INTERCURRENT ECLAMPSIA

(A Report of 4 Cases)

by

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Introduction

Intercurrent (antenatal) eclampsia has been rarely recorded in the available literature. Although various authors have put forward different definitions, none of them has been accepted by all (Lizard, 1933 and Bhatt, 1964). However, Menon's definition (1978), that is where the convulsions are controlled in ante-partum eclampsia and pregnancy continues for at least 10 days after cessation of convulsions, the foetus being alive, is the most accepted one. Not only the rarity of this problem, but also the disputed management, that has prompted us to report four such cases which were admitted in JIPMER Hospital, Pondicherry from 1972 to 1977.

Case 1

C., 30 years, gravida 2, para 1, was admitted on 11-11-1972 with a history of 7 months' amenorrhoea and swelling of the face and feet for 1 month. She was severely anaemia with haemoglobin 2.54%, edema of feet and legs +++ blood pressure 150/120 mm Hg and proteinuria +. Heart showed grade II systolic murmur. The patient was treated with bed rest, tablet Frusemide 40 mg daily and Adelphane, one tablet, six mourly. Total dose of Imferon was given intravenously. She had ankylostomiasis which was treated. The blood pressure remained between 150/120 mm Hg and 180/120 mm Hg.

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On 6-12-1972, patient went into eclamptic convulsions which were controlled with lytic cocktail regime i.e. Inj. Pethidine, inj. Phenargan and inj. Largactil. Vaginal examination after sedation revealed, tightly closed cervical os. After 48 hours the patient was put on Gardinal gr. I at bed-time and tablet Ismelin, 22 mg daily. However, the blood pressure remained 170/120 mm Hg or above.

On 5-1-1973 patient went into labour and 1800 gms alive baby was delivered with outlet forceps. Her blood pressure at the time of discharge on 23-1-1973 was 170/100 mm Hg. The baby was kept in the nursery for 6 weeks. On her last visit in September 1977, her B. P. was 110/80 mm Hg and she was asymptomatic.

Case 2

E., 24 years, gravida 2, para 1, last delivery 3½ years back, was admitted on 15-7-1975 with 8 months' amenorrhoea and convulsions since 2 hours. On examination, she was conscious, blood pressure 180/140 mm Hg, pedal edema + and proteinuria ++. Pulse 140/mt, temperature 102°F, C.V.S. and respiratory systems were normal. Uterus was 26 weeks size and F.H.S. were present.

The eclamptic convulsions were controlled with Menon's regime. Vaginal examination showed closed cervical os. In 48 hours her B.P. dropped down to 120/90 mm Hg and edema and proteinuria disappeared in 4 days. After 48 hours the patient was put on Gardinal tablet, gr. ½ twice and Adelphane, 1 tablet thrice daily.

The patient left against medical advice on 2-8-1975 and on 4-8-1975 delivered alive baby at home. On 1-8-1979 she was seen in Gynaecology O.P.D. with B.P. 100/60 mm.Hg and did not have any complaint.

Case 3

A., 17 years primigravida was admitted on 25-12-1976 with history of 5 months' amenorrhoea, swelling of feet one week and convulsions since 6 hours. On examination, she was unconscious, B.P. 210/150 mm.Hg., edema feet and legs ++, proteinuria ++ , pulse 160/mt. Heart was normal and there were crepitations in both the lungs. Uterus was 20 weeks gestation.

The patient was put on Menon's Regime and Inj. Streptopenicillin 1 vial I.M. daily for 7 days. The convulsions were controlled and B.P. dropped to 130/90 mm.Hg. After 48 hours, she was put on tablet Gardinal gr I at bed-time and Adelphane, one tablet six hourly. She had hookworm infestation which was treated. The blood pressure was maintained at 130/90 mm.Hg. The edema and proteinuria disappeared.

On 14-1-1977 she was discharged on request with advice to continue Gardinal gr. I at bedtime and tablet Esidrex, 25 mg daily for 4 days in a week. Uterus was 24 weeks at the time of discharge.

She was again admitted on 19-1-1977 with B.P. 140/110 mm.Hg. and edema feet and legs. She was put on complete bed rest and tablet Gardinal gr. I at bed-time and Adelphane, one tablet 6th hourly were started.

On 22-1-1977 foetal heart disappeared and a macerated foetus weighing 700 gms was expelled on 3-2-1977. The blood pressure at the time of discharge on 7-2-1977 was 140/90 mm.Hg. On 6-12-1977 she was again 28 weeks pregnant with B.P. 100/70 mm.Hg.

Case 4

A., 25 years, gravida 2, para 1, last delivery one and half years back was referred on 12-11-1977 from Neyvelli Hospital with history that on 15-10-1977 she was admitted and treated there as a case of ante-partum eclampsia. She had amenorrhoea for 8½ months. Her B.P. was 140/100 mm.Hg. and had proteinuria. C.V.S. and respiratory systems were normal. Uterus was 36 weeks size and F.H. sounds were present. On vaginal examination, cervical os was closed. Optic fundii, blood urea and uric acid were normal.

She was put on complete bed rest, and Adelphane, 1 tablet thrice daily. Proteinuria disappeared in 4 days and B.P. varied between 140/100 mm.Hg. and 160/110 mm.Hg. On 16-11-1977, the patient left against medical advice and delivered an alive baby at home on 20-11-1977.

Discussion

Four cases of intercurrent eclampsia were observed out of 54 known cases of eclampsia. However, Lazard (1933) had reported 19 cases of intercurrent eclampsia out of 82 cases of eclampsia.

As per the standard teaching the most accepted method of treating eclampsia is termination of pregnancy as a second attack may prove fatal. In our cases it was observed that recurrent fits could be prevented by adequate management i.e. continued hospitalization and keeping a frequent record of blood pressure, estimation of proteinuria and F.H.S. Similar views have been put forward by previous workers (Lizzard, 1933; Bhatt, 1964 and Kwathekar, 1968).

It is obvious from our cases, that if the convulsions are controlled and the cervix not favourable for induction, the patient should be treated conservatively till the foetus attains optimum maturity and the patient goes into labour spontaneously. All of our cases had spontaneous vaginal delivery and 3 out of 4 babies were born alive. There was no maternal mortality or long term morbidity in our cases. Kwathekar (1968) could save 1 out of 2 babies by terminating pregnancy with L.S.C.S. and the time of termination in her cases was decided by the sudden rise in serum transaminase levels.

It appears convincing that conservative management has a place in intercurrent eclampsia, provided the patient is kept in the hospital till she delivers. The risks of

failed induction and of operative delivery can be avoided by allowing the patient to go into spontaneous labour. Foetal salvage can be improved. Time of termination can be decided according to the foetal heart sounds, the blood pressure levels and the serial estimations of serum transaminase (Crisp *et al*, 1959 and Kwathekar, 1968) if the facilities are available

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