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CASE REPORT

An Unusual Case of Intercurrent Eclampsia

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ABSTRACT

Eclampsia (Greek, 'shining forth'), an acute and life-threatening complication of pregnancy, characterized by appearance of tonic clonic seizures in a patient of pre-eclampsia with maternal mortality ranging from 2 to 20%.

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 at least 10 days after cessation of convulsions. It had been standard advice that pregnancy should be terminated once the eclamptic fits are controlled for 24 to 48 hours because if the second attack of fits, if it recurs, is more severe and likely to be fatal. However, this need not necessarily be the case in every eclamptic. In the presence of a stable and cautiously monitored clinical situation the risk of second attack is negligible and an attempt for continuation of pregnancy to gain some critical fetal maturity and to reach favorable conditions compatible with vaginal delivery.

We report the case of 25-year-old primigravida patient with pregnancy of 27 weeks brought in emergency department with convulsion. On examination, she had altered consciousness, pulse 100/min, BP-170/100 mm Hg, and Uterus was 26 weeks in size and on vaginal examination os closed. All her blood investigations were normal, urine albumin+2, fundoscopy normal. After admission, she received oxygen, IV fluids, full dose $MgSO_4$, indwelling catheter, antihypertensive. USG showed single live intrauterine fetus with 27 weeks 3 days maturity, expected weight 1.1 kg, liquor-adequate, Doppler showed increased S/D ratio in umbilical artery. No further convulsion occurred, urine output adequate, BP was 140/94 after 24 hours. Patient showed rapid improvement thus eliminating the need for urgent termination. Patient kept in ward oral antihypertensives. Patient and fetus closely monitored, USG showed gradual increase of baby weight to 1.7 kg. After 40 days of conservative management, patient develop signs of pre-eclampsia and emergency LSCS taken and a single live baby weighing 1.6 kg delivered. Her postpartum period was uneventful and patient with healthy baby discharged.

Thus, the policy of termination of pregnancy in cases of intercurrent eclampsia requires occasional consideration in view of availability of better lines of medical treatment and fetal monitoring.[1]

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INTRODUCTION

Eclampsia (Greek, 'shining forth'), an acute and life-threatening complication of pregnancy, characterized by appearance of tonic clonic seizures in a patient of pre-eclampsia with maternal mortality ranging from 2 to 20%.

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 at least 10 days after cessation of convulsions. It is very rare and infrequent clinical form.

A controversy exists regarding definition, diagnosis and management of intercurrent eclampsia which has received inadequate attention so far.

Lazard (1933) defines the condition as those recovering from eclampsia and pregnancy continuing for several days to weeks without recurrence of eclampsia. In Lazard's series time interval ranges from 2 days to 2 months.[1]

Mundaliar and Menon (1972): Intercurrent eclampsia should be used to denote cases where fits are controlled and pregnancy continues to progress for at least 10 days after cessation of convulsion.[1]

In the presence of a stable, correctly controlled and cautiously monitored clinical situation there are two reasons to attempt continuation of pregnancy in the pre-eclamptic-eclamptic syndrome: to gain some critical fetal maturity and to reach favorable conditions compatible with vaginal delivery in parous women.[2]

CASE REPORT

A 25-year-old primigravida patient with pregnancy of 27 weeks brought in emergency department with 3 bouts of convulsion in quick succession on 21/8/11. Her LMP: 4/2/11 and EDD: 11/11/11. She had regular antenatal checkup and

had received two doses of tetanus toxoid in private clinic. Her family history and past history were not significant.

On general examination the patient was drowsy, not well-oriented to time place and person, well-built and well-nourished. Her height was 5 ft 3 inch and weight 63 kg. Her pulse 100/minute, BP: 170/100 mm Hg, Bilateral pedal edema with facial puffiness was present. Chest was clear, CVS normal and liver and spleen were not palpable. The uterus was 26 weeks size, relaxed and external ballottement present. On vaginal examination the cervix was posterior and OS was closed with no bleeding or leaking. On investigations Hb%-10.5 gm, BT-2'15", CT-5'00", PT INR O.9 sec TLC-6000/cumm, DC-WNL, total platelet count-2.1 lac/cumm, serum bilirubin 0.5 mg%, SGOT 27 IU/L, SGPT 23 IU/L, serum alkaline phosphatase-184 IU/L, serum urea-22 mg%, serum creatinine 0.6 mg%, serum uric acid 3.2 mg%, FBS 65 mg%, serum electrolyte: within normal limits, blood group-O positive, VDRL-NR, urine albumin-(++), fundoscopy normal.

Immediate management: After admission she received oxygen inhalation, IV fluids, magnesium sulfate, antibiotics, indwelling catheter and sublingual nifedipine. 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. USG showed single live intrauterine fetus with 27 weeks 3 days maturity, expected weight 1.1 kg, liquor-adequate, Doppler showed increased S/D ratio in umbilical artery. Patient showed rapid improvement thus eliminating the need for urgent termination. Oral feeding was started on the second day and patient was put on nifedipine 20 mg thrice daily and methyldopa 250 mg 6-hourly. As it was decided to continue the pregnancy, the patient was transferred to the ward on third day. In the ward the patient was given nifedipine 20 mg tablets tds, methyldopa 250 mg 6-hourly, iron, calcium and micronutrients, full dose injection. steroid. The patient and the fetus were being closely monitored. USG showed gradual increase of baby weight to 1.7 kg.

Outcome: After 40 days of conservative management, patient complained of headache, blurring of vision, vomiting. Her BP was 150/96 mm Hg, urine albumin (+++). Emergency LSCS was taken and a single live baby weighing 1.6 kg delivered. Her postpartum period was uneventful and patient with healthy baby discharged and advised to continue nifedipine for 2 weeks.

DISCUSSION

Intercurrent eclampsia is very rare and infrequent clinical form. To allow pregnancy to continue after occurrence of eclamptic fits is in conflict with generally accepted line of management to which we also agree. It has been the standard advise that pregnancy should be terminated once eclamptic fits are controlled for 24 to 48 hours.[1] The main argument given in favor of termination of pregnancy is that the second attack of fits, if it recurs, is more severe and likely to be more fatal.[1] However, this need not necessarily be the case in every eclamptic. It is felt that risk of a second attack is negligible in a controlled patient who is under constant care.[1]

Bhatt (1964) presented a study of 15 cases of intercurrent eclampsia which responds to treatment and where pregnancy was allowed to continue after fits were controlled.[1] The highest fit delivery interval was 38 days. Cesarean section was not necessary in any patient and there was no maternal mortality while about 33% babies could be salvaged.[1]

Thus, the policy of termination of pregnancy in cases of intercurrent eclampsia requires occasional consideration in view of availability of better lines of medical treatment.[1]

In this particular case pregnancy was continued as the patient showed rapid improvement thus eliminating the need for urgent termination.

Intercurrent eclampsia is considered oddly benign for the mother but not for the fetuses.[3]

However, it is mandatory that these patients be kept in hospital till delivery and carefully observed with special check on blood pressure and albuminuria. The pregnancy need be terminated only when blood pressure continues to rise, albuminuria persists, or until such time that the cervix is ripe and baby is of reasonable size to survive.[1]

CONCLUSION

Thus, the policy of termination of pregnancy in cases of intercurrent eclampsia requires occasional consideration in view of availability of better lines of medical treatment and fetal monitoring.

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