Pregnancy with high blood pressure

What counts as high blood pressure in pregnancy?

Blood pressure is recorded as systolic pressure over diastolic pressure. In pregnancy, hypertension is commonly defined as a systolic pressure of at least 140 mmHg or a diastolic pressure of at least 90 mmHg, typically confirmed with repeat measurements. A reading is considered severe when systolic pressure reaches 160 mmHg or higher, or diastolic pressure reaches 110 mmHg or higher. Severe-range blood pressure can become an emergency because it increases the risk of stroke and other serious complications.

Accurate measurement matters. The cuff should fit properly, the arm should be supported at heart level, and the person should be seated and rested when possible. Anxiety, pain, recent activity, caffeine, and an incorrectly sized cuff can influence readings. Still, repeated elevated results should never be dismissed, especially in pregnancy.

Types of hypertensive disorders in pregnancy

Clinicians classify high blood pressure in pregnancy partly by when it begins and whether there are signs of organ involvement. The categories overlap clinically, so your care team may update the diagnosis as pregnancy progresses.

Chronic hypertension: High blood pressure that was present before pregnancy or is detected before 20 weeks of gestation. It may persist after birth.
Gestational hypertension: New high blood pressure after 20 weeks of pregnancy without the defining organ or laboratory features of preeclampsia. It still requires careful follow-up because it can progress.
Preeclampsia: New hypertension after 20 weeks with protein in the urine or other signs of organ dysfunction, such as low platelets, impaired liver function, kidney involvement, pulmonary edema, neurological symptoms, or fetal growth concerns.
Chronic hypertension with superimposed preeclampsia: A person with pre-existing hypertension develops new or worsening features consistent with preeclampsia.
Eclampsia: Seizures in the setting of preeclampsia that cannot be explained by another cause. This is a medical emergency.

How high blood pressure can affect parent and baby

High blood pressure can strain maternal blood vessels and organs. In severe or poorly controlled cases, risks may include stroke, heart complications, kidney injury, liver injury, placental abruption, seizures, and the need for early delivery. Preeclampsia is particularly important because it is not only a blood pressure problem; it reflects abnormal vascular and placental processes that can affect multiple organs.

For the baby, hypertension may reduce blood flow through the placenta. This can contribute to fetal growth restriction, low amniotic fluid in some cases, preterm birth, and complications related to early delivery. Your team may recommend additional fetal surveillance, such as growth ultrasounds or antenatal testing, depending on the diagnosis and gestational age.

These risks can sound frightening, but risk is not destiny. Many pregnancies are managed safely with structured prenatal care, appropriate medication when needed, and timely decisions about monitoring and delivery.

Monitoring and tests you may encounter

Care usually includes more frequent blood pressure checks and may include home monitoring. If you are asked to measure at home, your clinician can help you

choose a validated device, select the right cuff size, and decide when to call about readings. Keep a written or digital log with the date, time, reading, pulse if available, and any symptoms.

Additional evaluation may include urine testing for protein, blood tests for platelet count, kidney function, and liver enzymes, and assessment for symptoms such as headache, visual disturbance, shortness of breath, and right upper abdominal or epigastric pain. Fetal monitoring may include ultrasound evaluation of growth and amniotic fluid, nonstress testing, or biophysical profile depending on the clinical picture.

Because hypertensive disorders can change quickly, a previously reassuring test does not eliminate the need to report new symptoms or worsening readings. If something feels unusual, it is appropriate to contact your maternity unit or clinician.

Medication considerations

Medication decisions in pregnancy require individualized medical care. Commonly used antihypertensive options in pregnancy include labetalol, nifedipine, and methyldopa, though the best choice depends on your medical history, gestational age, other conditions, side effects, and blood pressure pattern. Some people need dose adjustments as pregnancy progresses.

Certain medications used outside pregnancy are generally avoided because of fetal risks. These include angiotensin-converting enzyme inhibitors, angiotensin II receptor blockers, and direct renin inhibitors. If you were taking medication before pregnancy, do not stop or switch it on your own. Sudden discontinuation can be dangerous. Instead, contact your healthcare professional promptly for a pregnancy-safe plan.

Low-dose aspirin may be recommended for some people at increased risk of preeclampsia, often starting after the first trimester according to clinical guidance. It is not appropriate for everyone, so it should be started only after discussion with your clinician.

Lifestyle and self-care that support medical management

Lifestyle measures can support, but not replace, medical care. Keeping prenatal appointments, attending recommended laboratory and ultrasound visits, and following the monitoring plan are among the most important steps.

Nutrition: Aim for balanced meals with adequate protein, fiber-rich carbohydrates, fruits, vegetables, and healthy fats. Extreme salt restriction is not usually recommended unless specifically advised, but limiting highly processed, high-sodium foods may help overall cardiovascular health.
Activity: Physical activity may be beneficial for many pregnancies, but restrictions may apply if there are complications. Ask your clinician what level of activity is safe for you.
Weight and metabolic health: Your team may discuss healthy gestational weight gain, diabetes screening, and cardiovascular risk factors.
Substances: Avoid tobacco and recreational drugs, and discuss alcohol, supplements, and over-the-counter medicines with your clinician.
Rest and support: Stress does not directly cause preeclampsia, but practical support, sleep, and emotional care can help you cope with a demanding monitoring plan.

Delivery planning and the postpartum period

Delivery is the definitive treatment for preeclampsia, but timing depends on severity, gestational age, fetal status, and maternal condition. Some people can continue pregnancy with close monitoring, while others need earlier delivery to protect maternal or fetal health. The mode of birth is individualized; high blood pressure alone does not automatically mean cesarean birth.

Blood pressure often needs continued attention after delivery. Preeclampsia can appear for the first time postpartum, and blood pressure may peak several days after birth. Postpartum warning symptoms should be taken seriously, even if the pregnancy seemed stable. Follow-up visits, medication adjustments, and home readings may be recommended.

Having hypertension in pregnancy can also signal a higher long-term risk of chronic hypertension and cardiovascular disease. After recovery from birth, it is worth discussing long-term blood pressure, cholesterol, glucose screening, and heart-healthy prevention with a primary care clinician.