examinations are kept to a minimum. If tocolytics are being administered, the mother and fetus are monitored closely for any adverse effects.

Whether preterm labor is arrested or proceeds, the woman and her partner, if he is involved, experience intense psychologic stress. Decreasing the anxiety associated with the unknown and the risk of a preterm newborn is a primary aim of the nurse. The nurse also recognizes the stress of prolonged bed rest and of lack of sexual contact and helps the couple find satisfactory ways of dealing with these stresses. With empathetic communication, the nurse can facilitate the couple’s expression of their feelings, which commonly include guilt and anxiety, thereby helping the couple identify and implement coping mechanisms. The nurse also keeps the couple informed about the labor progress, the treatment regimen, and the status of the fetus so that their full cooperation can be elicited. In the event of imminent vaginal or cesarean birth, the couple should be offered brief but ongoing explanations to prepare them for the actual birth process and the events following the birth. The nurse may also offer to arrange consultation for the woman and her support person with the neonatologist, social worker, or hospital chaplain if requested.

Evaluation

Expected outcomes of nursing care include the following:

- The woman can discuss the cause, diagnosis, and treatment of preterm labor.
- The woman affirms that her fears about early labor are decreased.
- The woman states that she feels comfortable in her ability to cope with her situation and has resources to call on if needed.
- The woman can identify signs and symptoms of preterm labor that need to be reported to her caregiver.
- The woman can describe appropriate self-care measures to initiate in the event that she experiences any preterm labor.
- The woman successfully gives birth to a healthy infant.

Care of the Woman with a Hypertensive Disorder

Hypertension is the most common medical disorder in pregnancy, accounting for up to 15% of prenatal hospitalizations. The incidence of hypertension among pregnant women ranges from 3% to 10% (MacKay, Berg, & Atrash, 2001) and it is the third leading cause of all pregnancy-related death. Various attempts have been made to classify hypertensive disorders. The following classification is recommended by the NIH (2000):

- Preeclampsia-eclampsia
- Chronic hypertension
- Chronic hypertension with superimposed preeclampsia
- Gestational (or transient) hypertension

The pathophysiology and collaborative care of women with these disorders are quite different; thus, each is discussed separately.

Preeclampsia and Eclampsia

Preeclampsia is the most common hypertensive disorder in pregnancy. It is estimated that 50,000 women die from preeclampsia each year worldwide (Pipkin, 2001). Blood pressure normally increases in the first trimester, decreases in the second trimester, and returns to nonpregnant values by the end of the third trimester. In contrast, preeclampsia is clinically defined as an increase in blood pressure after 20 weeks’ gestation accompanied by proteinuria (NIH, 2000). Edema is no longer included in the definition because it is a common feature in normal pregnancy. However, sudden onset of severe edema warrants close evaluation to rule out preeclampsia or other pathologic processes such as renal disease (Higgins & de Swiet, 2001).

Eclampsia is the occurrence of a seizure in a woman with preeclampsia who has no other cause for seizure. Women who are going to develop preeclampsia usually become hypertensive before they develop proteinuria. In any event, the onset of hypertension in pregnancy warrants close observation.

PATHOPHYSIOLOGY OF PREECLAMPSIA

Preeclampsia has been called a “disease of theories” because the true mechanisms behind the pathogenesis are unknown. The only cure for this disease is birth of the fetus and re-