Keep Priorities Straight When Treating Eclampsia

BY CARL SHERMAN
Contributing Writer

NEW YORK — Eclampsia has become increasingly rare in Western countries, but it still occurs in 1 in 2,000-3,500 pregnancies—and obstetric clinics 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 after delivery; in two-thirds of these cases, it happened more than 48 hours later.

"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., cushioning 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 convulsion: 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.

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Hypertension 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 monitored. 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. The anticonvulsants diazepam and phenytoin, which can depress respiration and compromise alveolar reflexes, carry a higher mortality rate and should be avoided.

"Don't listen to what the neurologist or internist tells you to do," Dr. Sibai said.

The risk of magnesium toxicity should be kept in mind: look for such signs of rising serum levels as double vision, a feeling of warmth or flushing, and lethargy; monitor patellar reflexes hourly.

"Always talk to the patient. Slurred speech shows paralysis of the muscles of the jaw," he said.

Magnesium sulfate should be discontinued immediately while a blood level is taken, and restarted with appropriate adjustments. If serum magnesium is above 15 mg/dL—a level that threatens respiratory and cardiac arrest—1 g of calcium gluconate should be given intravenously and intubation and assisted ventilation provided if necessary.

For control of severe hypertension, labetalol and nifedipine are drugs of choice; hydralazine should be avoided, he said.

When possible, delivery should be done within 24 hours. Cesarean delivery is not always necessary, and vaginal delivery can be done with epidural or spinal anesthesia. ■