Keep Priorities Straight When Treating Eclampsia

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Contribution Writer

NEW YORK — Eclampsia has become increasingly rare in Western countries, but it still occurs in 1 in 2,000-3,500 pregnancies—and must be prepared to treat it, Baha M. Sibai, M.D., said at an obstetrics symposium sponsored by Columbia University and New York Presbyterian Hospital.

Although most episodes occur late in pregnancy, an increasing number occur more than 2 days after delivery, and patients should be counseled accordingly, said Dr. Sibai, professor and chairman of the obstetrics and gynecology department at the University of Cincinnati.

Eclampsia does not always come with a warning. It has been reported that in 15%-20% of cases neither hypertension nor proteinuria has occurred.

"Most women with eclampsia have had good prenatal care," Dr. Sibai said. In a 1992 U.K. study of 383 women, 85% had been seen by a medical care provider within a week before the episode.

Eclampsia is largely a late event: in a sample of 399 U.S. women, the episode occurred after the 32nd week of gestation in 72%, and before week 28 in roughly 10%.

In a substantial number of cases—28%, in the U.S. study—the condition developed more than 2 days after delivery, and patients should be counseled accordingly, he said. In a substantial number of cases—28%, in a U.K. study—the condition developed more than 2 days after delivery, and patients should be counseled accordingly, he said.

"More and more, the onset of convulsions is in the postpartum period. We've done an excellent job educating women to report signs and symptoms during pregnancy, but a poor one in educating them that they can have eclampsia after leaving the hospital," Dr. Sibai said.

The lapse can have medicolegal implications, he said.

Emergency management of eclampsia should focus on protecting the mother from injury (e.g., preventing extremities and preventing a fall off the bed), ensuring adequate oxygenation, and preventing aspiration. Once these are addressed, steps should be taken to avoid recurrent convulsions.

Never give anything to stop the convolution: no one dies from a seizure, and you could do damage if you give the wrong dose," Dr. Sibai said.

Most seizures are self-limiting, and medications to contain them may depress respiration. Hypotension should be the next concern, and then delivery. "It should be the last thing on your mind," he said.

If hypoxemia develops, 8-10 L/min of supplementary oxygen should be supplied by face mask, and pulse oximetry should be monitored. "Oximetry should be the last thing on your mind," he said.

If magnesium sulfate is required, a loading dose of 6 g over a 20-minute period, followed by maintenance at 2 g/hour. Ionizing and cardiac arrest—1 g of calcium gluconate should be given intravenously immediately, and intubation and assisted ventilation be provided if necessary.

Sodium bicarbonate may be required for acidemia.

To prevent further convulsions, IV magnesium sulfate should be begun with a loading dose of 6 g over a 20-minute period, followed by maintenance at 2 g/hour. Hypertension should be controlled, and the mother should be monitored. "Always talk to the patient. Slurred speech shows paralysis of the muscles of the jaw," he said.


