Case Report of Severe Preeclampsia and Associated Postpartum Complications

Pacarada M, Gashi AM*, Beha A and Obertinca B

Department of Obstetrics and Gynecology, University Clinical Centre of Kosovo, Pristina, Kosova

*Corresponding author: Gashi AM, Department of Obstetrics and Gynecology, University Clinical Centre of Kosovo, Pristina, Kosova, E-mail: astrit.m.gashi@hotmail.com

Citation: Pacarada M, Gashi AM, Beha A, Obertinca B (2016) Case Report of Severe Preeclampsia and Associated Postpartum Complications. J Case Rep Stud 4(4): 408. doi: 10.15744/2348-9820.4.408

Received Date: June 03, 2016 Accepted Date: August 29, 2016 Published Date: August 31, 2016

Abstract

Preeclampsia is clinically defined by hypertension and proteinuria, with or without pathologic edema that occurs after 20 weeks' gestation, but can also present up to 4-6 weeks post-partum. Worldwide, incidence of preeclampsia is 5-14 percent of all pregnancies, while severe preeclampsia can develop to about 25 percent of all cases of preeclampsia. Severe preeclampsia is a pathology characterized by endothelial dysfunction that can often be complicated, and thus may lead to liver and renal failure, disseminated intravascular coagulopathy (DIC), and central nervous system (CNS) abnormalities. Worldwide, preeclampsia and eclampsia is responsible for about 14 percent of maternal deaths per year. We present a case, from our clinic, which has had serious complications after birth and that ended with the death of the patient. Despite the adequate management with the timely diagnosis and therapy, patient died ten days after Caesarean delivery.

Keywords: Severe Preeclampsia; Postpartum; Complications

Introduction

Pre-eclampsia is clinically defined by hypertension and proteinuria, with or without pathological oedema that occurs after 20 weeks' gestation, but can also present up to 4-6 weeks post-partum [1].

Severe features of Preeclampsia include any of the following features;

(a) Systolic blood pressure of 160 mm Hg or higher, or a diastolic blood pressure of 110 mm Hg or higher on two occasions at least 4 hours apart while the patient is on bed rest (unless antihypertensive therapy is initiated before this time).

(b) Thrombocytopenia (platelet count less than 100,000/microliter).

(c) Impaired liver function as indicated by abnormally elevated blood concentration of liver enzymes (to twice normal concentration), severe persistent right upper quadrant or [epigastric pain unresponsive to medication and not accounted by alternative diagnosis, or both.

(d) Progressive renal insufficiency (serum creatinine concentration greater than 1.1 mg/dl or a doubling of the serum creatinine concentration in the absence of other renal disease).

(e) Pulmonary edema.

(f) New-onset cerebral or visual disturbances.

Worldwide, incidence of pre-eclampsia is 5-14 percent of all pregnancies. In developing nations, incidence of pre-eclampsia is 4-18 percent [2,3]. Severe pre-eclampsia can develop to approximately 25 percent of all cases of pre-eclampsia [4]. Morbidity and mortality in pre-eclampsia and eclampsia are frequent. Severe pre-eclampsia may lead to liver and renal failure, disseminated intravascular coagulopathy (DIC), and central nervous system (CNS) abnormalities. In world, preeclampsia and eclampsia is responsible for approximately 14 percent of maternal deaths per year (50,000-75,000) [5]. A woman with severe preeclampsia, and complicated with eclampsia or HELLP syndrome, has a 20% risk of developing preeclampsia in her subsequent pregnancy [6-11].

Case presentation

A 34-year-old woman pregnant presented in Department of Obstetrics and Gynecology, University Clinical Centre of Kosovo, with 29 weeks' gestation and dyspnoea, expressed cyanosis, tachycardia, and epigastric pain. At the admission office, she had a blood pressure of 160/95 mmHg; pulse of 105 beats per minute, oxygen saturation was 96. On physical examination, congenital deformity of the spine (kyphoscoliosis) was noticed. Skin and mucous membranes were pale. Data from the history show that the patient was treated by easy preeclampsia, from week 25 of gestation. Laboratory findings; hemogram was normal,
Preeclampsia is a pregnancy-specific hypertensive disorder with multisystem involvement. Severe preeclampsia can result in both acute and long-term complications for both the woman and her newborn. Maternal complications of severe preeclampsia include pulmonary edema, myocardial infarction, stroke, acute respiratory distress syndrome, coagulopathy, severe renal failure and retinal injury. These complications are more likely to occur in the presence of pre-existent medical disorders and with acute maternal organ dysfunction related to preeclampsia. Fetal and newborn complications of severe preeclampsia result from exposure to uteroplacental insufficiency or from preterm birth, or both. According to ACOG (2013), for women with severe preeclampsia at or beyond 34 0/7 weeks of gestation, and in those with unstable maternal-fetal conditions irrespective of gestational age, delivery soon after maternal stabilization is recommended.

Conclusion

This case report of patient who presented with 29 weeks of pregnancy, dyspnoea, expressed cyanosis, tachycardia, and epigastric pain to our clinical center. She developed complications associated with severe preeclampsia and unfortunately ended up with fatal outcome after 10 days of cesarean delivery post-partum, despite of timely diagnosis and adequate management.

Preeclampsia/eclampsia is associated with substantial maternal complications, both acute and long-term. Clear protocols for early detection and management of hypertension in pregnancy at all levels of health care are required for better maternal as well as perinatal outcome.

References

1. Laganà AS, Favilli A, Triolo O, Granese R, Gerli S (2015) Early serum markers of pre-eclampsia: are we stepping forward? J Matern Fetal Neonatal Med 29: 3019-23.
2. Villar J, Betran AP, Gulmezoglu M (2001) Epidemiological basis for the planning of maternal health services. WHO/RHR.
3. Khedun SM, Moodley J, Naicker T, Maharaj B (1997) Drug management of hypertensive disorders of pregnancy. Pharmacol Ther 74: 221-58.
4. Sibai BM (2004) Magnesium sulfate prophylaxis in preeclampsia: Lessons learned from recent trials. Am J Obstet Gynecol 190: 1520-6.
5. WHO (2004) The Global Burden of Disease, Geneva.
6. Sibai BM, Ramadan MK, Chari RS, Friedman SA (1995) Gestational diabetes mellitus complications: follow-up and long-term prognosis. Am J Obstet Gynecol 172: 125-9.

7. Chames MC, Haddad B, Barton JR, Livingston JC, Sibai BM (2003) Subsequent pregnancy outcome in women with a history of HELLP syndrome at < or = 28 weeks of gestation. Am J Obstet Gynecol 188: 1504-8.

8. Sibai BM, Sarinoglu C, Mercer BM (1992) Eclampsia. VII. Pregnancy outcome after eclampsia and long-term prognosis. Am J Obstet Gynecol 166: 1757-63.

9. Lopez-Llera M, Hernandez Horta JL (1974) Pregnancy after eclampsia. Am J Obstet Gynecol 119: 193-8.

10. Adelusi B, Ojengbede OA (1986) Reproductive performance after eclampsia. Int J Gynaecol Obstet 24: 183-9.

11. Sibai BM, Mercer B, Sarinoglu C. Severe preeclampsia in the second trimester: recurrence risk and long-term prognosis. Am J Obstet Gynecol 165: 1408-12.