

Maternity and Newborn Clinical Network

## **Eclampsia: Management** CALL FOR HELP Code or MET Call Resuscitate Acute treatment Ensure patent airway Do not allow BP to fall below 140/80 • Oxygen – 10 L/min via mask • Nifedipine, maximum 40mg, oral IV access • Labetalol, 20-80mg, IV bolus over 2 minutes • Hydralazine, 5-10mg, IV bolus over 5 minutes administered by a medical officer, or IM injection **Control Blood Pressure** Fluid restriction • Aim for BP <160/100 mmHG • Nil by mouth • 80 ml/hr IV crystalloid **Commence MGSO**<sub>4</sub> • Loading dose: 4 g IV over 20 minutes Maintenance dose: 1 g IV per hour Observations • During loading dose: Do not prescribe MgSO<sub>4</sub> before discussion with obstetric consultant - 5-minutely BP, pulse and respiratory rates • At completion of loading dose, record BP, PR, RR and deep tendon reflexes • During maintenance dose: When woman is stable - deliver the baby – hourly BP, PR and RR · Continuous CTG while waiting for delivery - hourly urine output • Senior paediatric clinician to attend delivery - hourly deep tendon reflexes • Record strict fluid balance Prevent further seizures • Continue MgSO4 for 24 hours from birth or last seizure Before discontinuing MgSO<sub>4</sub>, ensure • BP stable (consistently <150/100) • Adequate diuresis • Woman clinically improved, with no headache or epigastric pain Monitor for magnesium toxicity Signs of magnesium toxicity • MgSO4 serum levels must be taken: • Decreased deep tendon reflexes • Respiratory rate <12 breaths per minute - if there are signs of toxicity • Reduced urine output: < 40mL/hr - for women with renal impairment and/or low urine output (<30 ml/hr) Serum magnesium concentration >3.5mmol/L • Serum levels may be taken 6-hourly during infusion Antidote for magnesium toxicity • 10% calcium gluconate 10 mL IV

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