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Hypokalemic Periodic Paralysis in Pregnancy

Sangceta Saksena

Depart lncnf of Ol,strf rics and Gynaecology, Sr. johns Medical College, Bangalore, l11.dia

Hypokalemic Periodic Paralysis (HPP) has not
been reported in pregnancy. A case ofHPP occuring twice
during the first 28 weeks of gestation is reported.

A 2.f year old, G2

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, at 26 weeks gestation,
was admitted on 08 / 05 / 96, with weakness of right arm, diarrhoea (3-4 times) and pain in abdomen since 1 day. first pregnancy had been uneventful with FTND of 1.5 kg. Female child, (alive and well) 4 years ago. There was no relevant family history. During this current pregnancy, she had an acute attack of quadriparesis with loss of head control at 7 weeks gestation, and was admitted in a local hospital. At that time weakness was more in upper limbs than in lower limbs, more in proximal than distal muscles. Deep tendon reflexes (DTR) brisk in both Ur. L and sluggish in both LL. She recovered spontaneously and rapidly in 2 days, without any specific diagnosis or treatment. Investigations at that time showed normal RBS and renal functions, normal skull and spine X-rays. S. electrolytes were not done.

On admission here, she had generalised weakness and body ache. Poor nutrition, Ht. 150 ems. Wt. 39 kgs. CNS higher functions and cranial nerves normal. DTR normal, plan tars flexor. Power in rt. Arm 3 I
5. Rest of the limbs, 4/ 5. Mild pallor, B.P. 100/70. Pulse 90 per minute, regular. CVS and RSnormal. Uterus 26 wk size, relaxed, FHS 136/ min / regular.

Considering the past history, a differential diagnosis of HPP, poliomyelitis and collagen vascular di~ease wa~ considered. Investigation showed Hb 7.9 gms/ dl. TC13900 / cmm N84L12BF4• ESR 87, S Cr 0.88, RBS 74mg/ dl. Cr Kinase 238 (normal= 24-195u/lit). CKMB 22 (up to 5'1o of total CK is normal). Urine routine analysis was normal, culture no growth. Serum electrolytes (meg. I

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lit) Na 140, K 1.7, CI 100, Mg 0.8 mmoles/ lit. Ca 8.2 mg /
dl. Urine K 30 meg/ d., ECG normal. ABC, pH 7.288, pC02
18.3, p02 100.6. HC03 8.5, S02 97%. T3 1.2 ng / ml. T4 8.2 ug/dl, TSH 4.0 (thyroid function WNL). Rheumatoid factor negative.

Based on investigations, a diagnosis of HPP was
made. She was given IV KCI,40 meg inNS at 10 meq/hr, and oral KCI syrup was started. IV K was tapered over 2 days. She maintained serum K on 3 tsf KCI syrup 6hr.

She was discharged on 03 / 06 / 96 and subsequently had FTND of a SGA 1.5 kg female baby on 23/07/96, without any complications. 15 days post natal serum K was 3.2 meg/lit on oral KCI.

HPP is rare in pregnancy but it should be considered when a healthy young woman presents with acute paralysis