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MANAGEMENT OF REPRODUCTIVE WOMEN WITH ARTERIAL HYPERTENSION

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Arterial hypertension (AH) in women of reproductive age is a significant medical problem that can have serious consequences for both mother and fetus during pregnancy, as well as increase the risk of cardiovascular disease in the future [1,2]. Based on the recommendations of the European Society of Cardiology on the management of hypertension, updated guidelines for the diagnosis, risk assessment, and treatment of this category of patients should be considered, taking into account their characteristics and reproductive plans.

A comprehensive cardiovascular risk assessment should be performed, taking into account the history, risk factors (family history, smoking, dyslipidemia, obesity, diabetes), and the presence of target organ damage In women of reproductive age with sudden onset of hypertension, severe or treatment-resistant hypertension, screening for secondary causes, including primary aldosteronism and kidney disease, should be considered. It is also important to take a history of reproductive function, contraceptive use, previous pregnancies (including preeclampsia and gestational hypertension), and plans for future pregnancies [3].

Lifestyle modification includes general recommendations, including healthy eating, regular physical activity, maintaining a healthy weight, smoking cessation, and limiting alcohol consumption. The effect of various contraceptive methods on blood pressure should also be taken into account. In particular, estrogen-containing drugs can

increase blood pressure (BP) in some women, so progestin-containing or non-hormonal methods should be preferred, especially in the presence of risk factors for hypertension [4].

The decision to initiate pharmacologic treatment depends on the level of blood pressure and overall cardiovascular risk. Pharmacologic treatment outside of pregnancy has specifics regarding the choice of antihypertensive drugs. In particular, ACEIs and ARBs are the drugs of choice for women with concomitant diabetes mellitus, chronic kidney disease, or high cardiovascular risk. However, it is important to keep in mind their teratogenicity and the need to discontinue them when planning or becoming pregnant. Beta-blockers, calcium channel blockers, and thiazide diuretics can be used with caution before and during pregnancy, taking into account individual indications. Often, a combination of two or more antihypertensive drugs is required to achieve target blood pressure levels. [4,5].

An important aspect is the implementation of follow-up. Thus, women of reproductive age with hypertension need regular medical monitoring to control blood pressure levels, evaluate the effectiveness of treatment, and identify possible complications. It is important to inform women who had hypertension during pregnancy about the increased risk of developing chronic hypertension and cardiovascular disease in the future and recommend appropriate prevention measures. It is essential to emphasize lifestyle changes and control of risk factors to prevent cardiovascular events in the long term. [6,7].

Thus, the management of hypertension in women of reproductive age is a complex task that requires an individualized approach, taking into account reproductive plans and the potential impact of treatment on pregnancy. Involvement of cardiologists, obstetricians and gynecologists, general practitioners and other specialists is important to ensure comprehensive and effective management of hypertension in women of reproductive age.

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