An unusual Case of Intercurrent Eclampsia – A case report

*Surendra.N.*Panda, *Khetrabasi* Subudhi, *Sandhya R.*Panigrahi, *Ritanjali* Behera, and *Srikant* Sahu
Department of Obstetrics and Gynaecology, M.K.C.G. Medical College, Berhampur - 760004, Orissa

Key words : intercurrent eclampsia

Case Report

Mrs. S.P. aged 23, a primigravida, middle class housewife of rural habitat attended our OPD on 11-2-2001 with a pregnancy of 32 weeks and complaints of sudden blindness of both eyes and vomiting since 8 hours and unilateral head ache since 8 days. Her LMP was 2.7.00 and EDD 9.04.01. Though she had irregular antenatal checkup she had received two doses of tetanus toxoid and her antenatal period appeared uneventful. Her family history and past history were not significant. She was admitted to the labour room as a case of severe PIH and while she was being examined, at 12 noon she developed three bouts of convulsions, in quick succession and became unconscious. Her height was 5-ft and weight 63 kg. She had mild pallor, generalized oedema and no jaundice. Her pulse was 104/min., and B.P. 170/110 mmHg. Chest was clear, CVS normal and liver and spleen were not palpable. The uterus was 32 weeks size and relaxed, head was not engaged and the foetal heart sound was good. On vaginal examination the cervix was posterior, 50% effaced, os was closed with the head at –3 station.

The results of investigations done on admission were:- Hb % -9 gm, B.T. 2'15" , C.T. 5'00" , TLC -8,400/cmm, D.C.- WNL, S.bilirubin -0.5 mg% , SGOT - 27 IU/L SGPT -23 IU/L , S.alkaline phosphates -184 IU/L , S.urea - 22mg% ,S.creatine -0.6mg%, S.uric acid -3.2mg%, FBS. -65mg%, Total platelet count: 1.5 lac/cmm , Blood group O +ve, VDRL – nonreactive, Urine albumin : +++ , Fundoscopy : normal.

After admission she received oxygen inhalation, I V fluids, magnesium sulphate, antibiotics, indwelling catheter and sublingual nifedipine. Termination of pregnancy was advised, but the patient's attendants did not consent, for which reason conservative treatment was continued. No further convulsions occurred, she regained her consciousness, urine output was adequate and her BP came down to 130/94 mm Hg after 24 hours. Oral feeding was started on the second day and patient was put on nifedipine 20 mg retard twice daily and methyl dopa 500 mg six hourly. As it was decided to continue the pregnancy, the patient was transferred to the ward on third day. USG done on 14.02.01 showed a single live foetus of 30 weeks in cephalic presentation. AFI -10 cm, EFW -1.2 kg, Placenta - anterior fundal, with grade II maturation.

In the ward the patient was given nifedipine retard 20 mg bds, methyl dopa 500 mg six hourly, allylestrenol 10 mg TDS, iron, calcium and micronutrients. The patient and the foetus were being closely monitored. On 3.3.01, LSCS was proposed, but again the patient did not consent. On 7.03.01 at 4.00 am she complained of decreased foetal movements and she finally agreed for LSCS. A live baby weighing 1400 gm was delivered by LSCS on 7.03.01. Her postpartum period was uneventful and she was discharged on 17.03.01 with a healthy baby and advised to continue nifedipine for two weeks.

Discussion

Intercurrent eclampsia consists of convulsions and hypertension and or proteinuria appearing as in antepartum cases but stopping and subsiding with enough clinical improvement to allow continuation of pregnancy for > 7 days[1]. It is very rare and infrequent clinical condition. However to allow pregnancy to continue after occurrence of eclamptic fits is in conflict with generally accepted line of management[2] to which we also agree. But in this particular case pregnancy was continued, as the patient did not consent for termination. Moreover the patient showed rapid improvement thus eliminating the need for urgent termination.

In the presence of a stable, correctly controlled and cautiously monitored clinical situation there are two reasons to attempt continuation of pregnancy in the preeclamptic – eclamptic syndrome: - to gain some critical fetal maturity and to reach favorable conditions compatible with vaginal delivery in parous women[1].

Our experience in this case indicates that it may be possible to continue pregnancy for better fetal survival in eclampsia occurring before 32 weeks of pregnancy.

Paper received on6/6/2001 ; accepted on 10/12/01

Correspondence :
Prof. Surendra Nath Panda
Main Road, Khodasingi, Berhampur - 760010

References

1. M. Mario Lopez-Llera; Main Clinical Types and Subtypes of Eclampsia, *Am. J. Obstet Gynecol. 1992; 166: 4 -9.*
2. Leiberman J R; Comment on "What is Intercurrent Eclampsia", *Am. J. Obstet Gynecol.1992; 167:1481-2.*
3. M. Mario Lopez-Llera; Reply to "What is Intercurrent Eclampsia", *Am. J. Obstet Gynecol. 1992; 167:1482.*