

Atypical Preeclampsia About Three Cases

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ABSTRACT

Preeclampsia is a syndrome unique to pregnancy that remains one of the leading causes of maternal mortality and morbidity worldwide. The complexity of its physiopathology is reflected by a very large clinical polymorphism, which sometimes delays the diagnosis and therefore the management. To provide the clinician with an effective tool, the definition criteria are periodically reassessed by medical societies. However, there are cases of preeclampsia that fall outside the scope of these definitions. This article aims to discuss atypical presentations of preeclampsia, namely non-proteinuric preeclampsia, normotensive preeclampsia, preeclampsia before 20 weeks of amenorrhea, and postpartum preeclampsia.

Key words: Preeclampsia , serious disease, atypical , treatment

INTRODUCTION

Preeclampsia is a syndrome unique to pregnancy with a clinical polymorphism. In general, most parturients develop classic preeclampsia. Nevertheless, recent studies have shown that some will present atypical forms. The purpose of this presentation is to educate practitioners about the existence and severity of these forms.^[1]

CASE REPORTS

Case 1

This is a 33-year-old woman with no prior history: No known hypertensive or neurological pathology underlying her pregnancy was poorly followed. Who was admitted into our emergency training in an eclampsia crisis picture on pregnancy of 7 months with a blood pressure of 180 mm Hg systolic and 110 mm Hg diastolic, a negative proteinuria, and a normal biological assessment. The patient benefited after the provision of an emergency cesarean section for maternal rescue. The evolution was favorable with normalization of blood pressure figures after delivery.

Postpartum bioassay showed no biological disturbances and proteinuria remained negative. The post-operative brain scan was normal.

Case 2

This is a 39-year-old mother of a living child who has a scarred uterus with no history of chronic arterial hypertension, preeclampsia in the previous pregnancy, or underlying neurological pathology. Who was admitted in an eclampsia crisis chart on an active term pregnancy at the beginning of labor with normal blood pressure and negative proteinuria. The biological assessment showed anemia at 8 g/dl hypochromic microcyte, thrombocytopenia verified on smear of 80,000 el/mm³ with no cytolysis or other biological abnormalities. The patient received an emergency cesarean section for maternal rescue. Postpartum brain computed tomography scan revealed diffuse cerebral edema with no other apparent abnormality.

The newborn is male Apgar 10/10 birth weight at 3100 grams (6,8 pounds). The evolution was favorable with normalization of the balance sheet on the 3rd day of the postpartum. The tension was still normal with 24-h proteinuria negative.

Case 3

This is a 28-year-old patient admitted to the emergency department for high blood pressure figures of 18/12 cmhg with an intense headache over a pregnancy of 8 months; the proteinuria was negative. An initial biological assessment showed a Hellp syndrome associaton anemia with 7 g/dl,

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cytolysis with 6 times the normal one, and a thrombopénie with 75,000 elements/mm³. The patient was given initial conditioning, the administration of antihypertensives and magnesium sulfate with blood transfusion and fetal extraction after introduction of corticosteroid therapy. The evolution in post-operative was favorable with normalization of the tension figures, the disappearance of the headaches. The newborn was alive with a birth weight of 2 kg 300.

DISCUSSION

Preeclampsia is defined by the following triad: A blood pressure higher and/or equal to 14/9 cmgh, proteinuria greater than and/or equal to 0.3 g/24 h after 20 weeks of amenorrhea. In the absence of proteinuria, the diagnosis of preeclampsia should be made if the presence of arterial hypertension with signs:^[2]

- Persistent neurological type of headache
- Epigastric pain
- Pain of the right hypochondrium
- Nausea and vomiting
- Intrauterine growth retardation
- Biological disturbances such as thrombocytopenia and cytolysis.

Nearly 20–50% of patients with gestational hypertension may develop a preconception or need for good monitoring. Severe hypertension with no proteinuria is associated with a high risk of maternal-fetal morbidity and should be considered as an atypical form of preeclampsia and management as such.^[2]

The latest studies show that the disease can manifest itself in the absence of hypertension in other forms such as capillary dysfunction resulting in proteinuria or ascites abnormality of hemostasis or diffuse organic dysfunction. These are atypical forms of preeclampsia where the tension is normal with other abnormalities.^[3]

Cases of preeclampsia and/or eclampsia before 20 weeks of amenorrhea have been reported but are rare. They are often diagnosed as cases of nephrotic lupus or hypertensive encephalopathy or thrombotic purpura. Women with

hypertension and proteinuria during the first trimester should be considered at risk of developing eclampsia until proven otherwise. Any preeclampsia or eclampsia before 20 weeks of amenorrhea should be considered and treated as a severe preeclampsia and therefore monitored by obstetrical and fetal ultrasound and a Doppler and if necessary administration of magnesium sulfate and extraction if the maternal vital prognosis is put into effect. 48 h or 4 weeks after delivery, any patient known to be hypertensive or having a history of eclampsia with a seizure should be considered eclampsia until proven otherwise. Management of atypical forms should take into consideration maternal clinical risk factors, biological, radiological, and gestational age at the time of diagnosis.^[3,4]

CONCLUSION

The classic definition of preeclampsia should be revised to draw the attention of clinicians to its atypical forms while avoiding to miss another underlying pathology (neurological, renal, and endocrinological).

REFERENCES

1. Sibai BM, Stella CL. Diagnosis and management of atypical preeclampsia-eclampsia. *Am J Obstet Gynecol* 2009;200:e481-7.
2. Anev I, Rajasri AG, Reddy K, Pillai M. Triploidy without molar change presenting as severe pre-eclampsia and left ventricular failure at 15 weeks. *J Obstet Gynaecol* 2011;31:659-60.
3. Ochiai D. Atypical severe preeclampsia superimposed on chronic hypertension without molar change at 19 weeks of gestation: A case report. *Arch Gynecol Obstet* 2012. DOI: 10.1007/s00404-012-2412-5.
4. Stella CL, Sibai BM. Preeclampsia: Diagnosis and management of the atypical presentation. *J Matern Fetal Neonatal Med* 2006;19:381-6.

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