Inter-Current Eclampsia

Kausik Das

K. K. S. M. Matri Bhawan, Calcutta 700026.

Mrs. K. S. a 24 yrs old 2nd gravida was admitted in the hospital with convulsions for last one hour. She had bouts of convulsions before admission. She was a booked case in a private nursing home with regular antenatal check up without any complication. She had no history of past medical/surgical illness. Her previous pregnancy was 4 yrs back with regular antenatal check up without any complication; it was terminated by CS. as a case of failed induction of labour in postdated pregnancy. The child is now 4 yrs of age, healthy with normal growth parameters.

On admission, the pt. was afebrile, non-icteric with full bounding pulse (92/mm) and BP-220/140 mmHg. Her pupils and fundi were normal and there was no pedal oedema. She was unconcious with recurrent tonic clonic convulsions without any localizing signs. Per abdominally, uterus was 28 wks size, (corresponding with the POA), relaxed with normal FHS. Urine examination showed gross albuminuria (++++) but LFT, renal function tests and serum electrolytes were normal.

She was managed as a case of eclampsia with I.V. diazepam and intranasal nifedipine. After starting treatment, there was only one bout of convulsion and that was managed by I.V. diazepam. Her BP came down to 170/110 mmHg and she regained conciousness after about 12 hours. Despite such alarmingly high B.P. her general condition was stable with satisfactory urinary output. Treatment started with oral slow-release nifedipine, methyl-dopa and bed-time diazepam; within 72 hours her B.P. settled down on an average to 150/90 mmHg. U.S.G. showed a live foetus of ~28 wks gestation with AFI 6. Repeat LFT, renal function tests and serum electrolytes were normal. After a week she got discharged from the hospital when urinalysis showed only mild albuminuria (+)

Following discharge, she was under regular biweekly check-up. Her BP remained at around 150/160-90/100 mmHg. DFMC was normal but uterine height remained same. She was advised weekly U.S.G. with doppler velocimetry study. After 2 wks, foetal biometric profiles remained same with diminution of liquor volume and diastolic waves. Around 32 wks. POA, uterine height remained 28 wks. (4 wks disparity – thus clinically evident IUGR) and on 4th successive screening there were definite signs of asymmetrical IUGR with gross oligohydramnios and ABSENT diastolic waves. Pt. and her family were counselled about the events and possible outcome and after 2 doses of I.M. steroid at 12 hourly interval, pregnancy was terminated by elective C.S. under G.A. The female baby was both SGA and preterm (birth wt. 1250 gm) and put immediately in the incubator in the NICU. Post-operative period was uneventful though the pressure remained at around 150/90 mmHg. Stitches were removed on 6th post-operative day and the scar was healthy.

The baby was put on I.V. drip to maintain nutrition and hydration. Gavage feeding started on 5th day and 1-2 ml of expressed breast milk given from 7th day. Unfortunately, on the 10th day, the baby suddenly developed convulsions and gastric haemorrhage and expired within 2 hours. After proper bereavement counselling the patient was discharged

The pt. was followed up weekly for 3 wks. and the puerperium was uneventful and she was coping with the psychological trauma quite satisfactorily. But till the last follow-up, her B.P. remained at 140/90 mmHg.