**Hypertensive disorders of pregnancy: term and conditions**

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Hypertensive disorders of pregnancy (HDP) are a significant cause of maternal morbidity and mortality. Prophylactic low dose aspirin reduces the risk of preterm preeclampsia but does not prevent disease at term (Rolnik et al. *N Engl J Med* 2017;377:613-22). The ultimate – and unsophisticated – “cure” for preeclampsia is delivery. In the context of preterm disease, there is a balancing act between the protective effect of delivery on the mother versus the potential adverse effect of exposing the infant to the major determinant of neonatal morbidity, namely, prematurity. However, for disease at term, delivery reduces risks to the mother and is much more benign for the infant, particularly if effected at 39 weeks of gestational age (wkGA) or later. Hence, the low hanging fruit in screening and prevention of HDP is disease manifesting at term (Smith GCS. *PLoS Med* 2012;9:e1001274).

A potential criticism of this approach is that HDP occurring at term are relatively benign and not associated with significant risks, a question addressed by this secondary analysis of the ARRIVE trial. The main study reported a reduced risk of HDP with routine induction of labour at 39wkGA (Grobman WA et al. *N Engl J Med* 2018;379:513-23). The current analysis studied the control group (expectant management), compared maternal and offspring outcomes in women with and without HDP, and found that diagnosis of an HDP was associated with an 84% increased risk of their primary maternal morbidity outcome, a 32% increase in the odds of caesarean delivery, but no significant difference in outcome for the infant. The findings suggest that preventing HDP at term may reduce maternal morbidity.

A caveat when interpreting the current study is its external validity. The median maternal age was <25 years, about half of the women were unemployed and the majority were obese. A further caveat is that the study was underpowered to address the rare but most severe sequelae of HDP. However, a previous analysis of Australian data (Thornton C et al. *Am J Obstet Gynecol* 2013;208:476 e1-5) demonstrated that the mean gestational age of delivery among women with eclampsia, one of the most severe sequelae of HDP, was 37.6 weeks. As the median gestational age will be higher, the majority of cases of eclampsia occur at term. Consequently, preventing term HDP may also prevent some of the most severe maternal sequelae of HDP.

A more attractive approach than routine induction at 39wkGA would be to target the intervention to the women at highest risk. Currently, we screen women for complications near term using abdominal palpation, measurement of the symphyseal-fundal, measuring the blood pressure and performing urinalysis, an approach that would be recognised by obstetricians practicing 40 years ago. The 21st Century has seen incredible development of technology platforms (“omics”) which analyse the composition of a given category of molecules (DNA, RNA, protein, metabolites etc) in biological samples. There is huge potential for harnessing the power of these methods to develop enhanced predictive tests for HDP and other determinants of both maternal and perinatal morbidity at term (Smith GCS. *Trends Mol Med* 2021;27:743-52). Better predictive tools could facilitate stratified antenatal care, targeting the useful intervention of induction of labour to the mothers and infants who will benefit most.

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