Introduction

Hypertensive disorders complicating pregnancy are common and form one of the deadly triad, along with hemorrhage and infection that result in much of the maternal morbidity and mortality related to pregnancy, ***(Cunningham et al., 2001)***.

Many of the problems relating to maternal mortality arise from failure by clinicians to appreciate the varied presentation of preeclampsia and its severity or from inappropriate or inadequate treatment. Thus it is critical that obstetricians appreciate fully the nature of this condition and avoid complacency in its management ***(Abramovici, et al, 1999)***.

Hypertension in pregnancy consists of broad spectrum of clinical diagnosis that includes gestational hypertension, chronic hypertension and preeclampsia.

Gestational hypertension is high blood pressure that develops after twentieth week of pregnancy and returns to normal after delivery, in women with previously normal blood pressure ***(Wegeland, et al., 1998)***.

Gestational hypertension may be an early sign of either preeclampsia or chronic hypertension ***(Franx, et al, 1999)***. If this complication donot develop, or if chronic hypertension develops but remains mild, the outcome of pregnancy is usually good for both the mother and new born. ***(Gofton, et al., 2001)***.

Preeclampsia is not simply hypertension arising in pregnancy but is a disorder that can affect virtually every organ and body system hypertension represents one facet of a complex disease process.

The common pathological feature of the disease, whether in the placental bed or in the renal microcirculation is endothelial damage and dysfunction.

Hypertension is usually the first clinical feature of PE before the onset of proteinuria in most cases. At first presentation, it is often difficult to know if pregnant women with new hypertension will remain thus or progress to develop preeclampsia. On the other hand, women with GH may be managed safely as out patient and it would be helpful to know both

the absolute risk of progression from gestational hypertension to preeclampsia and the factors at initial presentation which predict this progression ***(Brown, 1996)***.

In fact; preeclampsia becomes evident clinically only near the end of a covert pathophysiological process that may begin 3 to 4 months before hypertension develops ***(Cunningham et al., 2001)***.