

## Hypertension in Pregnant Women and Its Risk Factors

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### DESCRIPTION

Disorders of pregnancy-induced hypertension are one of the main causes of maternal and perinatal morbidity and mortality, making them a serious health concern in the obstetric community. According to the World Health Organization, complications from hypertensive disorders of pregnancy claim at least one woman's life every seven minutes. According to the World Health Organization (WHO) and the American College of Obstetricians and Gynecologists' definition of hypertensive disorder in pregnancy, which was adopted in 1986, the condition occurs when the pregnant woman exhibits an increased blood pressure during pregnancy or puerperium. Pregnancy-related hypertension was previously described as having a systolic blood pressure of at least 140 mmHg or a diastolic blood pressure of at least 90 mmHg, or a rise in either of those numbers of at least 15 mmHg or 30 mmHg. The Working Group recently defined hypertension in pregnancy as a condition where either the systolic blood pressure is greater than 140 mmHg or the diastolic blood pressure is greater than 90 mmHg. Additionally, the WHO only uses a high diastolic blood pressure number as a requirement for classifying the disease. 4%-10% of pregnancies are complicated by the condition. Pregnancy-related hypertension falls into four categories, according to both the United Nations Organization and the American College of Obstetricians and Gynecologists. These include preeclampsia, eclampsia, superimposed preeclampsia/eclampsia, which is chronic hypertension aggravated by preeclampsia/eclampsia, gestational hypertension, and chronic hypertension in general. Despite all the efforts, maternal mortality from hypertensive diseases of pregnancy generally remained high. Numerous risk variables were identified by

studies carried out over the world, yet results were inconclusive due to variances in people and ethno-geographic groups.

Additionally, contradictory results are common among literatures, even for a specific risk factor and there is a dearth of data addressing Ethiopian factors linked to hypertensive diseases of pregnancy. Even the few studies that have been published in Ethiopia were founded on a document review, which may have created bias because the data at the health facility were inadequate and of poor quality. Thus, in order to produce data that are most pertinent to bolstering health policies and strategies, the current study tried to analyze risk factors for hypertensive disorders of pregnancy in the Tigray region.

Pre-conceptional counseling is advised for women who already have hypertension as part of management. There are some maternal traits that raise the chance of superimposed pre-eclampsia, and modifiable risk factors including obesity and poorly managed diabetes need to be addressed. An discussion of the dangers of pre-eclampsia and fetal development limitation should be part of counseling. Pre-eclampsia's warning signals and symptoms should be made clear to women. Pre-eclampsia prevention strategies are the focus of ongoing, significant research efforts, however there is no single treatment that can consistently prevent pre-eclampsia. While the lady is trying to get pregnant, she should consider changing her antihypertensive medication. When considering becoming pregnant or as soon as it is discovered that you are pregnant, ACE inhibitors, ARBs, and Renin inhibitors should all be stopped. In women who are more likely to develop pre-eclampsia, taking Low-Dose Aspirin (LDA) daily seems to lower the risk of the illness. In order to prevent pre-eclampsia, pregnant women at high risk should take 75 mg of aspirin every day starting at 12 weeks until the baby is born.

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