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EXPECTANT MANAGEMENT IN PREECLAMPSIA

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Outcome of preeclampsia is changed depending on severity. Maternal and perinatal mortality and morbidity in the hospitalized case with mild preeclampsia are extremely low and approaches those of normotensive pregnancies. In contrast in case of severe preeclampsia the maternal and perinatal mortality are very high. The most effective therapy for severe preeclampsia and eclampsia is delivery of the fetus and placenta. There is universal agreement that all such patients should be delivered at or after 32-34 week's gestation. Depending on the situation, delivery has to be taken into account in severe preeclampsia between 28 and 32 weeks' gestation. At this stage, the neonatal mortality is not very high depending on the ability and experience of the neonatal intensive care unit10. Aggressive management with immediate delivery will result in extremely high neonatal mortality and morbidity. In contrast attempts to prolong pregnancy may result in fetal demise and high maternal morbidity and mortality. There was no structured policy to deliver the cases with severe preeclampsia in the first period of the study (1989-91). In the second part (1991-99), the cases were classified as moderate preeclampsia if there is hypertension (Diastolic pressure more than 100 mm/Hg), proteinuria less tham 5gr/l and no any other pathological signs for severity. Moderate preeclampsia were managed conservatively. The outcomes were reviewed retrospectively. There were 252and 188 cases with hypertension in the two period of the study (years of 1989-91 and 1991-99) respectively. The perinatal mortality are 182‰ and 142‰ retrospectively. Also There were 5 cases of maternal mortality in 252 patients and 1 case in 188 cases in this two groups of patients. It has been achieved better outcome in cases with the classification of moderate preeclampsia by expectant management.

In order to evaluate and properly manage the cases with hypertension in pregnancy we should identify which case is at high risk. In our practice we do classify the cases with hypertension in pregnancy as follow: 1) Chronic hypertension 2) gestational hypertension (appeared in this pregnancy without proteinuria) 3) Mild preeclampsia (Hypertension less than 110 mm/Hg diastolic pressure and proteinuria >0.5 gr/L and <5 gr/L) 4) Moderate preeclampsia (Hypertension equal or more than 110 mm/Hg diastolic pressure and proteinuria less than 5 gr/L, no other clinical/laboratory signs for severity) 5) Severe preeclampsia (Hypertension equal or more than 110 mm/Hg and/or proteinuria more than 5 gr/L, and/or clinical-laboratory sign for severity such as oliguria, scotom, headache, confusion, epigastric pain, retinal haemorrhage, pulmonary oedema, HELLP syndrome) or (a moderate preeclampsia which can not be undercontrolled by antihypertensive therapy) 6) Superimposed preeclampsia 7) Eclampsia.

The cases with moderate preeclampsia, as classified above, can be managed with expectant management. At this stage of pathophysiology blood supply from mother to placenta and fetus can be achieved by increased blood pressure. The pathophysiology is not generally systemic and the organ systems of the mother are not compromised. There is no increased risk for the mother but fetal morbidity and mortality are very high in which fetal well being should be undertaken as a main approach. Another important point is that the expectantly managed pregnant should be hospitalized and followed intensively for the probability of severe form of preeclampsia which can cause severe maternal morbidity and mortality.

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