treatment of Mild-to-Moderate Hypertension in Pregnancy

The benefits of antihypertensive therapy for mild-to-moderately elevated BP in pregnancy (≥160/110 mm Hg), either chronic or pregnancy induced, have not been demonstrated in clinical trials. Recent reviews, including a Cochrane meta-analysis, concluded that there are insufficient data to determine the benefits and risks of antihypertensive therapy for mild-to-moderate hypertension (defined as 140 to 169 mm Hg systolic BP and 90 to 109 mm Hg diastolic BP).5,12–15 Of note, with antihypertensive treatment, there seems to be less risk of developing severe hypertension (risk ratio: 0.50, with a number needed to treat of 10) but no difference in outcomes of preeclampsia, neonatal death, preterm birth, and small-for-gestational-age babies with treatment.9

International guidelines for the treatment of hypertension in pregnancy vary with respect to thresholds for starting treatment and targeted BP goals, but all are higher than the Joint National Committee guidelines for treatment of (non-obstetric) hypertension. Therapy is recommended in the United States for a BP of ≥160/110 mm Hg4 with no set treatment target; in Canada, therapy is considered at ≥140/90 mm Hg targeting diastolic pressure to 80 to 90 mm Hg,16 and in Australia, elevations ≥160/90 mm Hg are treated to a target of ≥110 systolic.17 A recent retrospective review of 28 patients who suffered stroke in the setting of preeclampsia demonstrated that the cause of stroke was usually arterial hemorrhage, that the average BP before stroke was 159 to 198 mm Hg systolic and 81 to 133 mm Hg diastolic, and that 54% of women died.18 Of note, systolic hypertension (155 to 160 mm Hg) was more prevalent than diastolic hypertension (most women did not reach a diastolic BP of 110 mm Hg) in women who suffered strokes. This case series underscores the need for clinical trials and evidence-based guidelines for antihypertensive treatment in pregnant women. Our practice is to initiate treatment when BP is ≥150 systolic and 90 to 100 mm Hg diastolic.

When the diagnosis is preeclampsia, the gestational age, as well as the level of BP, influences the use of antihypertensive therapy. At term, women with preeclampsia are likely to be delivered, treatment of hypertension (unless severe) can be delayed, and BP can be reevaluated postpartum. If preeclampsia develops remote from term, and expectant management is undertaken, treatment of severe hypertension is initiated, and BP can usually be safely lowered to 140/
90 mm Hg with oral medications as described below. It should be emphasized that there are no studies addressing safe BP treatment targets for pregnant women, and guidelines and reviews generally recommend treating to BP levels that are likely to be protective against acute adverse cerebrovascular or cardiovascular events, which is usually in the range of 140 to 155/90 to 105 mm Hg. When antihypertensive therapy is used in women with preeclampsia, fetal monitoring is helpful to recognize any signs of fetal distress that might be attributable to reduced placental perfusion. Indeed, temporizing management of early onset preeclampsia (<34 weeks) includes judicious use of antihypertensive medications along with work cessation, bed rest, and close in-hospital maternal and fetal monitoring, followed by delivery for specific maternal and fetal indications. This approach has been shown to delay delivery in selected cases for an average of 2 weeks, which has been associated with improved outcomes later in childhood. It must be emphasized that daily of assessment of both maternal (review of symptoms, BP, and blood work) and fetal well being are necessary in such cases, and delivery may be necessary if either deteriorate.

For women with chronic hypertension and mild-to-moderately elevated BP before pregnancy, it is reasonable to expect that pressures may decrease early in pregnancy because of physiological vasodilation, and if there is no known target organ damage, clinicians can consider discontinuing antihypertensive treatment and monitoring, provided patients are closely followed. Therapy can then be initiated if the BP again rises to 140 to 150/90 to 100 mm Hg. In women with underlying renal dysfunction, it may be reasonable to choose a slightly lower threshold for treatment. There are a wide variety of agents available for use, and orally administered antihypertensive agents can be used in standard doses in pregnancy (Table 2). First-line agents for nonsevere hypertension are methyldopa and labetalol, with nifedipine as second line, followed by others in third line.

### Treatment of Severe Hypertension

There is consensus that severe hypertension in pregnancy, defined as >160/110 mm Hg, requires treatment, because these women are at an increased risk of intracerebral hemorrhage, and that treatment decreases the risk of maternal death. Those with hypertensive encephalopathy, hemorrhage, or eclampsia require treatment with parenteral agents to lower mean arterial pressure (2/3 diastolic + 1/3 systolic...
Antihypertensive Drugs in Pregnancy

Table 3. Drugs for Urgent Control of Severe Hypertension in Pregnancy

<table>
<thead>
<tr>
<th>Drug (FDA Risk*)</th>
<th>Dose and Route</th>
<th>Concerns or Comments†</th>
</tr>
</thead>
<tbody>
<tr>
<td>Labetalol (C)</td>
<td>10 to 20 mg IV, then 20 to 80 mg every 20 to 30 minutes, maximum of 300 mg; for infusion: 1 to 2 mg/min</td>
<td>Because of a lower incidence of maternal hypotension and other adverse effects, its use now supplants that of hydralazine; avoid in women with asthma or congestive heart failure</td>
</tr>
<tr>
<td>Hydralazine (C)</td>
<td>5 mg, IV or IM, then 5 to 10 mg every 20 to 40 minutes; once BP controlled repeat every 3 hours; for infusion: 0.5 to 10.0 mg/h; if no success with 20 mg IV or 30 mg IM, consider another drug</td>
<td>A drug of choice according to NHBEP; long experience of safety and efficacy</td>
</tr>
<tr>
<td>Nifedipine (C)</td>
<td>Tablets recommended only: 10 to 30 mg PO, repeat in 45 minutes if needed</td>
<td>We prefer long-acting preparations; although obstetric experience with short acting has been favorable, it is not approved by the FDA for management of hypertension</td>
</tr>
<tr>
<td>Diazoxide (C)</td>
<td>30 to 50 mg IV every 5 to 15 minutes</td>
<td>Use is waning; may arrest labor; causes hyperglycemia</td>
</tr>
<tr>
<td>Nitroprusside (C)$</td>
<td>Constant infusion of 0.25 to 5.00 μg/kg per minute</td>
<td>Possible cyanide toxicity if used for &gt;4 hours; agent of last resort</td>
</tr>
</tbody>
</table>

Drugs indicated for acute elevation of diastolic BP ≥105 mm Hg; the goal is gradual reduction to 90 to 100 mm Hg. NHBPEP indicates National High Blood Pressure Education Program Working Group Report on High Blood Pressure in Pregnancy; FDA, Food and Drug Administration.

*Food and Drug Administration classification; C indicates that either studies in animals have revealed adverse effects on the fetus (teratogenic, embryocidal, or other) and/or there are no controlled studies in women or studies in women and animals are not available. Drugs should only be given if the potential benefits justify the potential risk to the fetus.

†Adverse effects for all of the agents, except as noted, may include headache flushing, nausea, and tachycardia (primarily because of precipitous hypotension and reflex sympathetic activation).

‡We would classify in category D: there is positive evidence of human fetal risk, but the benefits of the use in pregnant women may be acceptable despite the risk (eg, if the drug is needed in a life-threatening situation or for a serious disease for which safer drugs can not be used or are ineffective).

Choice of Antihypertensive Drug for Use in Pregnancy

The Food and Drug Administration reviews human and animal data to assign letter grades corresponding with risk of fetal exposure in pregnancy. Most antihypertensive agents used in pregnancy are designated as “category C,” which states that human studies are lacking, animal studies are either positive for fetal risk or are lacking, and the drug should be given only if potential benefits justify potential risks to the fetus. This category cannot be interpreted as no evidence of risk and is so broad to preclude usefulness in practice, leading some groups to suggest that the Food and Drug Administration classification be abandoned. Information is, thus, based on clinical cases, small studies, and meta-analyses.

Sympathetic Nervous System Inhibition

Methyldopa remains one of the most widely used drugs for the treatment of hypertension in pregnancy. It is a centrally acting α₂-adrenergic agonist prodrug, which is metabolized to α-methyl norepinephrine and then replaces norepinephrine in the neurosecretory vesicles of adrenergic nerve terminals. BP control is gradual, over 6 to 8 hours, because of the indirect mechanism of action. It is not thought to be teratogenic based on limited data and a 40-year history of use in pregnancy. It has been assessed in a number of prospective trials in pregnant women compared with placebo or with alternative antihypertensive agents. Treatment with methyldopa has been reported to prevent subsequent progression to severe hypertension in pregnancy and does not seem to have adverse effects on uteroplacental or fetal hemodynamics or on fetal well being. One placebo-controlled trial (>200 women with diastolic BP >90 mm Hg at entry) noted fewer midpregnancy losses in patients randomly assigned to methyldopa, but this observation was not confirmed in a more recent trial of a similar size. Importantly, birth weight, neonatal complications, and development during the first year were similar in children exposed to methyldopa as in the placebo group. In a follow-up study of offspring who were exposed to methyldopa in utero, at 7.5 years of age, the children exhibited intelligence and neurocognitive development similar to control subjects.

Adverse effects are consequences of central α₂-agonism or decreased peripheral sympathetic tone. These drugs act at sites in the brain stem to decrease mental alertness and impair sleep, leading to a sense of fatigue or depression in some patients. Frequently, decreased salivation, leading to xerostomia, is experienced. Methyldopa can also cause elevated liver enzymes in 5%; hepatitis and hepatic necrosis have also been
reported. Some patients will develop a positive antinuclear antigen or antitubulin (Coombs') test with chronic use, and this is occasionally associated with clinical hemolytic anemia. In these cases, medications from other classes are substituted.

Clonidine, a selective α2-agonist, acts similarly and is comparable to methyldopa with respect to safety and efficacy, but of some concern is a small controlled follow-up study of 22 neonates that reported an excess of sleep disturbance in clonidine-exposed infants. In pregnancy, it is mainly used as a third-line agent for multidrug control of refractory hypertension.

**Peripherally Acting Adrenergic Receptor Antagonists**

β-Blockers have been used extensively in pregnancy. Although several randomized trials comparing β-blockers with either placebo or other agents have been conducted, there are still some unresolved issues regarding their use in pregnancy, largely a result of a few small studies that suggest an association with lower birth weight infants. None of the β-blockers have been associated with teratogenicity. In a meta-analysis and Cochrane review, individual agents were not distinguishable in their perinatal effects with the exception of atenolol, which in 1 small study was started at 12 to 24 weeks' gestation and resulted in clinically significant fetal growth restriction and decreased placental weight compared with placebo. This observation was supported in a subsequent retrospective review comparing atenolol with alternative therapies. Given differences in β-blockers with respect to lipid solubility and receptor specificity, the potential for clinically relevant differences between agents exists but has not been investigated in pregnancy. Oral β-blockade had been associated with nonclinically significant neonatal bradycardia, although in a systematic review of trials, labetalol does not (along with oral methyldopa, nifedipine, or hydralazine) seem to cause neonatal heart rate effects. Parenteral therapy has been found to increase the risk of neonatal bradycardia, requiring intervention in 1 of 6 newborns. Further reassurance is derived from a 1-year postpartum follow-up study, which showed normal development of infants exposed to atenolol in utero. Maternal outcomes are improved with the use of β-blockers, with effective control of maternal BP, decreased incidence of severe hypertension, and decreased rate of preterm admission to hospital; they have been found in a recent Cochrane analysis to be more effective in lowering BP compared with methyldopa in 10 trials.

Labetalol, a nonselective β-blocker with vascular α1-receptor blocking capabilities, has gained wide acceptance in pregnancy. When administered orally to women with chronic hypertension, it seems as safe and effective as methyldopa, although neonatal hypoglycemia with higher doses has been reported. Of some concern, 1 placebo controlled study reported an association with fetal growth restriction in the management of preeclampsia remote from term. Parenterally it is used to treat severe hypertension, and because of a lower incidence of maternal hypotension and other adverse effects, its use now supplants that of hydralazine.

Adverse effects may be predicted as consequences of β-receptor blockade. Fatigue, lethargy, exercise intolerance (because of β2-blocking effects in skeletal muscle vasculature), peripheral vasoconstriction, sleep disturbance (with use of more lipid-soluble drugs), and bronchoconstriction may be seen; however, discontinuation because of adverse effects is uncommon.

Peripherally acting α-adrenergic antagonists are second-line antihypertensive drugs in nonpregnant adults. These are indicated during pregnancy in the management of hypertension because of suspected pheochromocytoma, and both prazosin and phenoxybenzamine have been used, with β-blockers used as adjunctive agents after α-blockade is accomplished. Because there is but limited experience with these agents in pregnancy, their routine use cannot be advocated.

**Calcium Channel Antagonists**

Calcium channel antagonists have been used to treat chronic hypertension, mild preeclampsia presenting late in gestation, and urgent hypertension associated with preeclampsia. Orally administered nifedipine and verapamil do not seem to pose teratogenic risks to fetuses exposed in the first trimester. Most investigators have focused on the use of nifedipine, although there are reports of nicardipine, isradipine, felodipine, and verapamil. Although used in pregnancy, the dihydropyridine amlodipine is yet unstudied in this population. Maternal adverse effects of the calcium channel blockers include tachycardia, palpitations, peripheral edema, headaches, and facial flushing. Nifedipine does not seem to cause a detectable decrease in uterine blood flow. Short-acting dihydropyridine calcium antagonists, particularly when administered sublingually, are now not recommended for the treatment of hypertension in nonpregnant patients because of reports of myocardial infarction and death in hypertensive patients with coronary artery disease. Administration of short-acting nifedipine capsules has been, in case reports, associated with maternal hypotension and fetal distress. If rapid BP control is desired, then we recommend using parenteral labetalol or hydralazine until the desired target is achieved. One study has shown efficacy and safety of long-acting oral nifedipine in pregnant patients with severe hypertension in pregnancy, and given possible untoward fetal effects of short-acting sublingual nifedipine, we also advocate use of the long-acting preparation.

A concern with the use of calcium antagonists for BP control in preeclampsia has been the concomitant use of magnesium sulfate to prevent seizures; drug interactions between nifedipine and magnesium sulfate were reported to cause neuromuscular blockade, myocardial depression, or circulatory collapse in some cases. In practice and in a recent evaluation, these medications are commonly used together without increased risk.

**Diuretics**

Diuretics are commonly prescribed in essential hypertension before conception and, given their apparent safety, the National High Blood Pressure Education Program Working Group on High Blood Pressure in Pregnancy concluded that they may be continued through gestation (with an attempt made to lower the dose) or used in combination with other...
agents, especially for women deemed likely to have salt-sensitive hypertension. Older anecdotal studies suggested that diuretics might prevent preeclampsia, a finding that was supported by a meta-analysis (published in 1985) of 9 randomized trials involving >7000 subjects. Although volume contraction might be expected to limit fetal growth, outcome data have not supported these concerns. However, mild volume contraction with diuretic therapy may lead to hyperuricemia and in so doing invalidate serum uric acid levels as a laboratory marker in the diagnosis of superimposed preeclampsia.

Hydrochlorothiazide may be continued during pregnancy; the use of low doses (12.5 to 25 mg daily) may minimize untoward metabolic effects, such as impaired glucose tolerance and hypokalemia. Triamterene and amiloride are not preferable first-line agents, with hydralazine as a suitable second-line agent.

Isosorbide dinitrate, an NO donor, has been investigated in a small study of gestational hypertensive and preeclamptic pregnant patients. It was found that cerebral perfusion pressure is unaltered by isosorbide dinitrate, despite significant changes in maternal BP, thus decreasing the risk for ischemia and infarction when BP is lowered.

Sodium nitroprusside is a direct NO donor, which nonselectively relaxes both arteriolar and venular vascular smooth muscle. Administered only by continuous intravenous infusion, it is easily titrated because it has a near-immediate onset of action and duration of effect of 3 minutes. Nitroprusside metabolism releases cyanide, which can reach toxic levels with high infusion rates; cyanide is metabolized to thiocyante, and this toxicity usually occurs after 24 to 48 hours of infusion unless its excretion is delayed due to renal insufficiency. It is seldom used in pregnancy, usually only in cases of life-threatening refractory hypertension in the moments before delivery. Adverse effects include excessive vasodilation and cardiogenic (ie, paradoxical bradycardia) syncope in volume-depleted preeclamptic women. The risk of fetal cyanide intoxication remains unknown. Given the long experience with hydralazine and alternative use of parenteral labetalol or oral calcium channel blockers, this drug is considered as a last resort.

Serotonin, Receptor Blockers

Serotonin-induced vasodilation is mediated by S1 receptors and subsequent release of prostacyclin and NO. Endothelial dysfunction and loss of endothelial S1 receptors allows serotonin, of which the levels are greatly increased in pregnancy, to react only with S2 receptors, resulting in vasoconstriction and platelet aggregation. Ketanserin is a selective S2 receptor-blocking drug that decreases systolic and diastolic BP in nonpregnant patients with acute or chronic hypertension. Ketanserin has not been found to be teratogenic in animals or humans and has been studied primarily in Australia and South Africa in small trials, which suggest that it may be safe and useful in the treatment of chronic hypertension in pregnancy, preeclampsia, and hemolysis elevation of liver enzymes, low platelets syndrome. Ketanserin has not been Food and Drug Administration approved in the United States.

Direct Vasodilators

Hydralazine selectively relaxes arteriolar smooth muscle by an as-yet-unknown mechanism. Its greatest use is in the urgent control of severe hypertension or as a third-line agent for multidrug control of refractory hypertension. It is effective orally, intramuscularly, or intravenously; parenteral administration is useful for rapid control of severe hypertension. Adverse effects are mostly those due to excessive vasodilation or sympathetic activation and include headache, nausea, flushing, or palpitations. Chronic use can lead in rare cases to a pyridoxine-responsive polyneuropathy or to immunologic reactions, including a drug-induced lupus syndrome. Hydralazine has been used in all trimesters of pregnancy, and data have not shown an association with teratogenicity, although neonatal thrombocytopenia and lupus have been reported. It has been widely used for chronic hypertension in the second and third trimesters, but its use has been supplanted by agents with more favorable adverse effect profiles. For acute severe hypertension later in pregnancy, intravenous hydralazine has been associated with more maternal and perinatal adverse effects than intravenous labetalol or oral nifedipine.
Management of Hypertension Postpartum

In the postpartum period, previously normotensive women have been noted to have a rise in BP, which reaches a maximum on the fifth postpartum day, and in 1 study 12% of patients had a diastolic BP exceeding 100 mm Hg.92 This is thought to be a consequence of physiological volume expansion and fluid mobilization in the postpartum period. The natural history of gestational hypertension and preeclampsia in the postpartum period and the maximum time to normalization (beyond which chronic hypertension should be diagnosed) are not known. As such, and noted in a recent Cochrane analysis, the need for treatment, the management of antihypertensive medication, and patient counseling have been unguided by the literature.93 Postpartum, no guidelines currently exist, but Tan and de Swiet94 have suggested that antihypertensive drugs should be given if the BP exceeds 150 mm Hg systolic or 100 mm Hg diastolic in the first 4 days of the puerperium. Choice of antihypertensive agent in the postpartum period is often influenced by breast feeding,95 it has not been our practice to recommend pregnancy termination. Of note, direct renin inhibitors might be expected to have similar effects as ACE-I and angiotensin receptor blocking agents in pregnancy; however, we are unaware of any reports of their use in pregnancy, and, consequently, they should be avoided in this setting.

Antihypertensive Use in Breastfeeding

There are no well-designed studies assessing neonatal effects of maternally administered antihypertensive drugs delivered via breast milk. The pharmacokinetic principles that govern drug distribution to milk and ensuing exposure to the infant are well established.98,99 Milk, secreted by alveolar cells, is a suspension of fat globules in a protein-containing aqueous solution with a pH lower than that of maternal plasma.

Table 4. Maternal Antihypertensive Medications Usually Compatible With Breastfeeding

<table>
<thead>
<tr>
<th>Drug</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Captopril</td>
<td>Diuretics (furosemide, hydrochlorothiazide, and spironolactone) may reduce milk production. Metoprolol is classified as compatible with breastfeeding, although it is given in human milk. Acetobutolol and atenolol should not be used in nursing mothers.</td>
</tr>
<tr>
<td>Labetalol</td>
<td>Data are from Reference 104.好似drug passage into milk are a small maternal volume of distribution, low plasma protein binding, high lipid solubility, and lack of charge at physiological pH. Even when drugs are ingested by nursing infants, exposure depends on volume ingested, intervals between drug administration and nursing, oral bioavailability, and the capacity of the infant to clear the drug. Neonatal exposure to methyldopa via nursing is likely low, and it is considered safe (Table 4). Atenolol and metoprolol are concentrated in breast milk, possibly to levels that could affect the infant; by contrast, exposure to labetalol and propranolol seems low. Although milk concentrations of diuretics are low and considered safe, these agents can decrease milk production significantly.</td>
</tr>
<tr>
<td>Propranolol</td>
<td>Factors that favor drug passage into milk are a small maternal volume of distribution, low plasma protein binding, high lipid solubility, and lack of charge at physiological pH. Even when drugs are ingested by nursing infants, exposure depends on volume ingested, intervals between drug administration and nursing, oral bioavailability, and the capacity of the infant to clear the drug. Neonatal exposure to methyldopa via nursing is likely low, and it is generally considered safe (Table 4). Atenolol and metoprolol are concentrated in breast milk, possibly to levels that could affect the infant; by contrast, exposure to labetalol and propranolol seems low. Although milk concentrations of diuretics are low and considered safe, these agents can decrease milk production significantly.</td>
</tr>
<tr>
<td>Timolol</td>
<td>Factors that favor drug passage into milk are a small maternal volume of distribution, low plasma protein binding, high lipid solubility, and lack of charge at physiological pH. Even when drugs are ingested by nursing infants, exposure depends on volume ingested, intervals between drug administration and nursing, oral bioavailability, and the capacity of the infant to clear the drug. Neonatal exposure to methyldopa via nursing is likely low, and it is generally considered safe (Table 4). Atenolol and metoprolol are concentrated in breast milk, possibly to levels that could affect the infant; by contrast, exposure to labetalol and propranolol seems low. Although milk concentrations of diuretics are low and considered safe, these agents can decrease milk production significantly.</td>
</tr>
<tr>
<td>Verapamil</td>
<td>Factors that favor drug passage into milk are a small maternal volume of distribution, low plasma protein binding, high lipid solubility, and lack of charge at physiological pH. Even when drugs are ingested by nursing infants, exposure depends on volume ingested, intervals between drug administration and nursing, oral bioavailability, and the capacity of the infant to clear the drug. Neonatal exposure to methyldopa via nursing is likely low, and it is generally considered safe (Table 4). Atenolol and metoprolol are concentrated in breast milk, possibly to levels that could affect the infant; by contrast, exposure to labetalol and propranolol seems low. Although milk concentrations of diuretics are low and considered safe, these agents can decrease milk production significantly.</td>
</tr>
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Summary

The use of antihypertensive agents in pregnancy for control of mild-to-moderate hypertension or for control of severe hypertension is summarized in Tables 2 and 3. Currently, there is little evidence to support the concept that BP control in pregnant women with chronic hypertension will prevent the subsequent occurrence of preeclampsia, itself the cause for most adverse outcomes in these patients. As BP falls in early pregnancy, decreasing or even discontinuing medication...
and monitoring is often possible in women with mild or moderate hypertension. Acknowledging limitations in evidenced-based data and other concerns discussed above regarding gestational age, we recommend a threshold for treatment of most pregnant hypertensive women of 140 to 150 mm Hg systolic, and/or 95 to 100 mm Hg diastolic to prevent worsening hypertension in the mother. Acceptable agents include methyldopa, labetalol, and nifedipine in standard doses. Atenolol use should probably be avoided in pregnancy, because it has been associated with slightly lower birth weights. ACE-I and angiotensin receptor blockers should be avoided in all trimesters; when administered in the second and third trimesters, they are associated with a characteristic fetopathy, neonatal renal failure, and death, and, thus, are contraindicated. Recent data suggest that they should also be avoided in the first trimester. Finally, control of severe hypertension has been studied in a recent meta-analysis, and this suggests that intravenous labetalol or oral nifedipine is as effective as intravenous hydralazine, with fewer adverse effects.

Many research questions surrounding hypertension in pregnancy and preeclampsia remain unanswered. Advancement of clinical knowledge requires studies that are large, collaborative, and multicentered. For example, to better understand the need for antihypertensive therapy in mild-to-moderate chronic hypertension, a study designed to detect a moderate (20%) relative risk reduction in preeclampsia or intrauterine growth restriction would require a randomized trial with enrollment of 1000 to 3000 women with chronic hypertension. Preconception management of hypertension, the necessity for antihypertensive agents, specific drug agents, racial differences, BP levels for initiation of therapy, and treatment targets all remain to be determined. Current guidelines rely only on evidence from small, largely underpowered trials and expert opinion. Finally, studies of antihypertensive medication in pregnancy often evaluate the effectiveness of a drug without examining fetal outcomes associated with harm; future studies must include detailed outcomes of risk and benefit for both the mother and baby. Better surveillance systems to routinely monitor adverse events and numbers of women exposed to particular agents are required to guide treatment efficacy, advance our knowledge of drug safety, and ultimately improve treatment options.

Disclosures

None.

References


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