

MALARIA IN PREGNANCY

by

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As pregnancy is a 'stress' condition and again protein requirement during pregnancy is high, pregnancy is likely to lower the acquired immunity of an individual. Thus malaria is not uncommon during pregnancy, specially in tropical countries.

Fifty cases of malaria complicating pregnancy were studied in this series. Cases were taken from various hospitals of Calcutta, some occurring during endemic of the disease in the city.

That malaria alters the course of pregnancy by both affecting the maternal and foetal health was vividly observed in our study. Maternal and perinatal morbidity and mortality were significantly high.

Maternal mortality was 2%. Perinatal mortality was 20%. A significant finding. 30% of our cases were primigravida and 20% were multigravida.

Thus it is noteworthy that 24% of our cases presented with anaemia. Of 24%, 4% cases came with signs of heart failure. In 16% cases anaemia was of dimorphic variety while in 12% cases it was of macrocytic variety. In 16% hepatosplenomegaly was present while in 4% only splenomegaly was present.

In our study the incidence of toxæmia was 40%. 30% of cases of toxæmia had

TABLE 1
Clinical Features

Clinical feature	No. of cases	Percentage
1. With coma	1	2%
2. With fits	4	8%
3. With hyperpyrexia & vomiting	4	8%
4. With anaemia	12	24%
5. With abortion	5	10%
6. With P.E.T.	20	40%
7. With dysuria, periodic fever, pallor & I.U.D.	2	4%
8. With early rupture of the membranes (Preterm labour)	2	4%

co-existent anaemia. In 8% cases I.U.G.R. was detected and in 2% cases I.U.D. occurred.

In all our cases clinical examination was the primary factor in making diagnosis which was confirmed by demonstration of parasite in the blood film, H.P. examination of placenta and postmortem examinations of the baby in cases of I.U.D. wherever feasible.

In all our cases chloroquine or amodiaquine was used in schedule dosage. Two of our cases needed I.V. Chloroquine therapy in addition to anti-eclamptic regime.

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Outcome (both maternal and foetal) was not bad in early diagnosed cases of mild to moderate severity in our cases. Perinatal mortality was quite high due to the fact that patients came to us in grave condition with complications. No case of congenital malaria occurred. Birth weight of babies was less than 2.5 kg. in 25% of our cases.

Concluding remarks

Early diagnosis of malaria is the key to achievement of success in malaria complicating pregnancy. All cases of unexplained severe anaemia should be specially reviewed to exclude co-existent

malaria. Cases of cerebral malaria cause a proportionate degree of diagnostic pit-fall. Toxaemia or pseudotoxaemia with anaemia are likely to have malaria. Malaria is likely to cause interruption of course and outcome of pregnancy by pyrexia, placental parasitisation, or maternal parasitaemia. Thus abortion, premature labour, A.P.H. are not unlikely to result in I.U.G.R., prematurity or even I.U.D.

Proper scanning of the cases for diagnosis and treatment is the single factor required to minimise maternal and/or perinatal mortality and morbidity.