

ECLAMPSIA

Pregnancy with Convulsion and BP \geq 140/90 mm Hg Immediate Management

1 Keep women in bed with padded rails on sides, preferably near nursing station

2 Position her on left side, Oropharyngeal airway to be kept patent, Oronasal suction to remove secretions and put airway

3 Ensure preparedness to manage maternal and foetal complications

Start Oxygen by mask at 6-8 l/min, Start IV fluids-RL/ NS at 75 ml/hr

Acute hypertensive crisis

SBP \geq 160 mm Hg or
DBP \geq 110 mm Hg

Aim for SBP between 130-150 mm Hg
DBP 80-100 mm Hg.

- **Inj Labetalol** 20 mg IV bolus slowly over 1-2 min, if BP not controlled, repeat 40 mg after 10 minutes, repeat 80 mg every 10 minutes if BP not controlled (max 300 mg) with cardiac monitoring

OR

- **Inj Hydralazine** 5 mg I/V slowly over 1-2 min, if BP not controlled, repeat 5-10 mg over 2 min after 20 min. If BP not controlled again repeat 10 mg over 2 min (max 20 mg). If no response switch to other antihypertensive drug

OR

- **Tab Nifedipine** orally 10 mg stat, repeat 10-20 mg after 20 min, if BP not controlled repeat 10-20 mg after 20 min (max 30 mg). {Give through Ryle's tube if unconscious patient}. If no response switch to other antihypertensive drug

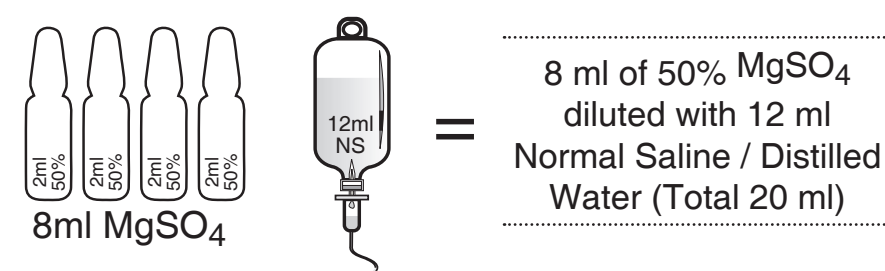
- Keep record of BP as sometimes there is sudden hypotension
- Continue B.P monitoring every 15 minutes for 2 hours after stabilization then every 30 min for 1 hour. Then every hour, if in labor or 4 hours, if not in labor

Anti Convulsants

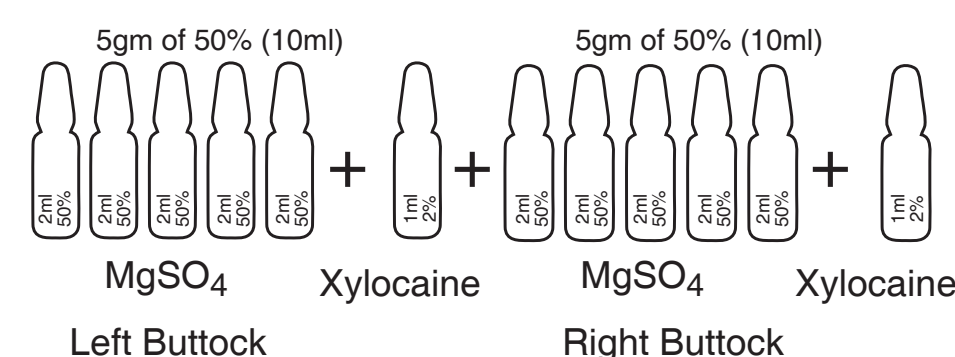
Drug of Choice - Magnesium Sulfate ($MgSO_4$)

- *Loading Dose - Total 14 gm of $MgSO_4$

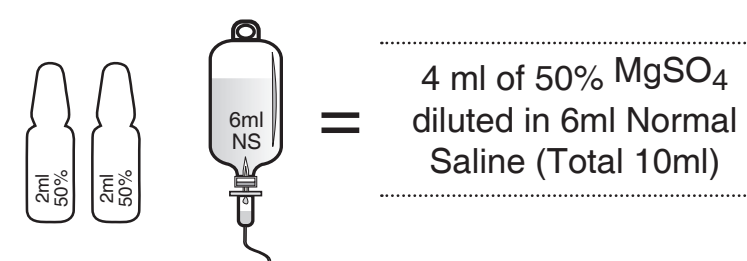
1) 4 gm of 20%, slow IV in 5 – 10 mins



2) 10 gm of 50%, deep IM (5 gm in each buttock)

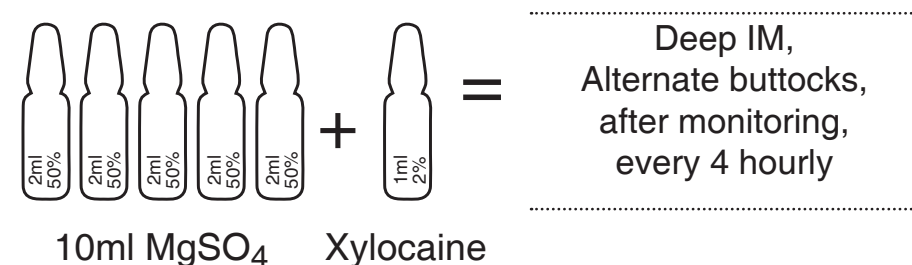


If recurrent fits after 15 – 30 mins of loading dose – repeat 2 gm 20% slow IV in 2 minutes.



*Preparation of IV loading dose with 25% $MgSO_4$: 16ml of 25% $MgSO_4$ diluted with 4ml Normal Saline/Distilled water (Total 20 ml)

- **Maintenance Dose — 5 gm IM (50%)**



If Patellar jerk absent or urine output $<$ 30 ml/hr withhold $MgSO_4$ and monitor hourly- restart maintenance dose when criteria is fulfilled

- **Monitor**

Presence of Patellar Jerks	Respiratory Rate (RR) $>$ 16/min	Urine Output \geq 30ml/hr in last 4 hours
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Continue maintenance dose till 24 hours after last fit/delivery, whichever is later

If RR $<$ 16/min, withhold $MgSO_4$, give antidote— Calcium Gluconate 1 gm IV 10 ml of 10% solution in 10 minutes

- Deliver the baby irrespective of gestational age after stabilization and reviewing investigations
- Convulsion-delivery interval should not be more than 12 hours. But can wait for vaginal delivery if patient goes in active labor within this time

Favourable Cervix
Bishop score 6 or more- Cervix soft, short, partially dilated

Unfavourable Cervix
Bishop score 5 or less- Cervix firm, long, closed

- Induction with Artificial Rupture of Membranes and Oxytocin
- 2nd stage to be cut short by Forceps/ Ventouse

- Ripening with Dinoprostone gel/Misoprostol tablet/indwelling catheter and assess after 6 hours

If platelet count is less than 30,000 (thrombocytopenia), I/M regime is contraindicated. Use I.V regimen of Zuspan: Magnesium sulphate 4g is given as IV loading dose in the beginning. This is followed by intravenous infusion of Magnesium sulphate at the rate of 1g/hour till 24 hours have elapsed after the last seizure or after delivery, whichever is later.

Manage patient in Obstetric HDU. Active management of third stage of labour is a must. Use of Methergine is contraindicated.

Supportive management:

Catheterize bladder. Monitor fluids input and output. Maintain airway, regular suction. Monitor vital signs: pulse, BP, temperature, respiration.

Indication for C-Section:

• If fits not controlled/status eclampticus • Foetal distress • Deteriorating maternal condition • Failed Induction • Any other obstetric indication

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