



Guidelines

Hypertension Canada's 2018 Guidelines for the Management of Hypertension in Pregnancy

Sonia Butalia, BSc, MD, MSc,^{a,b,c} Francois Audibert, MD, MSc,^d Anne-Marie Côté, MD, MHSc,^e Tabassum Firoz, MD, MSc,^f Alexander G. Logan, MD,^g Laura A. Magee, MD, MSc,^{h,i} William Mundle, MD,^j Evelyne Rey, MD, MSc,^k Doreen M. Rabi, MD, MSc,^{a,b,c} Stella S. Daskalopoulou, MD, PhD,^l and Kara A. Nerenberg, MD, MSc;^{b,c,m} for Hypertension Canada

^a Departments of Medicine and Community Health Sciences, University of Calgary, Calgary, Alberta, Canada; ^b Libin Cardiovascular Institute of Alberta, University of Calgary, Calgary, Alberta, Canada; ^c O'Brien Institute for Public Health, University of Calgary, Calgary, Alberta, Canada; ^d Department of Obstetrics and Gynecology, CHU Sainte Justine, Université de Montréal, Montréal, Québec, Canada; ^e Université de Sherbrooke, Sherbrooke, Québec, Canada; ^f Department of Medicine, The Warren Alpert Medical School of Brown University, Providence, Rhode Island, USA; ^g University of Toronto, Toronto, Ontario, Canada; ^h Department of Women and Children's Health, St Thomas' Hospital, London, United Kingdom; ⁱ School of Life Course Sciences, Faculty of Life Sciences and Medicine, King's College London, London, United Kingdom; ^j Maternal Fetal Medicine Clinic, Windsor Regional Hospital, Windsor, Ontario, Canada; ^k Division of Obstetric Medicine, Department of Obstetrics and Gynecology, CHU Sainte Justine, Montréal, Québec, Canada; ^l Division of General Internal Medicine, Department of Medicine, McGill University, Montreal, Quebec, Canada; ^m Departments of Medicine, Obstetrics and Gynecology, and Community Health Sciences, University of Calgary, Calgary, Alberta, Canada

ABSTRACT

We present Hypertension Canada's inaugural evidence-based Canadian recommendations for the management of hypertension in pregnancy. Hypertension in pregnancy is common, affecting approximately 7% of pregnancies in Canada, and requires effective management to reduce maternal, fetal, and newborn complications. Because of this importance, these guidelines were developed in partnership with the Society of Obstetricians and Gynaecologists of Canada with the main common objective of improving the management of women with hypertension in pregnancy. Guidelines for the diagnosis, assessment,

RÉSUMÉ

Nous présentons les premières recommandations d'Hypertension Canada fondées sur des données probantes pour la prise en charge de l'hypertension pendant la grossesse. L'hypertension en cours de grossesse, un trouble fréquent qui touche 7 % des grossesses au Canada, nécessite une prise en charge efficace pour réduire les complications tant chez la mère que chez le fœtus et le nouveau-né. Compte tenu de leur importance, ces lignes directrices ont été élaborées en partenariat avec la Société des obstétriciens et gynécologues du Canada avec l'objectif principal commun d'améliorer la prise en charge des femmes

Hypertensive disorders of pregnancy (HDP) occur in approximately 7% of all pregnancies in Canada.¹ HDP represent a broad range of conditions including: chronic hypertension (ie, preexisting hypertension), gestational hypertension (ie, hypertension that develops after 20 weeks' gestation), and/or preeclampsia/eclampsia (gestational hypertension with proteinuria and/or other target organ involvement).^{2,3} HDP have a major effect on maternal, fetal, and newborn outcomes including: fetal growth restriction, preterm delivery, and fetal and neonatal morbidity and mortality.² After pregnancy, emerging evidence shows that women

with HDP represent a high-risk population for the development of cardiovascular risk factors (hypertension, type 2 diabetes, and obesity), chronic kidney disease, premature cardiovascular disease (cardiac, cerebrovascular, and peripheral arterial), and cardiovascular mortality.³⁻⁶ Notably, HDP are an independent risk factor for cardiovascular disease associated with gradually elevated risk of cardiovascular disease with increasing severity of HDP from 1.7 (adjusted hazard ratio; 95% confidence interval [CI], 1.3-2.2) in women with gestational hypertension to 4.4 (adjusted hazard ratio; 95% CI, 2.4-7.9) in women with severe preeclampsia with fetal death.^{3,4}

Because HDP are prevalent and have important short- and long-term health effects, Hypertension Canada's target audience expressed a need for guidance on the management of hypertension in pregnancy. In response, a Pregnancy Subgroup was formed in 2014 to develop evidence-based blood pressure (BP) management guidelines for pregnancy. A formal partnership was then established between Hypertension

Received for publication February 2, 2018. Accepted February 20, 2018.

Corresponding author: Dr Sonia Butalia, 1820 Richmond Rd SW, Division of Endocrinology and Metabolism, University of Calgary, Calgary, Alberta T2T 5C7, Canada. Tel.: +1-403-955-8327; fax: +1-403-955-8249.

E-mail: sbutalia@ucalgary.ca

See page 531 for disclosure information.

<https://doi.org/10.1016/j.cjca.2018.02.021>

0828-282X/© 2018 Canadian Cardiovascular Society. Published by Elsevier Inc. All rights reserved.

prevention, and treatment of hypertension in adults and children are published separately. In this first Hypertension Canada guidelines for hypertension in pregnancy, 7 recommendations for the management of nonsevere and severe hypertension in pregnancy are presented. For nonsevere hypertension in pregnancy (systolic blood pressure 140-159 mm Hg and/or diastolic blood pressure 80-109 mm Hg), we provide guidance for the threshold for initiation of antihypertensive therapy, blood pressure targets, as well as first- and second-line antihypertensive medications. Severe hypertension (systolic blood pressure ≥ 160 mm Hg and/or diastolic blood pressure ≥ 110 mm Hg) requires urgent antihypertensive therapy to reduce maternal, fetal, and newborn adverse outcomes. The specific evidence and rationale underlying each of these guidelines are discussed.

Canada and the Society of Obstetricians and Gynaecologists of Canada (SOGC) to ensure harmonization of guidelines through shared guideline development as well as for broader reach of the guidelines through knowledge translation and dissemination strategies.

These inaugural Hypertension Canada guidelines for hypertension in pregnancy are intended to provide a framework for evidence-based care of hypertension in pregnancy but should not replace clinical judgement. Practitioners are advised to consider patient preferences, values, and clinical circumstances when determining how to best apply these guidelines to individual patients.

Methods

The Hypertension Canada guidelines are developed annually through a highly structured and systematic process designed to minimize bias. Hypertension Canada's guideline process has been externally reviewed and is in concordance with the Appraisal of Guidelines for Research and Evaluation II (AGREE II) instrument for guideline development (guidelines.hypertension.ca/about/overview-process).⁷ The Hypertension Canada Guidelines Committee (HCGC) is comprised of a multidisciplinary panel of content as well as methodological experts divided into 16 subgroups in distinct areas of hypertension (see Supplemental Appendix S1 and S2 for list of members and conflicts of interest, respectively). The Pregnancy Subgroup consisted of 8 members with a broad range of expertise, including internal medicine subspecialties as well as obstetrics (2 members from the SOGC Maternal Fetal Medicine subcommittee).

The comprehensive literature search was performed by a highly trained medical librarian on the basis of key words and terms provided by the subgroup. The initial literature search was performed in June 2015 and updated in June 2016 (details of search strategies and retrieved articles are available upon request). The literature was reviewed and graded using the standardized method developed by Hypertension Canada (Supplemental Table S1) and according to the Hypertension Canada guidelines established process.⁸

The proposed pregnancy guidelines were then reviewed and modified by the Central Review Committee, unbiased

hypertendues pendant leur grossesse. Les lignes directrices relatives au diagnostic, à l'évaluation, à la prévention et au traitement de l'hypertension chez l'adulte et l'enfant sont publiées séparément. Dans ces premières lignes directrices sur l'hypertension pendant la grossesse d'Hypertension Canada, sept recommandations pour la prise en charge de l'hypertension bénigne et grave chez les femmes enceintes sont présentées. Pour l'hypertension bénigne pendant la grossesse (pression artérielle systolique de 140 à 159 mm Hg et/ou pression artérielle diastolique de 80 à 109 mm Hg), nous donnons des indications relatives au seuil d'instauration du traitement antihypertenseur, aux pressions artérielles cibles et aux médicaments antihypertenseurs de première et de deuxième intention. L'hypertension grave (pression artérielle systolique ≥ 160 mm Hg et/ou pression artérielle diastolique ≥ 110 mm Hg) nécessite un traitement antihypertenseur urgent pour réduire ses effets néfastes chez la mère, le fœtus et le nouveau-né. Les données probantes et la justification qui sous-tendent chacune de ces lignes directrices sont analysées.

experts in clinical epidemiology, to ensure that the guidelines reflected the evidence and to verify proposed grading. The draft guidelines and supporting evidence were presented to the HCGC in Toronto, on October 12, 2017. After the discussions, the guidelines were further revised and finalized for an electronic vote by all 81 members of the HCGC, with > 70% support required for approval of each new/revised guideline.

Challenges in Pregnancy Research

There are several methodologic challenges in the obstetrical research related to BP that were taken into consideration during the hypertension in pregnancy guidelines development process (Table 1). First, the definition of hypertension in pregnancy has changed over time.⁹ Older studies included pregnant women with a diastolic BP (DBP) ≥ 90 mm Hg, whereas more recent studies have included women with a systolic BP (SBP) ≥ 140 mm Hg or a DBP ≥ 90 mm Hg. Similarly, the definition of severe hypertension in pregnancy was reduced from $\geq 170/110$ mm Hg to $\geq 160/110$ mm Hg after the association of stroke in pregnancy with a lower BP level.⁹ Second, as outlined previously, the HDP represent a broad range of conditions with differing underlying pathophysiologies. Thus, the clinical outcomes (eg, the neonate's birth weight) might be a result of the

Table 1. Hypertension in pregnancy research: methodologic challenges

1. Definitions of HDP:
 - a. Change in definition of hypertension in pregnancy over time
 - b. Variable definition of preeclampsia between studies:
 - Restrictive (GHTN $\geq 140/90$ mm Hg plus ≥ 300 mg proteinuria in 24 hours)
 - Broad (GHTN $\geq 140/90$ mm Hg plus either ≥ 300 mg proteinuria in 24 hours or other end-organ involvement)
2. Heterogeneity in types of HDP included might differentially affect clinical outcomes:
 - a. Variable severity of disease (ranging from GHTN to severe preeclampsia)
 - b. Represent different underlying pathophysiology
3. Clinical outcomes not cardiovascular events or mortality
 - a. Use of surrogate outcomes
4. Small sample sizes
5. Short duration of follow-up (hours to months)

GHTN, gestational hypertension; HDP, hypertensive disorders of pregnancy.

underlying process (ie, maternal endothelial dysfunction) and not solely the maternal BP values. Further, there is a lack of consensus on the definition of preeclampsia ranging from a restrictive definition (gestational hypertension plus proteinuria) to a broader definition (gestational hypertension plus either proteinuria or ≥ 1 relevant target organ complication).¹⁰ This heterogeneity might influence clinical outcomes and as such it was taken into consideration when examining the findings of the studies. Third, the duration of antihypertensive treatment in pregnancy is relatively short (often a few weeks to months) compared with studies of hypertension in nonpregnant populations. Fourth, the clinical outcomes in studies of hypertension in pregnancy are generally not hard cardiovascular outcomes (ie, cardiovascular events or cardiovascular mortality), which are associated with higher grades in the Hypertension Canada grading system (Supplemental Table S1).⁸ Studies of hypertension in pregnancy use other clinical outcomes (eg, severe hypertension $\geq 160/110$ mm Hg, preterm birth, etc). Whereas severe hypertension is considered a validated surrogate outcome because of its relationship with adverse maternal, fetal, and newborn outcomes, it is associated with a lower grade of evidence.¹¹ Finally, the sample size of studies of hypertension in pregnancy are generally small and, therefore, this limits accurate assessment of rates of adverse events associated with individual antihypertensive medications.

Hypertension Canada's 2018 Guidelines: Management of Hypertension in Pregnancy

Measurement and diagnosis

Accurate BP measurement is essential to appropriately recognize and treat HDP. Detailed information on BP measurement as well as the classification and definitions of the HDP, are presented in SOGC's 2014 guideline, "Diagnosis, Evaluation and Management of the Hypertensive Disorders of Pregnancy."² In brief, women should have their BP measured using a standardized protocol after a period of rest in a quiet environment, be in sitting position with their arm at the level of the heart using an appropriately sized cuff (ie, length 1.5 times the circumference of the arm).² The arm with higher BP values should be used for hypertension diagnosis and BP monitoring.² Nonsevere elevated BP should be remeasured at the same visit, with at least a gap of 15 minutes from the first measurement. More than 50% of women with a first BP reading of $\geq 140/90$ mm Hg have white coat effect.¹²⁻¹⁴ Hypertension in pregnancy is defined as an SBP ≥ 140 mm Hg and/or a DBP ≥ 90 mm Hg (average of at least 2 measurements taken at least 15 minutes apart). Severity of hypertension in pregnancy is considered on the basis of the presence of target organ involvement (ie, maternal or the fetus itself) as well as the actual BP level. BP levels between 140/90 mm Hg and $< 160/110$ mm Hg are considered nonsevere hypertension in pregnancy. A BP level of $\geq 160/110$ mm Hg is associated with increased risk of maternal stroke in pregnancy and is therefore considered the diagnostic threshold of severe hypertension in pregnancy.^{2,10} Classification of HDP are summarized in Figure 1.

I. Management of nonsevere hypertension (BP 140-159/ 90-109 mm Hg) in pregnancy

Background. HDP treatment of nonsevere hypertension in pregnancy is important to reduce maternal, fetal, and newborn

complications including: pregnancy loss, need for high-level neonatal care, preterm birth, and low birth weight.^{11,15} In a 2014 Cochrane Collaboration systematic review, antihypertensive medication use for nonsevere hypertension in pregnancy (49 randomized trials; $n = 4723$)¹⁶ was associated with a halving in the risk of progression to severe hypertension (relative risk, 0.49; 95% CI, 0.40-0.60). The number needed to treat was 10 (95% CI, 8-13). This finding was consistent across all HDP ranges of conditions.¹⁶ There was no consistent statistically significant reduction in other clinically important maternal, fetal, or newborn outcomes.¹⁶ Although this Cochrane systematic review was methodologically strong, the primary studies were relatively old (only 4 after 2001), had small sample sizes, and were of low methodologic quality.¹⁶

The international multicentre randomized controlled trial, Control of Hypertension in Pregnancy Study (CHIPS), examined the effects of maternal BP targets on perinatal and maternal outcomes.¹⁵ Pregnant women with nonsevere gestational hypertension or chronic hypertension were randomized to either less tight BP control (target DBP of 100 mm Hg) or tight BP control (target DBP of 85 mm Hg).¹⁵ The CHIPS trial reported an increase in the incidence of severe hypertension (defined as $\geq 160/110$ mm Hg) in the less-tight group (relative risk, 1.8; 95% CI, 1.34-2.28).¹⁵ In post hoc analyses of the CHIPS trial, the occurrence of severe hypertension was associated with an increased risk of pregnancy loss, the need for high-level neonatal care > 48 hours, low birth weight, and preterm delivery.¹¹

In considering specific antihypertensive agents for the management of nonsevere hypertension in pregnancy, the previously mentioned Cochrane systematic review showed a similar benefit in reduction of severe hypertension among the following oral agents: labetalol, methyldopa, long-acting nifedipine, or other β -blockers (Table 2).¹⁶ Additionally, a secondary analysis of the CHIPS trial showed no statistically significant difference in clinical outcomes between different antihypertensive medications used (ie, labetalol, methyldopa, or others).¹⁷ Other oral antihypertensive medications such as clonidine, hydralazine, and thiazide diuretics can be considered as second-line drugs because they have not been associated with congenital malformations or other evidence to suggest harms. Angiotensin-converting enzyme (ACE) inhibitors have not been consistently associated with congenital malformations but are associated with fetotoxic adverse effects to the developing fetal renal system (ie, acute kidney injury and oligohydramnios) and, as such, should be avoided in pregnancy.¹⁸ Similarly, angiotensin receptor blockers have limited published safety data in pregnancy and should be avoided in pregnancy because of similar fetotoxic mechanisms associated with ACE inhibitors.²

Overall, decisions regarding a specific antihypertensive drug must consider the context of the patient and fetus, medication side effect profile (including maternal hypotension), availability of medications, clinician experience, and a woman's preference. Other components of the management of women with nonsevere hypertension in pregnancy are beyond the scope of this guideline. The involvement of an interdisciplinary team of care providers (ie, obstetrics, maternal fetal medicine, and medical specialists as appropriate) is prudent to ensure the ongoing well-being of the mother and fetus through frequent assessments, monitoring, and delivery planning, as indicated (Figure 2).²

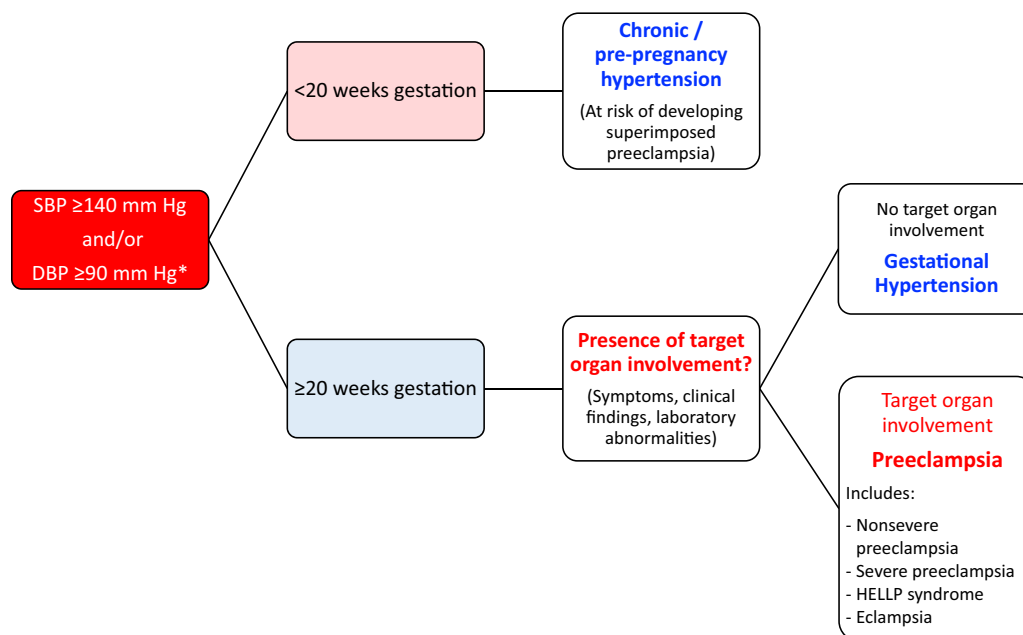


Figure 1. Simplified classification of hypertensive disorders of pregnancy. DBP, diastolic blood pressure; HELLP, hemolysis elevated liver enzymes and low platelets; SBP, systolic blood pressure. * Rule out: white coat hypertension and transient hypertension.

Guidelines

1. Antihypertensive therapy is recommended for average SBP measurements of ≥ 140 mm Hg or DBP measurements of ≥ 90 mm Hg in pregnant women with chronic hypertension, gestational hypertension, or preeclampsia (Grade C).
2. A. Initial antihypertensive therapy should be monotherapy from the following first-line drugs: oral labetalol, oral methyldopa, long-acting oral nifedipine, or other oral β -blockers (acebutolol, metoprolol, pindolol, and propranolol) (Grade C).
 B. Other antihypertensive drugs can be considered as second-line drugs including: clonidine, hydralazine, and thiazide diuretics (Grade D).
 C. ACE inhibitors (Grade C) and angiotensin receptor blockers (Grade D) should not be used in pregnant women.
3. A. A DBP of 85 mm Hg should be targeted for pregnant women receiving antihypertensive therapy with chronic hypertension or gestational hypertension (Grade B). A similar target could be considered for pregnant women with preeclampsia (Grade D).

- B. Additional antihypertensive drugs should be used if target BP levels are not achieved with standard-dose monotherapy (Grade C). Add-on drugs should be from a different drug class chosen from first-line or second-line options (Grade D).

II. Management of severe hypertension (BP $\geq 160/110$ mm Hg) in pregnancy

Background. In a secondary analysis of the CHIPS trial, BP $\geq 160/110$ mg Hg was associated with significantly worse maternal and perinatal outcomes, independent of the development of preeclampsia. These included: increased maternal hospital length of stay > 10 days, pregnancy loss or need for high-level neonatal care > 48 hours, increased risk of preterm birth at < 34 and < 37 weeks' gestation, low birth weight (ie, weight less than the 10th percentile), maternal platelets $< 100 \times 10^9/L$, and elevated maternal liver enzymes.¹¹ The CHIPS trial did not find a significant difference in the rate of stroke between study arms because of a low event rate ($n = 1$; 0.2% in the tight arm vs $n = 0$ in the less tight arm), because stroke in pregnancy and the immediate postpartum period is a relatively uncommon adverse outcome (30 per 100,000 pregnancies).^{15,19} Importantly, BP $\geq 160/110$ mm Hg and the presence of HDP are both considered risk factors for ischemic and hemorrhage stroke in pregnancy.^{10,19,20} Specifically, a large US population-based study reported that women with HDP were 5.2 times more likely to be hospitalized for stroke compared with pregnant women with normal BP.²⁰ In a case series of 28 women with HDP with stroke in pregnancy or early postpartum, immediately before the stroke, SBP was recorded as ≥ 160 mm Hg in 95.8% (23 of 24) and DBP ≥ 110 mm Hg in 12.5% of women (3 of 24).¹⁰ Although no trials included in a Cochrane systematic review of the management of severe hypertension in pregnancy directly

Table 2. Antihypertensive medications commonly used in pregnancy

First-line oral drugs (Grade C)	Second-line oral drugs (Grade D)	Medications to avoid
Labetalol	Clonidine	ACEi* (Grade C)
Methyldopa	Hydralazine	ARBs* (Grade D)
Long-acting oral nifedipine	Thiazide diuretics	
Other β -blockers (acebutolol, metoprolol, pindolol, and propranolol)		

ACEi, angiotensin-converting enzyme inhibitors; ARBs, angiotensin receptor blockers.

* Fetotoxicity of renal system.

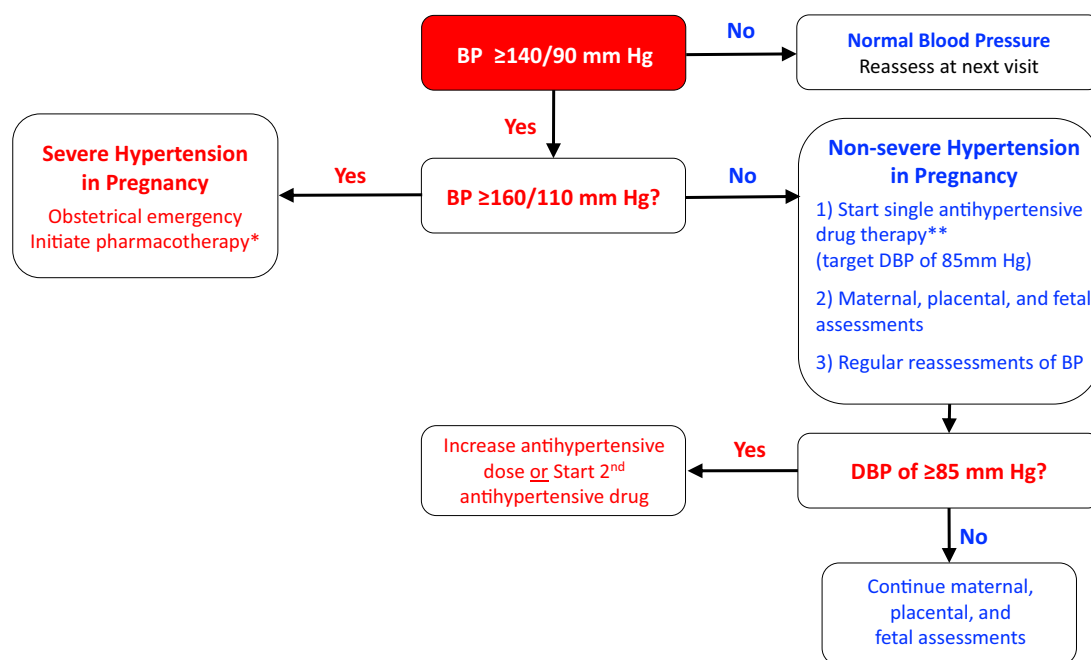


Figure 2. Management of hypertension in pregnancy. BP, blood pressure; DBP, diastolic blood pressure. * See Magee et al.² ** See Table 2.

examined the effect of immediate BP lowering on stroke, BP reduction below this threshold of $\geq 160/110$ mm Hg is considered to play an important role in the prevention of stroke in pregnancy and is recommended.^{19,21} Accordingly, severe hypertension is considered an obstetrical emergency from maternal and fetal perspectives, which requires immediate in-hospital care and urgent antihypertensive therapy (Figure 2).^{2,21}

The specific antihypertensive management of severe hypertension is beyond the scope of this guideline and requires the involvement of an interdisciplinary team of care providers (ie, obstetrics, maternal fetal medicine, and medical specialists as appropriate) in a hospital setting to ensure the ongoing well-being of the mother and fetus through frequent assessments, monitoring, and delivery planning, as indicated.²

Guidelines

1. Women with severe hypertension with SBP ≥ 160 or DBP ≥ 110 mm Hg in pregnancy require urgent antihypertensive therapy because it is considered an obstetrical emergency (Grade D).

Summary/Future Directions

The present guidelines summarize the best available evidence to guide clinicians in the management of hypertension in pregnancy and represent 3 years of work by the Hypertension in Pregnancy subgroup with the support of the HCGC and the SOGC. The next update for Hypertension Canada's guideline is planned for 2020 to allow for optimal dissemination of the 2018 guidelines although literature searches will be continued on an annual basis. New evidence identified as being "practice changing" for clinicians (ie, associated with strong reduction in cardiovascular events or mortality; or a substantial reduction in resource utilization) will be brought forward for an interim

update to ensure timely implementation of important evidence. Priorities identified for the development of new guidelines in 2020 for the Hypertension in Pregnancy subgroup include, among others, the development of evidence-based guidelines addressing the management of hypertension in preconception as well as in postpartum women.

Implementation

Implementation and dissemination of the guidelines is a priority for Hypertension Canada. Many strategies are used to reach a variety of providers who care for patients with hypertension. Efforts include knowledge exchange forums, targeted educational materials for primary care providers and patients, "Train the Trainer" teaching sessions, as well as slide kits and summary documents, which are freely available online in French and English (www.hypertension.ca). Hypertension Canada receives feedback from end users to continually improve guideline processes and content. The Research and Evaluation Committee conducts hypertension surveillance studies, and reviews existing Canadian health surveys to identify gaps between current and best practices.

Acknowledgements

Hypertension Canada thanks Ms Angela Eady for assistance with the literature searches. We sincerely thank Ms Susan Carter for providing technical assistance with the manuscript and administrative support of the process and committee.

Funding Sources

Activities of the HCGC are supported by Hypertension Canada. The members of the HCGC are unpaid volunteers who contribute their time and expertise to the annual development and dissemination of the Hypertension Canada

guidelines. To maintain professional credibility of the content, the process for the development of the guidelines is fully independent and free from external influence. External partners assist with the dissemination of the approved guidelines.

Disclosures

Please see [Supplemental Appendix S2](#) for a complete list of disclosures.

References

1. Public Health Agency of Canada. Canadian Chronic Disease Indicators. 2016. Available at: <https://infobase.phac-aspc.gc.ca/ccdi-imcc/indicator-details-en.aspx?id=8>. Accessed December 29, 2017.
2. Magee LA, Pels A, Helewa M, et al. Diagnosis, evaluation and management of the hypertensive disorders of pregnancy. *Pregnancy Hypertens* 2014;4:105-45.
3. Ray JG, Vermeulen MJ, Schull MJ, Redelmeier DA. Cardiovascular health after maternal placental syndromes (CHAMPS): population-based retrospective cohort study. *Lancet* 2005;366:1797-803.
4. McDonald SD, Malinowski A, Zhou Q, Yusuf S, Devereaux PJ. Cardiovascular sequelae of preeclampsia / eclampsia: a systematic review and meta-analysis. *Am Heart J* 2008;156:918-30.
5. Mongraw-Chaffin ML, Cirillo PM, Cohn BA. Preeclampsia and cardiovascular disease death: prospective evidence from the child health and development studies cohort. *Hypertension* 2010;56:166-71.
6. Nerenberg K, Daskalopoulou SS, Dasgupta K. Gestational diabetes and hypertensive disorders of pregnancy as vascular risk signals: an overview and grading of the evidence. *Can J Cardiol* 2014;30:765-73.
7. Brouwers MC, Kho ME, Browman GP, et al. AGREE II: advancing guideline development, reporting and evaluation in health care. *CMAJ* 2010;182:E839-42.
8. Leung AA, Daskalopoulou SS, Dasgupta K, et al. Hypertension Canada's 2017 guidelines for diagnosis, risk assessment, prevention, and treatment of hypertension in adults. *Can J Cardiol* 2017;33:557-76.
9. Tranquilli AL, Dekker G, Magee L, et al. The classification, diagnosis and management of the hypertensive disorders of pregnancy: a revised statement from the ISSHP. *Pregnancy Hypertens* 2014;4:97-104.
10. Martin JN, Thigpen BD, Moore RC, et al. Stroke and severe preeclampsia and eclampsia: a paradigm shift focusing on systolic blood pressure. *Obstet Gynecol* 2005;105:246-54.
11. Magee LA, von Dadelszen P, Singer J, et al. The CHIPS randomized controlled trial (Control of Hypertension in Pregnancy Study): is severe hypertension just an elevated blood pressure? *Hypertension* 2016;68:1153-9.
12. Penny JA, Halligan AW, Shennan AH, et al. Automated, ambulatory, or conventional blood pressure measurement in pregnancy: which is the better predictor of severe hypertension? *Am J Obstet Gynecol* 1998;178:521-6.
13. Brown MA, Mangos G, Davis G, Homer C. The natural history of white coat hypertension during pregnancy. *BJOG* 2005;112:601-6.
14. Denolle T, Weber JL, Calvez C, et al. Diagnosis of white coat hypertension in pregnant women with teletransmitted home blood pressure. *Hypertens Pregnancy* 2008;27:305-13.
15. Magee LA, von Dadelszen P, Rey E, et al. Less-tight versus tight control of hypertension in pregnancy. *N Engl J Med* 2015;372:407-17.
16. Abalos E, Duley L, Steyn DW. Antihypertensive drug therapy for mild to moderate hypertension during pregnancy. *Cochrane Database Syst Rev* 2014;2:CD002252.
17. Magee LA, the CHIPS Study Group, von Dadelszen P, et al. Control of Hypertension In Pregnancy Study randomised controlled trial—are the results dependent on the choice of labetalol or methyldopa? *BJOG* 2016;123:1135-41.
18. Barr M Jr. Teratogen update: angiotensin-converting enzyme inhibitors. *Teratology* 1994;50:399-409.
19. Swartz RH, Cayley ML, Foley N, et al. The incidence of pregnancy-related stroke: a systematic review and meta-analysis. *Int J Stroke* 2017;12:687-97.
20. Leffert LR, Clancy CR, Bateman BT, Bryant AS, Kuklina EV. Hypertensive disorders and pregnancy-related stroke: frequency, trends, risk factors, and outcomes. *Obstet Gynecol* 2015;125:124-31.
21. Duley L, Meher S, Jones L. Drugs for treatment of very high blood pressure during pregnancy. *Cochrane Database Syst Rev* 2013;7:CD001449.

Supplementary Material

To access the supplementary material accompanying this article, visit the online version of the *Canadian Journal of Cardiology* at www.onlinecjc.ca and at <https://doi.org/10.1016/j.cjca.2018.02.021>.