Pregnancy with Help Syndrome, Disseminated Intravascular Coagulation and Renal Failure

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HELP syndrome (haemolysis, raised liver enzymes, and low platelets) is a rare variant of pre-eclampsia associated with high maternal and perinatal morbidity and mortality. It has aptly been quoted that patient and obstetrician both ask for "help" in HELP syndrome. We report successful management of a young woman with HELP syndrome and multiorgan failure who required multi-disciplinary approach.

Mrs. S. S., female aged 22 years, unbooked patient, G2 PO A1, was admitted in labour room on 14.05.1997 at 0.20 a.m. through casualty services of Jawaharlal Nehru Hospital and Research Centre, Bhilai, with the chief complaints of severe headache, vomiting and blurring of vision of 2 hours duration. On examination : blood pressure was 190/120 mm of Hg, pulse rate 90/minute, oedema feet present. Occular fundi showed disc hyperaemia and grade II hypertensive retinopathy. She had bilaterally symmetrical brisk limb reflexes and ankle clonus. Abdomen revealed enlarged uterus of 28 weeks gestation, fetal heart rate 140/minute and regular. Per vaginal examination showed fully effaced cervix, Os 4 cm dilated, and presenting part at - 2 station. Patient delivered a fresh stillborn male child (weight 1.2 Kg) along with placenta and membranes on 15.5.97 at 6.30 a.m.

Clinical condition of the patient was worsened by eclamptic convulsions. She was treated at Intensive Care Unit with intravenous magnesium sulphate, diazepam, phenytoin, intravenous fluids guided by central venous pressure monitoring, alpha methyl dopa through Ryle's tube, oxygenation through endotracheal tube, mechanical ventilatory support, and other supportive measures. Patient went into oligoanuric renal failure after delivery. She started bleeding through nose, stomach and venepuncture sites. On 4th hospital day stay she developed widespread petechiae and purpuric spots with the laboratory evidence of disseminated intravascular coagulation. Over the next 6 days, she received 6 units of fresh blood and 4 litres of fresh plasma. Laboratory investigations : Hb 8.6 gram/dL, TLC 18300/c.m.m. (Polymorphs 88%), reticulocyte count 4%; Blood group B Rh +ve; bleeding time 10 minutes, clotting time 18 minutes, platelet count 30,000/c.m.m., prothromin time 45 seconds; blood fibrinogen 310 mg/dL; FDP 80 mg/dL, no clot retraction and lysis after 24 hours. Blood urea nitrogen 73 mg/dL, cretinine 3.2 mg/dL, uric acid 8 mg/dL; serum bilirubin 6.6 mg/dL (direct fraction 4 mg/dL), SGOT 93 U/L, SGPT 98 U/L, alkaline phosphatase 182 U/L, LDH 1014 U/L, serum proteins 4.2 gram/dL, (albumin 2.5 gram), ammonia 1319m gram/dL, potassium 5.1 mEd/L, amylase 960 U/L, Urine showed +++ proteinuria.

Patient's general condition improved after 48 hours; urine output increased; liver, kidney and haematological functions normalized on 16th hospital day. She was discharged on 20th hospital day. Follow up done at 2nd and 4th week intervals revealed a healthy asymptomatic woman.