INTERCURRENT ECLAMPSIA

(Report of Two Cases)

by

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Following antepartum eclampsia the patient usually goes into labour within a few hours. Sometimes labour does not ensue, the patient comes out of coma and this improvement may last several days and is known as intercurrent eclampsia.

Intercurrent eclampsia is a condition where there are various opinions regarding definition and management of the patient. The condition is believed to be described by Lichenstein as early as 1911. He noted that certain patients would have no more convulsions after a large venesection even though the delivery did not take place for a week or longer. He then designated the condition as intercurrent eclampsia. He also stated that 40 per cent of his 255 patients had this condition.

Dickmann states—"I have not been able to find any time limit given for this condition and suggests a period over 3 days".

Eastman states, "This improved state may continue for several days or longer —a condition known as intercurrent eclampsia".

Menon (1962) has specified further saying "in intercurrent eclampsia the fits are controlled and pregnancy continues for at least 10 days after cessation of convulsions. Menon, however, does not mention regarding the outcome of the foetus and Bhatt (1964) further adds to the definition that any pregnancy that continues for more than seven days after the eclamptic fits, irrespective of the life or death of the foetus, should be considered as intercurrent eclampsia.

Taking all these facts into consideration we are reporting two cases of intercurrent eclampsia.

Case 1

Mrs. N.P., age 20, was admitted to the hospital on 9-1-1973 with 8 months' amenorrhoea and pre-eclampsia. On examination it was found that she had a B.P. of 140/100, oedema of feet ++ and albuminuria was ++.

Abdominal examination revealed a uterus of 32 weeks and the foetus was presenting as breech. FHS were good.

Vaginal examination revealed that the os was closed and cervix was not ripe. She was treated as a case of moderate pre-eclampsia with sedatives, diuretics, antihypertensives and bed rest. Despite this she developed eclamptic convulsions, on 9-1-1973. She had two convulsions at the interval of one hour and she was managed as a case of eclampsia. She did not have any more convulsions and did not go into labour, cervix remained unripe and FHS remained good. She regained consciousness and 48 hours after the fits she reverted to a case of mild toxaemia with blood pressure of 136/90, oedema ++ and albuminuria +, Her urine output was over 1500 cc. throughout. It was decided to allow the pregnancy to continue under close observation. The signs of pre-eclampsia disappear-

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ed with treatment and pregnancy continued. Thirty days after the last fit on 10-2-1973, patient started labour pains and delivered a macerated foetus with spina bifida. She had no signs of pre-eclampsia and post-natally showed no evidence of hypertension or albuminuria.

The investigations carried out were as follows: Hb. 10 gms%, Blood grouping A +ve, Blood urea 11 mg%, Fundoscopy NAD. Urine: Alb. ++, Urine Culture—no growth. Serum electrolytes were within normal limits. NAD.

Case 2

Mrs. V.R., 23 years old. primi. came with severe pre-eclampsia on 10-1-1973. On examination it was found that she had a blood pressure of 180/120 mm. Hg. oedema of feet ++, albuminuria+++.

The uterus was 26 weeks' size with vertex presentation and good FHS. Patient was treated with pethidine, antihypertensives and diuretics. She developed eclampsia the same day and had three fits with an interval of 45 minutes to 2 hours. Patient was treated as a case of eclampsia with a pethidine drip of 200 mg. and largactil, phenargen alternating every 4 hours.

Vaginal examination revealed a non-ripe cervix. Patient did not have any more fits and she too reverted to a case of mild pre-eclampsia with a B.P. of 130/90, albuminuria + and no oedema of feet. It was decided to continue the pregnancy. She was treated as a case of pre-eclampsia and she remained controlled till 2-2-1973 when her B.P. started rising despite antihypertensives and continuous sedation. She developed B.P. of 180/100, albuminuria ++ and complained of headache on 4-2-1973. Labour was induced by ARM and pitocine drip. Patient delivered a live baby on 5-2-1973 which was treated in the Premature Baby Care Unit. During the post-partum period her B.P. took 11 days to reach normal levels and be cleared of albuminuria. Repeat check-up after 6 weeks revealed no residual hypertension.

Investigations carried out were—Hb. 10 gms%. Urine culture, Klebseilla organisms, Blood group A +ve. Blood urea nitrogen 13 mg., Serum creatinine 0.7 mg. VDRL —ve, ECG—NAD, Serum electrolytes within normal limits, Post-partum IVP—NAD.

Discussion

In recent English and American literature intercurrent eclampsia is almost non-existent as the pregnancy is terminated within 24-48 hours after the fits have ceased, either by induction of labour or caesarean section depending on the condition of the cervix. This is because it has been known that in the majority of cases fits do recur after a variable period of time and in such cases maternal and foetal prognosis is much worsened.

Bhatt (1964) reported 15 cases of intercurrent eclampsia where pregnancy was allowed to continue under close medical supervision. There were no maternal death in this series. A salvage of 5 foetuses out 15—a salvage rate of 33 per cent. No patient in his series required a caesarean section for delivery. He, with these results pleads for a conservative attitude of certain selected cases of eclampsia.

With the advent of newer and safer hypotensive agents and increasing attention focussed on the salvaging of a foetus, the patient responds well and remains as a case of milde pre-eclampsia or no toxaemia, the pregnancy should be allowed to continue. Menon also advocates continuation of pregnancy as long as toxaemia is controlled and to terminate at the slightest exacerbation of toxaemia.

Dickmann in 1952 states "Undelivered eclamptic patients must be given special attention. If the toxaemia reverts to one of mild pre-eclampsia one may delay the termination till the cervix is ripe."

Both the cases presented above reverted to mild toxaemia after the eclamptic fits and were treated conservatively. The

second patient developed signs of exacerbation and the labour was induced with the delivery of a live foetus.

Summary

Two cases of intercurrent eclampsia are presented with their intrapartum management.

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