



Royal College of  
Obstetricians &  
Gynaecologists

# Information for you

Updated in February 2022

## Pre-eclampsia

### About this information

Pre-eclampsia is a complication of pregnancy that typically causes you to have high blood pressure and protein in your urine. It can make you unwell and can affect your baby's growth and wellbeing.

This information is for you if you have been diagnosed with pre-eclampsia or if you wish to know more about it. This information may also be helpful if you are a partner, relative or friend of someone in this situation.

The information here aims to help you better understand your health and your options for treatment and care now and in the future. Your healthcare team is there to support you in making decisions that are right for you. They can help by discussing your situation with you and answering your questions.

A glossary of medical terms is available on the RCOG website at: [www.rcog.org.uk/en/patients/medical-terms](http://www.rcog.org.uk/en/patients/medical-terms).



## Key Points

- Pre-eclampsia is a condition that affects between 1– 5 in 100 pregnant women.
- It is usually diagnosed in the second half of pregnancy, during labour or soon after you have given birth.
- Signs of pre-eclampsia include having high blood pressure (hypertension) and protein in your urine (proteinuria).
- Although many cases are mild, pre-eclampsia can sometimes lead to serious complications for both you and your baby.
- You may be offered medication to lower your high blood pressure but pre-eclampsia will not get better until after you have given birth.
- If you have pre-eclampsia you are at more risk of developing high blood pressure, stroke and heart disease in later life.

## What is pre-eclampsia?

Pre-eclampsia is a condition that usually happens after 20 weeks of pregnancy. The exact cause of pre-eclampsia is not understood. It is usually a combination of:

- raised blood pressure (hypertension)
- protein in your urine (proteinuria).

Sometimes pre-eclampsia can affect your liver, kidneys and blood clotting without protein in your urine.

Pre-eclampsia is common, affecting between 1–5 in 100 women during pregnancy. It is usually mild but in a small number of cases, it can develop into a more serious illness. Around one in 200 women develop severe pre-eclampsia, which can be life-threatening for both you and your baby.

## How will I know if I have pre-eclampsia?

Often you will have no symptoms and pre-eclampsia may be diagnosed for the first time at your routine antenatal appointments or during labour when you have your blood pressure checked and your urine tested.

If you do develop symptoms they usually happen towards the end of your pregnancy but can also happen for the first time only after you have given birth.

The symptoms of pre-eclampsia may include:

- a severe headache that doesn't go away with simple painkillers
- problems with your eyesight, such as blurred vision or flashing lights in front of your eyes
- severe pain just below your ribs
- heartburn that doesn't go away with antacids
- rapidly increasing swelling of your face, hands or feet
- nausea and vomiting
- feeling very unwell.

These symptoms can be serious and you should seek medical help immediately if you develop any of them.

## **What does pre-eclampsia mean for me?**

If you have severe pre-eclampsia, organs, such as your liver, kidneys or brain, can sometimes be affected and you may develop problems with blood clotting.

If you have a seizure because of pre-eclampsia it is called an eclamptic fit or eclampsia. This is rare affecting only one in 4000 pregnancies in the UK.

## What does pre-eclampsia mean for my baby?

Pre-eclampsia affects how well your **placenta** (afterbirth) works. This can affect the growth of your baby meaning they are smaller than they should be. If your placenta is severely affected, your baby may become very unwell or in some cases even die in your uterus (womb).

If you have severe pre-eclampsia that is making you or your baby unwell, your baby may need to be born prematurely (before 37 weeks). Premature babies are at increased risk of complications with their health and may need to be cared for in a **neonatal unit** when they are born.

## Who is at risk of pre-eclampsia and can it be prevented?

Pre-eclampsia can happen in any pregnancy but you are at higher risk if:

- your blood pressure was high before you became pregnant
- your blood pressure was high in a previous pregnancy
- you have a medical problem such as kidney disease or a condition affecting your immune system, such as lupus
- you have type 1 or type 2 diabetes.

If any of these apply to you, you should be advised to take aspirin (75–150 mg) once a day from 12 weeks of pregnancy until 36 weeks of pregnancy, to reduce your chance of developing pre-eclampsia.

You may also be at risk of developing pre-eclampsia if more than one of the following applies:

- this is your first pregnancy
- you are aged 40 or over

- your last pregnancy was more than 10 years ago
- you are overweight – you have a BMI (body mass index) of 35 or more
- your mother or sister had pre-eclampsia during her pregnancy
- you are carrying more than one baby (twins, triplets or more).

If you have more than one of these risk factors, you should take aspirin once a day from 12 weeks of pregnancy.

## How is pre-eclampsia monitored?

If you are diagnosed with pre-eclampsia, you will have an individualised care plan depending upon how many weeks pregnant you are, how high your blood pressure is and whether there are any concerns about you or your baby's wellbeing.

Depending on how severe your pre-eclampsia is you will either be offered admission to hospital for monitoring and treatment or will be offered outpatient monitoring with regular (sometimes daily) follow up appointments. Your blood pressure will be checked frequently and if it is too high blood pressure tablets may be recommended. You will have regular blood tests and you will be offered ultrasound scans at least every 2 weeks to check that your baby is growing normally.

## When will my baby be born?

You will continue to be monitored closely to check that you can safely carry on with your pregnancy. If you reach 37 weeks pregnant or are diagnosed with pre-eclampsia after 37 weeks you will be advised to have your baby. You may be advised to give birth earlier than 37 weeks if you or your baby become unwell.

This would mean that your baby is premature so it would only be advised if your healthcare team feel that it is safer than carrying on with the pregnancy. The risks and benefits to both you and your baby will be discussed with you to enable you to make an informed choice.

Your options for birth will depend on your individual circumstances but will include either an **induction of labour** or a planned **caesarean birth**.

## **What happens if I develop severe pre-eclampsia?**

If you develop severe pre-eclampsia, you will be admitted to hospital and cared for by a specialist team. You may need to be cared for in a high dependency unit or intensive care unit. Treatment may include medication (either tablets or via a drip) to lower and control your blood pressure. You may also be given a medication called magnesium sulfate to reduce the chance of you having an eclamptic fit. This medication can also be used to treat eclampsia if you have already had a fit.

The only way to cure pre-eclampsia is for your baby to be born. Each pregnancy is unique and the timing of birth, together with how your baby will be born, will depend on your own particular situation. Your healthcare team will discuss your options with you.

## **What happens after birth?**

Pre-eclampsia goes away after birth, however complications may still happen within the first few days and you will continue to be monitored closely. You may need to stay in hospital for several days longer than normal after birth. You will need to have your blood pressure checked regularly after leaving hospital, and you may need to continue taking medication to control your blood pressure for several weeks.

Your healthcare team will make sure that any medications you need will be safe to use if you are breastfeeding. If your baby has needed admission to a neonatal unit you can still express milk to give to them. However you choose to feed your baby, you will be offered support in doing this.

You should have a follow-up appointment with your healthcare professional 6–8 weeks after giving birth. If you are still on medication to treat your blood pressure at this stage or if there is still protein in your urine, you may be referred to a specialist for further investigations.

## **How will I feel after birth?**

Experiencing a complicated pregnancy or birth can be distressing for you and your family, particularly if your baby has needed to go to the neonatal unit, or if you have had a prolonged stay in hospital. If you feel that you are developing anxiety, have low mood or feel that you need additional support you should talk to your healthcare professional.

## **Will I get pre-eclampsia in a future pregnancy?**

Pre-eclampsia can happen again in future pregnancy. The likelihood of this depends on how early your baby needed to be born:

- one in three women will get pre-eclampsia in a future pregnancy if their baby needed to be born between 28–34 weeks of pregnancy
- one in four women will get pre-eclampsia in a future pregnancy if their baby needed to be born between 34–37 weeks of pregnancy
- one in six women will get pre-eclampsia in a future pregnancy if their baby is born after 37 weeks.

You should be given information about your individual chance of getting pre-eclampsia in a future pregnancy and about any additional care that you may need. If you have had pre-eclampsia in one pregnancy you are advised to take aspirin tablets (75–100 mg) from 12 weeks in any future pregnancy to reduce the risk of it happening again. You should contact your healthcare team as soon as possible in any future pregnancy to make a plan of care for your pregnancy.

## How will having pre-eclampsia affect my future health?

If you have pre-eclampsia you are at more risk of developing high blood pressure, stroke and heart disease in later life.

Things you can do to reduce this risk include:

- avoiding smoking
- maintaining a healthy lifestyle
- maintaining a healthy weight.

## Further information

National Institute for Health and Care Excellence (NICE) guidance on Hypertension in pregnancy: diagnosis and management <https://www.nice.org.uk/guidance/ng133>

NHS information: <https://www.nhs.uk/conditions/pre-eclampsia/symptoms>

Action on Pre-eclampsia: [www.apec.org.uk](http://www.apec.org.uk)

Tommy's: <https://www.tommys.org/pregnancy-information/pregnancy-complications/pre-eclampsia-information-and-support>



A full list of useful organisations (including the above) is available on the RCOG website at: <https://www.rcog.org.uk/en/patients/other-sources-of-help/>

## Making a choice

### Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



#### Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

\* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84:379-85



<https://aqua.nhs.uk/resources/shared-decision-making-case-studies/>

## Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on NICE guideline on *Hypertension in pregnancy: diagnosis and management*, published in June 2019. The guideline contains a full list of the sources of evidence used and is available at <https://www.nice.org.uk/guidance/ng133>.