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Eclampsia Complication Molar Pregnancy at 8 Weeks Gestation-A Case Report

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Abstract: We report a case of molar pregnancy at 8 weeks gestation presenting as eclamptic fit and illustrate the typical management difficulties in inner rural African communities where most of African population live.

Key words: Eclampsia, hydatidiform mole, developing economy

INTRODUCTION

A 16 year old gravida 2 para 0+1 house wife in her 3rd year of marriage was brought unconscious to Wurno General Hospital in rural northwestern Nigeria. She was brought on the back of a donkey after 3 h journey from an inner rural village with no access road. Her spouse volunteered a history of 8 weeks amenorrhea and progressively worsening headache, visual disturbance, marked leg swelling, vomiting and epigastric pain (in the week before presentation) followed by generalized seizure (on the day of presentation) associated with mild salivation and dark brownish-red bleeding per vaginum. There was no urinary nor fecal incontinence. The patient was not known to be epileptic and had no history of fever, diarrhoea nor dysuria. She had a spontaneous abortion at 12 weeks gestation 4 months before the index amenorrhea with the expulsion of products of conception containing identifiable fetal parts, followed by regular menstruations. She had never practiced any form of contraception. Examination revealed an unconscious young lady afebrile, not pale and anicteric; pulse: 104 bpm, BP: 180/110 mmHg (supine), RR: 18/min, bilateral pitting lower limbs edema up to the knee, no eye opening, no verbal response but localized pain. Pupils were of normal size and shape and responded to direct and consensual light. There was no neck stiffness but hyperreflexia at the knee and ankle joints without clonus. Chest was clear. The abdomen was full. Vulva was normal except for moderate bloodstain. Cervical Os was open and with protruding vesicles. Uterus was 12 weeks size, doughy and with bilateral soft, freely mobile adnexal masses about 6 cm. There was 3+ proteinuria, positive urinary Pregnancy Test (PT) but no glycosuria. Urine microscopy profile was normal. PCV was 27% and standard peripheral blood smears for malaria parasite was negative. We had neither ophthalmoscope nor facility for ultrasonography, X-ray, quantitative HCG assay, blood sugar, white blood cells, platelets, renal or hepatic function studies.

Treatment was started on a working diagnosis of eclampsia complicating molar gestation. Patient had diazepam, hydralazine, standard course of malaria medication and parenteral antibiotics. Manual Vacuum Aspiration (MVA) was done 2 h after presentation when the BP had come down to 150/90 mmHg. Product was consistent with complete hydatidiform mole. Patient had no subsequent

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fits and regained full consciousness 24 h after MVA. PT and test for proteinuria became negative after 2 weeks of admission. Patient was by then bright and active and had a stable BP of 120/80 mmHg. The patient and spouse refused a referral for follow up at a tertiary center for financial reason, distance and the anticipated difficulty of city life. Family Planning counseling was done and she was discharged home but scheduled for follow up and contraception in 6 weeks. The patient has not returned 6 months later.

DISCUSSION

Pre-eclampsia is known to occur early in molar pregnancies but it rarely presents as eclamptic fits at 8 weeks gestation (Newman and Eddy, 1998). The case presented is important because even in developed countries where ultrasound is widely available only 10% of patients are diagnosed by ultrasound before clinical presentation and the average gestational age at evacuation is 11.8 weeks (Curry *et al.*, 1975; Soto-Wright *et al.*, 1995). At 16 years of age this patient was already in her second pregnancy and presented to the hospital only when she appeared moribund to her spouse. It appears understandable that there may be little incentive to make the obviously difficult journey to the hospital for less dramatic illnesses. In our hospital, which serves a population of over 80,000, few facilities exist and diazepam is the only anticonvulsant available for the treatment of eclampsia. The short term outcome of this patient was good. The lack of good roads necessitated a rather lengthy hospital admission until we had a negative PT; though we recognize that it is highly unreliable for follow up. Even then, a negative urinary PT 2 weeks after MVA is quite reassuring and suggests at least a significant fall in HCG level. Lost of patients to follow up is the rule in developing economies.

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