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One Case of Severe Preeclampsia Who Died from Postpartum Complications Ten Days after Caesarian Delivery

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ABSTRACT

Preeclampsia is clinically defined by hypertension and proteinuria, with or without pathologic edema that can happen after 20 week's gestation, but can happen well 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 that can often be complicated. This pathology 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 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 Caesarian delivery.

Keywords: Severe Preeclampsia; Eclampsia; Postpartum Complications; Caesarian Delivery; Bad Outcomes

SOMMARIO

Preeclampsia è clinicamente definita da ipertensione e proteinuria, con o senza edema patologica che può accadere dopo la gestazione di 20 settimana, ma può succedere ben 4-6 settimane dopo il parto.

In tutto il mondo, l'incidenza di preeclampsia è 5-14 per cento di tutte le gravidanze, mentre preeclampsia grave possono sviluppare a circa il 25 per cento di tutti i casi di preeclampsia. preeclampsia severa è una patologia che spesso può essere complicato.

Questa patologia può portare a fegato e insufficienza renale, coagulopatia intravascolare disseminata (DIC), e le anomalie del sistema nervoso centrale (SNC).

Nel mondo, preeclampsia e eclampsia è responsabile di circa il 14 per cento delle morti materne ogni anno.

Presentiamo un caso, dalla nostra clinica, che ha avuto gravi complicazioni dopo la nascita e che si conclude con la morte del paziente. Nonostante una gestione adeguata con la diagnosi tempestiva e la terapia, il paziente è morto dieci giorni dopo il parto cesareo.

INTRODUCTION

MPre-eclampsia is clinically defined by hypertension and proteinuria, with or without pathological oedema that can happen after 20 week's gestation, but can occur well 4-6 weeks post-partum⁽¹⁾. Severe preeclampsia defined as the presence of high blood pressure (systolic blood pressure is 160 mm Hg or higher and diastolic blood pressure 110 mm Hg or higher). b). Impaired hepatic function (doubling of the liver enzymes levels) c). Epigastric pain or right upper quadrant pain d). Renal insufficiency (doubling of the serum creatinine levels). e). Pulmonary edema, f). Visual

disturbances g). Thrombocytopenia. 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% of maternal deaths per year (50,000-75,000)⁽⁵⁾. A woman with severe preeclampsia ago, and complicated in eclampsia or HELLP syndrome, she has a 20% risk of developing preeclampsia in her subsequent pregnancy⁽⁶⁻¹¹⁾.

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CASE PRESENTATION

A 34-year-old woman who was 29 weeks pregnant, was accepted in Department of Obstetrics and Gynecology, University Clinical Centre of Kosovo, in severe general condition, with dyspnoea, expressed cyanosis, tachycardia, epigastric pain. At the office of admission she had a blood pressure of 90/60 mmHg, plus 105 beats per minute, saturation was 96. In physical examination see a defect congenital of curvature of the spine (kyphoscoliosis). Skin and mucous membranes were pale. Laboratory findings; hemogram was normal, urine analysis (protein 1+). Biochemical laboratory tests: serum aspartate aminotransaminase (AST), 67 IU/L; serum alanine aminotransaminase (ALT), 120 IU/L; serum lactate dehydrogenase (LDH), 839 IU/L; serum urea 10.74 and creatine was normal; Triglyceride, 3.49 mmol/L; hemoglobin and platelet count were normal. Coagulation profile was normal. There were consultations with a cardiologist, anesthesiologist and pulmonologist, was found that the patient is in acute pulmonary edema. With echocardiography is found pericardial effusion, other parameters anatomical structure of the heart to normal. Are done chest x-ray, electrocardiogram and all necessary imaging examinations. The patient was transferred to intensive care unit, where intubated and connected to the respiratory apparatus. After consultations is completed diagnosis: 29 weeks pregnant, Preeclampsia, Pericardial effusion, Pulmonary edema, Respiratory insufficiency, Kyphoscoliosis, Neurofibromatosis, Rh incompatibility. After stabilization of vital parameters for several hours, decided to terminate the pregnancy, obtained a written consent of the patient. A Pfannenstiel incision was made and a fetus the female was delivered, who had birth weight 1340 grams and apgar score 1 in the first minute and 3 in the fifth minute. The patient was treated with supplementary oxygen, crystalloid, antibiotics, H2-blockers, LMWH, B-blockers, diuretic, analgesic, enteral nutrition, vitamin preparations, mucolytics, corticosteroids, anti hypertensive and anti-emetic. After a week of treatment in intensive care unit, the patient's condition was improving,

extubated and back again in Department of Obstetrics and Gynaecology in monitoring by the cardiologist, anaesthesiologist and pulmonologist. After seven days reiterates the patient's condition deteriorates rapidly, the patient undergoes cardiac arrest, despite the resuscitation measures, ends with death (exitus letalis).

DISCUSSION

Pre-eclampsia is disseminated disease the vascular endothelial malfunction and generalized vasospasm. However, the pathophysiologic mechanism for preeclampsia is very complex. Severe preeclampsia can develop to approximately 25 percent of all cases of preeclampsia⁽¹²⁾. In world, preeclampsia and eclampsia is responsible for approximately 14 percent of maternal deaths per year⁽¹³⁾. This disease may lead to liver and renal failure, disseminated intravascular coagulopathy (DIC), and central nervous system (CNS) abnormalities and end with the death of patient. Often clinicians could not predict the development of life-threatening complications from preeclampsia, development of rapid of this disease may end very easily so fatal for the patient. The correct management is very important for patients with preeclampsia. The clinician must perform a detailed assessment as history and physical examination with careful. Laboratory values including complete blood count, urine protein, liver enzymes, and a coagulation profile should be obtained. The patient in our case complained of epigastric pain, breathing difficulties (dyspnoea), in inspection she had expressed cyanosis, while in auscultation tachycardia.

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 Caesarian delivery.

Conflict of Interests

All the authors not have any conflict of interests that of the monument to Victor Emmanuel II

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