



Unmasking the Challenge: Managing White Coat Syndrome in Pregnancy



AUTHOURS: LAXMI SAHA¹, HIRSI-FARAH SUAD¹
¹ GEORGE ELIOT HOSPITAL NHS TRUST, O&G, NUNEATON, UNITED KINGDOM. EP 1114

BACKGROUND

White Coat Hypertension (WCH) in pregnancy is defined as elevated blood pressure (BP $\geq$ 140/90 mmHg) recorded in clinical settings, with normal BP readings outside those settings. It is believed to be caused by anxiety or stress during medical consultations.

- Prevalence: Affects 4–30% of pregnancies¹
- Misclassification: Up to 30% of women diagnosed with gestational hypertension may actually have WCH²
- Clinical Implication: Misdiagnosis can lead to unnecessary antihypertensives, maternal anxiety, increased intervention rates, and longer hospital admissions³

OBJECTIVE

To explore the clinical impact and management strategies of White Coat Syndrome (WCS) in pregnancy through a case series and to highlight the importance of accurate diagnosis, appropriate monitoring, and collaborative, patient-centred care.

CASE SERIES SUMMARY

Significance

Correct identification of WCH:

- Prevents overtreatment (as in Case 2)
- Reduces maternal distress
- Avoids unnecessary induction and early delivery
- Supports shared decision-making through transparent communication and respect for patient autonomy

Diagnosis

Gold Standard:

- Ambulatory Blood Pressure Monitoring (ABPM)⁴

Alternative:

- Home Blood Pressure Monitoring (HBPM) with validated equipment and correct cuff size⁵

ISSHP recommends WCH management without antihypertensives unless office BP exceeds 160/110 mmHg⁶

Management Approach

- Avoid unnecessary pharmacological intervention
- Initiate low-dose aspirin (75–150 mg/day) by the end of the first trimester
- Monitor closely with serial BP and urinalysis
- Schedule growth scans as per local protocol
- Offer psychological support where appropriate

Outcomes

In our series:

- All women delivered at term
- None required antihypertensive therapy
- No adverse maternal or fetal events were recorded

Despite the benign nature of WCH compared to sustained hypertension, it may still be associated with:

- Slightly increased risk of fetal growth restriction (FGR)⁸
- Higher rates of preterm birth than normotensive pregnancies⁹

Case	Gravida	History	Presentation	Management	Outcome
1	G1	WCS history disclosed	Persistently high clinic BP	Home BP monitoring with team support	No treatment; term delivery
2	G2P1	Previous birth trauma after PIH diagnosis	Elevated clinic BP; concern over prior mismanagement	Ambulatory BP Monitoring (ABPM) confirmed WCH	Spontaneous vaginal delivery at 39 weeks
3	G1	Asymptomatic, high clinic BP	Normal home readings, no end-organ signs	Avoided medication with collaborative monitoring	Uncomplicated term birth

DICUSSION & KEY LEARNING POINTS

- **Routine clinic BP alone is not sufficient** to diagnose gestational hypertension
- **ABPM/HBPM is essential** to confirm diagnosis and guide treatment
- **WCH is not always benign**, and continued vigilance is required
- **Patient-centred care** is essential to reduce medical trauma, particularly in women with previous negative experiences
- **Early aspirin and monitoring protocols** should be adopted even in WCH cases due to preeclampsia risk

CONCLUSION

White Coat Syndrome in pregnancy is more than just anxiety-induced BP elevation—it is a **distinct clinical entity** requiring **accurate diagnosis, individualised management**, and **multidisciplinary coordination**.

Appropriate identification of WCH:

- Avoids **unwarranted pharmacotherapy**
- Promotes **positive birth experiences**
- Optimises **maternal and fetal outcomes**

Continued research is necessary to refine **risk stratification, counselling practices**, and **guideline development**.

REFERENCES

- 1.Magee LA, Pels A, Helewa M, Rey E, von Dadelszen P. Diagnosis, evaluation, and management of the hypertensive disorders of pregnancy. Pregnancy Hypertension. 2014;4(2):105–145.
- 2.Brown MA, Lindheimer MD, de Swiet M, Van Assche A, Moutquin JM. The classification and diagnosis of the hypertensive disorders of pregnancy: statement from the International Society for the Study of Hypertension in Pregnancy (ISSHP). Hypertens Pregnancy. 2001;20(1):IX–XIV.
- 3.Lo C, Mission J, Yeo SA, et al. White coat hypertension in pregnancy: A systematic review and meta-analysis. BJOG. 2022;129(5):723–732.
- 4.National Institute for Health and Care Excellence (NICE). Hypertension in pregnancy: diagnosis and management (NG133). 2019.
- 5.Khan KS, Wojdyla D, Say L, Gülmezoglu AM, Van Look PF. WHO analysis of causes of maternal death: a systematic review. Lancet. 2006;367(9516):1066–1074.
- 6.ISSHP. Guidelines for the Management of Hypertensive Disorders of Pregnancy. 2018.
- 7.Rolnik DL et al. Aspirin versus placebo in pregnancies at high risk for preterm preeclampsia. N Engl J Med. 2017;377(7):613–622.
- 8.Thilaganathan B, Kalafat E. Cardiovascular system in preeclampsia and beyond. Hypertension. 2019;73(3):522–531.
- 9.Bodnar LM, Ness RB, Markovic N, Roberts JM. The risk of preeclampsia rises with increasing prepregnancy body mass index. Ann Epidemiol. 2005;15(7):475–482.