Managing Eclampsia and Preterm Delivery in a Geographically Isolated Location

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BACKGROUND

Eclampsia is rare, however in isolated remote locations, obstetric emergencies such as eclampsia remain a reality. We describe a case of management of eclampsia with preterm delivery in a remote location.

CASE

A 20-year-old G1 female from a remote location presented to the local hospital at 30 weeks' gestation with eclampsia, post 2 tonic-clonic seizures.

Previously well, her pregnancy had been uncomplicated, her routine antenatal investigations, combined first trimester screening and morphology ultrasound revealed no abnormalities. Her medical history included sickle cell trait and obesity.

On immediate assessment, she was GCS 15, post-ictal and hypertensive (170/111); vaginal examination and foetal status was reassuring. Her urine dipstick was negative and no contractions were present. The patient was admitted to hospital, commenced on Magnesium Sulphate, and a Hydralazine infusion, and corticosteroids were administered for promotion of foetal lung maturation.

Arrangements were made to medically evacuate the patient to the nearest tertiary centre (4 hours distance by plane), for delivery and subsequent management. Despite rapid initiation of medical treatment and planned transfer within 24 hours, the blood pressure remained elevated, and continuous foetal monitoring detected non-reassuring features on CTG (recurrent late decelerations and decreased foetal variability). An emergency caesarean section was performed, delivering a premature live male (APGARS 6 & 9) with partial placental abruption.

The male infant died whilst being medically evacuated. The patient was stable post-surgery, with no further seizures, or HELLP syndrome. The patient developed resistant hypertension which resolved 1 month post-partum with additional anti-hypertensive medications required.

DISCUSSION

This case empathises the health gap between remote and metropolitan populations, and highlights challenging aspects of coordinating emergencies in remote obstetrics. We need to continue to increase access to antenatal care and obstetric services in remote locations to minimise such tragedies and reach health equity.

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