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# Late Onset Pre Eclampsia Presenting with Abruptio Placentae; Case Report

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**Abstract:** ***Placental abruption is a leading cause of maternal morbidity and perinatal mortality. With a placental abruption, the woman is at risk for hemorrhage and the need for blood transfusions, hysterectomy, bleeding disorders specifically disseminated intravascular coagulopathy, renal failure, and Sheehan syndrome or postpartum pituitary gland necrosis. With the availability of blood replacement, maternal death is rare but continues to be higher than the overall maternal mortality rate. Neonatal consequences include preterm birth and low birthweight, perinatal asphyxia, stillbirth and neonatal death. In many countries, the rate of placental abruption has been increasing, even with improved obstetrical care and monitoring techniques. This suggests a multifactorial etiology which is not well understood.***

## 1. Case Presentation

25 year old female, G3P1L1A1, previous spontaneous vaginal delivery 4 years back, no co morbidities in previous pregnancy. Booked and immunized pregnant women, at 28 weeks diagnosed to have GDM with OGCT value of 185mg/dl and on control with medical nutrition therapy. At 33 weeks one course of antenatal steroid prophylaxis given , at 34 weeks glycemic profile done, all pre meal values were less than 90mg/dl and all post meal value <120mg/dl. Patient monitored weekly.

At 37 weeks + 3 days patient came for ante natal care, grade 1 bilateral pitting pedal edema noted, BP 110/70mmhg, urine albumin 2+ with elevated pus cells and bacteria present. Platelets 2,28,000, FBS -78mg/dl, PPBS – 98mg/dl. Growth scan at 37 weeks normal. Patient advised to do urine C/S and come biweekly for antenatal checkup.

At 38 weeks she came to us with complains of lower abdominal pain for one hour, bleeding per vaginum for 30 minutes and absent fetal movement for 3o minutes. No history of blunt trauma to abdomen. On general examination, pallor present, grade 2 bilateral pitting pedal edema present, PR 110/minute, BP – 140/90mmHg. Obstetric examination: uterus term,, tense and tender, cephalic, fetal heart sound absent. Bed side ultrasound showed placenta fundal and antereior, Intra uterine demise with multiple retroplacental clots. Patient was planned for emergency LSCS under blood and blood product coverage. Intra operative findings: couvelaire uterus, fresh dead male baby delivered, 400 grams of retroplacental clots seen, seepage of blood into left side of broad ligament noted, continuous oozing of blood noted from muscular layer.intra operatively 2 packed cell and 4 fresh frozen plasma given. Hemostasis achieved. DT kept and abdomen closed.

Immediate post operatively, signs of disseminated intravascular coagulation noted. Prothrombin time and activated partial thromplastin time prolonged, platelets 54,000, hemoglobin 5.4g/dl, patient treated with massive transfusion of 3 point packed cell, 10 fresh frozen plasma, 2 platelets and 3 cryoprecipitates. Patient revived, stable and then discharged with anti hypertensive coverage.

**Conclusion**

Late onset pre eclampsia can present as abruptio placenta even in low risk pregnant women. Once abruption is diagnosed, patient should be given optimized treatment.

## 2. Discussion

Preeclampsia and Placental abruption are more interrelated in the complication of pregnancy. It remains one of the leading causes of maternal mortality world wide and has a profound influence on maternal and perinatal morbidity. Various factors cause preeclampsia and preeclampsia is directly associated with placental abruption and lead risk for both mother and baby. Currently there has been a change in the definition and understanding of Preeclampsia, known as Early Onset Preeclampsia (EOPE) and Late Onset Preeclampsia (LOPE). Early onset where preeclampsia occurs at <34 weeks gestational age and late onset occurring at >34 weeks of gestation.Even though the presenting features overlap, there are differences in maternal and perinatal outcome, prognosis and complications. Early and late onset preeclampsia have different aetiologies and should be considered as different disease.

The overall prevalence rate of abruption was 9.6 per 1000, of which two-thirds of cases were classified as being severe (6.5 per 1000).* Severe placental abruption was defined as a delivery with an abruption accompanied by 1 of the following maternal, fetal, or neonatal complications. Maternal complications included disseminated intravascularcoagulation, hypovolemic shock, blood transfusion, hysterectomy, renal failure, and in-hospital death. Fetal complications included non reassuring fetal status, Intrauterine growth restriction, or fetal death. Neonatal complications included neonatal death, preterm delivery, andsmall-for-gestational-age (SGA) births.

In a study done by L.Kenneth, Primigravida patients constituted 56.8% of the group, while 57.6% were graded as severe late onset preeclampsia. Median gestational age at diagnosis was 37 (34–43) weeks. 30.7% of patients experienced ≥1 major maternal complication including 34 (12.9%) cases of eclampsia. There were no maternal or early neonatal deaths. Five intrauterine deaths occurred, all due to placental abruption. The perinatal mortality rate was 18.9 per thousand births.

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