Pregnancy and the postpartum period are associated with an increased risk of ischemic and hemorrhagic stroke and stroke is the leading cause of pregnancy-related disability. There are few long-term prospective studies of the incidence of stroke in pregnancy. The data from multiple retrospective studies about the incidence and mortality of stroke in pregnancy are summarized in Table 1. Various studies estimate the incidence of all types of stroke in pregnancy and puerperium between 25 and 34 per 100,000 deliveries.1–8 By comparison, the incidence of stroke in non-pregnant women in the 15–45 years age group is 11 per 100,000 women. A population-based retrospective study conducted from 1988 to 1991 found no increase during pregnancy but a relative risk of 8.7 during the first 6 weeks postpartum.9

Kuklima et al reported their recent analysis of hospital discharge data from the Nationwide Inpatient Sample of the Healthcare Cost and Utilization Project, which is the largest nationwide all-payer inpatient care database in the United States.4 That report demonstrated that between 1994–1995 and 2006–2007, the rates of antenatal and postpartum hospitalizations for all types of stroke increased by 47% and 83%, respectively.

### Article p?????

Risk factors associated with pregnancy-related stroke include hypertension, diabetes, valvular heart disease, hypercoagulable disorders, sickle cell disease, lupus, abuse of tobacco and other substances, and migraines.1–6 Several studies have demonstrated that hypertensive disorders are the leading cause of both hemorrhagic and ischemic strokes in pregnant and postpartum women.1–3,6,7 Preeclampsia/eclampsia and pregnancy-induced hypertension (PIH) are the 2 most important hypertensive disorders of pregnancy. Preeclampsia is defined as progressively worsening high blood pressure (BP) in pregnancy, occurring in the setting of proteinuria (≥300mg of protein in a 24-h urine specimen).8 Eclampsia is preeclampsia that progresses to seizures. PIH is described as high BP (systolic BP ≥140mmHg or diastolic BP ≥90mmHg) after 20 weeks’ gestation that occurs without the other signs and symptoms of preeclampsia.

Compared with women without hypertension, women with hypertension complicating pregnancy are 6–9-fold more likely to have a stroke.3 Therefore, control of PIH is considered to reduce the risk of maternal death from stroke (especially hemorrhagic stroke) during pregnancy. There are few reports about the relationship of maternal death due to stroke and PIH.

In this issue of the Journal, Hasagawa et al review case reports from medical institutions in Japan, and describe the clinical features of maternal death associated with PIH.9,10 In this review of maternal deaths in Japan between 2010 and

### Table 1. Summary of Studies on the Incidence, Mortality and Morbidity of Pregnancy-Associated Stroke

<table>
<thead>
<tr>
<th>Study date and first author</th>
<th>Subjects</th>
<th>Incidence (per 100,000 deliveries)</th>
<th>Mortality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lanska (1998)3</td>
<td>Women aged 15–44 years National Hospital Discharge Survey in the USA (1979–1991)</td>
<td>All strokes: 17.7 CVT: 11.4</td>
<td>3.3 (0)</td>
</tr>
<tr>
<td>Jaigobin (2000)8</td>
<td>Pregnancy and 6 weeks PP Tronto Hospital, Canada (1980–1997)</td>
<td>Ischemic stroke: 16 ICH: 8</td>
<td>0 (23)</td>
</tr>
</tbody>
</table>

CVT, cerebral venous thrombosis; ICH, intracerebral hemorrhage; PP, postpartum.

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2012, 11% of all maternal deaths were associated with PIH. More than 70% of the causes of maternal death associated with PIH were due to stroke, and 12 of 25 deaths (48%) due to stroke were associated with PIH. In this series, the most frequent type of stroke was intracerebral hemorrhage (ICH). Of all stroke types, ICH during pregnancy and the puerperium leads to the highest risk of morbidity and mortality. Pregnancy increases the risk of hemorrhagic more than ischemic stroke (relative risk of 2.5 and 28.5 during pregnancy and the postpartum period).\footnote{8}\footnote{9} The underlying mechanism of pregnancy-related hemorrhage is likely to be the consequences of physiologic changes, such as blood volume expansion and vascular tissue remodeling in pregnancy, plus the risk from the strain and trauma of labor and delivery. Major causes of pregnancy-related hemorrhage are preeclampsia and eclampsia, which contribute to a large proportion of cases, followed by intracerebral aneurysm, arteriovenous malformation and moyamoya disease.\footnote{10}\footnote{11} The present study revealed that PIH is strongly related with poor outcomes of stroke, especially ICH, associated with pregnancy in Japan.

In February 2014, the American Heart Association and the American Stroke Association released their first guideline focused on stroke prevention in women.\footnote{12} Their recommendations are shown in Table 2. Regarding control of hypertension during pregnancy, they recommend that severe hypertension should be treated with safe and effective antihypertensive medications, such as methyldopa, labetalol, and nifedipine, with consideration of maternal and fetal side effects (Level of Evidence A). For moderate hypertension, consideration may be given with safe and effective antihypertensive medications, given the evidence for possibly increased stroke risk at currently defined systolic and diastolic BP cutoffs, as well as evidence for decreased risk for the development of severe hypertension with treatment (although maternal-fetal risk-benefit ratios have not been established) (Class IIa, Level of Evidence B). In this guideline, high BP during pregnancy is defined as mild (diastolic BP 90–99 mmHg or systolic BP 140–149 mmHg), moderate (diastolic BP 100–109 mmHg or systolic BP 150–159 mmHg), or severe (diastolic BP ≥110 mmHg or systolic BP ≥160 mmHg). They mention that the goal of BP management in pregnancy is to maintain systolic BP between 130 and 155 mmHg and diastolic BP between 80 and 105 mmHg.

An important point in the present study is that although 83% of patients with PIH who died had experienced initial symptoms in a hospital, more than half required medical transport due to lack of local medical resources. They point out that such delays in receiving proper treatment sometimes resulted in maternal death. Although the mortality rate associated with cardiovascular disease such as stroke or acute myocardial infarction is not high in Japan,\footnote{13}\footnote{14} timely transport and treatment of patients who have risk factors in pregnancy, especially PIH, is important for improving the outcome of pregnancy in Japan.

**Disclosures**

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**References**


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**Table 2. AHA/ASA Recommendations for Treatment of Hypertension in Pregnancy and PP**

| Class I recommendation | - Severe hypertension in pregnancy should be treated with safe and effective antihypertensive medications, such as methyldopa, labetalol, and nifedipine, with consideration of maternal and fetal side effects (Level of Evidence A). |
| Class IIa recommendation | - Consideration may be given to treatment of moderate hypertension in pregnancy with safe and effective antihypertensive medications, given the evidence for possibly increased stroke risk at currently defined systolic and diastolic BP cutoffs, as well as evidence for decreased risk for the development of severe hypertension with treatment (although maternal-fetal risk-benefit ratios have not been established) (Level of Evidence B). - After giving birth, women with chronic hypertension should be continued on their antihypertensive regimen, with dosage adjustments to reflect the decrease in volume of distribution and glomerular filtration rate that occurs after delivery. They should also be monitored carefully for the development of PP preeclampsia (Level of Evidence C). |
| Class III recommendation | - Atenolol, angiotensin-receptor blockers, and direct renin inhibitors are contraindicated in pregnancy and should not be used (Level of Evidence C). |

BP, blood pressure; PP, postpartum.