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Case Report on : Intercurrent Eclampsia

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ABSTRACT

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. Here I present a case of 27yr old primigravida with history of convulsion with 30 weeks of pregnancy with full dose of Mgso4 given. Advised termination but no consent given by the relatives. Hence conservative management of the case done for 20 days following which patient developed signs of pre eclampsia and emergency lscs done with healthy baby of 1.6kg. Her postpartum period was uneventful and patient with healthy baby discharged.

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. 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.

KEYWORDS : Intercurrent eclampsia,Mgso4,Convulsions.

CASE REPORT:

- *We report the case of 27-year-old primigravida patient with pregnancy of 30weeks brought in emergency department with convulsion. On examination, she had altered consciousness, pulse 100/min, BP-170/100 mm Hg, and Uterus was 30 weeks in size and on vaginal examination her cervical os was closed . Chest was clear,CVS normal and liver and spleen were not palpable. 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. All her blood investigations were normal. The results of investigation done on admission were: Hb%-9.2gm%,BT-2'15",CT-5'00",TLC-8400/cmm,DC-WNL, Serum bilirubin-0.5 mg%,SGOT-27 IU/L,SGPT-23 IU/L,Serum alkaline Phosphatase-183 IU/L, Serum Urea-20 mg%,-Serum Creatinine-0.7 mg%, Serum Uric acid-3.2 mg%, Total Platelet Count-1.5 lac/cmm, Blood group-O positive, VDRL-NR, urine albumin+2, fundoscopy normal. Termination of pregnancy was advised initially, but patients attendant did not consent for which reason conservative treatment was continued. After admission, she received oxygen, IV fluids, full dose $Mgso_4$, indwelling catheter, antihypertensive. USG showed single live intrauterine fetus with 31 weeks 6days maturity, expected weight 1.2 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 on oral anti hypertensives. Patient and fetus closely monitored, USG showed gradual increase of baby weight to 1.7 kg. After 20 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]

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 atleast 10 days. It is very rare and infrequent clinical form. However to allow pregnancy to continue after occurrence of eclamptic fits is in conflict with generally accepted line of management 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 pre eclamptic-eclamptic syndrome:-to gain some critical fetal maturity and to reach favourable 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.

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