CASE PRESENTATION

Posterior reversible encephalopathy syndrome- A rare complication of severe preeclampsia

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• 23 year old Mrs X w/o Mr Y home maker by occupation belonging to low socioeconomic class with 9 months of amenorrhea,

was referred from Nalgonda govt hospital on

11-06-2015 at 10:30pm in veiw of pregnancy induced hypertension since 4 days and loss of vision since evening

•She was able to percieve fetal movements well

HISTORY OF PRESENT ILLNESS

- Patient was apparently asymptomatic 4 days back and was diagnosed as PIH 4 days back in Nalgonda govt hospital on routine antenatal checkup and was started on cap. depin 10mg bd.
- h/o headache since evening associated with vomiting 3 episodes since evening non projectile and not blood stained.

- h/o loss of vision since evening which was sudden in onset in both the eyes
- h/o of b/l pedal edema since 15 days.
- No h/o epigastric pain
- No h/o pain abdomen or tightness of abdomen
- No h/o bleeding p/v or leaking p/v
- No h/o of convulsion, no h/o of fever

MENSTRUAL HISTORY

- LMP:23-9-2014
- EDD:30-6-2015
- POG:37 weeks

- AOM:14 years
- Regular cycles
- 5/30
- No h/o passage of clots
- No h/o dysmenorrhea

MARITAL HISTORY

- 2 years of married life
- No h/o consanguinity

OBSTETRIC HISTORY

- Conceived spontaneously after 1 yr of marriage
- Diagnosed at 2 months of amenorrhoea by UPT
- 1st TRIMESTER
  - Had regular antenatal checkups
  - No h/o hyperemesis or No h/o bleeding p/v
  - Folic acid supplementation taken
  - Dating scan was done

2nd TRIMESTER

- Had regular ANCs
- Quickening felt @24 weeks of GA
- Two doses of tetanus toxoid taken at 16 wks &24 wks GA
- Iron calcium supplementation taken

• 3rd TRIMESTER:

- Had regular ANCs
- Uneventful till patient came with present complaints

PAST HISTORY

- Not a known case of DM/TB/asthma/thyroid/epilepsy/heart disease
- No h/o surgeries
- No h/o blood transfusions

PERSONAL HISTORY

- Mixed diet
- Sleep normal
- Bowel $ bladder : regular
- No addictions

- FAMILY HISTORY:
  - No h/o DM/HTN/TB/Asthma/epilepsy/thyroid/heart disease in the family
- DRUG HISTORY:
  - No h/o drug allergy

-using cap.depin10 mg bd since 4 days

GENERAL EXAMINATION

- Pt is conscious, coherent, cooperative
- Moderately built $ moderately nourished
- b/l pedal edema present
- No pallor/icterus/cyanosis/clubbing/koilonychia/ lymphadenopathy
- thyroid, breast, spine normal
- Ht: 152 cm
- Wt:65 kg
- BMI:28 kg/m2

- GC fair
- Afebrile
- PR: 85beats/min, regular in rhythm &normal in volume.
- BP: 150/100 mm of Hg in Right arm in supine position
- RR: 18cycles/min, thoraco abdominal type of respiration

SYSTEMIC EXAMINATION

CVS: S1,S2 heard, No murmurs.

RESPIRATORY SYSTEM: B/L Air entry+ normal vesicular breath sounds present

No added sounds.

CNS EXAMINATION: higher motor functions normal

b/l visual loss present .

b/l pupils normal size reacting to light .

No focal neurological deficit.

PER ABDOMEN

- On inspection : abdomen uniformly distended ovoid up to the level of xiphisternum.
- linea nigra & stria gravidarum present
- Umbilicus normal and central
- No scars and sinuses
- Hernial orifices free
- No visible pulsations & all quadrants moving equally with respiration.

palpation

- Fundal height – ut 36weeks corresponding to gestational age
- SFH: 36 cms
- Abdominal girth 36 inches
- Abdomen is irritable
- Fundal grip:soft boggy non ballotable mass felt s/o breech

•Umbilical grip: right – knob like structures felt s/o limbs.

Left umbilical grip- uniform resistance felt s/o spine

1st pelvic grip- globular hard ballotable mass felt suggestive of head

2nd pelvic grip- hands are converging suggestive of head not engaged.

Auscultation: FHS heard on left spino umbilical line. rate :148/min

Local examination:

Ext genetilia normal

Labia major and minora normal.

p/s examination : cervix and vagina healthy

PER VAGINAL EXAMINATION:

cervix soft mid postion

70-80% effaced

Internal os:1 cm

PP(vx)at -2

Membranes thin over the presenting part

•Pelvis : sp not with in reach

Sacrum well curved

ISD < average

side walls converging

outlet less than normal size

PROVISIONAL DIAGNOSIS

- Primigravida with 36 weeks of gestational age with single live intrauterine gestation in cephalic presentation with imminent eclampsia with loss of vision for evaluation.

INVESTIGATIONS

A positive.
HB- 10.1 gms %
TC- 12000/ Cumm
Platelet count : 3.3 lakh/cumm
BT-2 min
CT-4 min
Serology -NR
CUE : albumin ++
Pus cells 3 -6

- LFT- normal
- RFT- normal
- PT - 15 [10-16 sec] APTT- 32[24-33]
- LDH- 380IU/L[230-460]
- RBS:82 mg/dl

Obstetric scan

- GA:36 weeks
- BPD:8.9 cm
- FL:7 cms
- EFW:2.86 KG
- AFI:11 cm
- Placenta: anterior US Grade 3
- Doppler: normal study
- BPP:8/8

- High risk consent taken
- Packed cell & fresh frozen plasma reserved
- OPTHALMOLOGY REFERRAL DONE:

  Fundoscopy: normal study

  and advised MRI brain
- GENERAL MEDICINE REFERRAL DONE:

  advised MRI brain

•Preanaesthetic checkup was done and patient was posted for emergency LSCS

INDICATION: Primi with 36 weeks of gestational age with imminent eclampsia with cephalo pelvic disproportion in early labour with loss of vision.

INTRAOPERATIVE FINDINGS:

Lower uterine segment well formed

Bladder normal in position

Liquor clear and adequate

- Deliverd an alive female wt 2.5 kg with APGAR 8 and 10 @1:59am on 12/6/2015.
- Placenta expelled in toto and normal in morphology.
- Other intra operative findings uneventful.
- Intra operative and postoperative vitals stable

Post operative instructions

- NBM till further order
- Intravenous fluids
- Inj piperacillin and tazobactam 4.5g IV bd
- Inj metronidazole 100ml IV tid
- Inj tramadol IM bd
- Inj ranitidine iv bd
- Cap. Depin 10mg tid
- Monitor vitals
- I/ O charting

- At 10:00 am on the same day patient complained of blurring of vision
- Opthalmology referal done :

visual acuity: b/l eye counting fingers[CF]
b/l pupils normal size reacting to light

normal fundus study .

MRI brain was done.

MRI report :

MRI revealed high intensity signals involving subcortical white matter in both occipital lobes,

Diagnostic of posterior reversible encephalopathy syndrome (PRES).

- Post operative her blood pressure was controlled with atenalol 25mg and amlodipine 5mg daily
- Clinical improvement of vision was noticed with in 48 hours (POD -3)
- POD3: opthalmology referral done

  her visual acuity was found to be b/l eye 6/6

  b/l pupils NSRL and normal fundoscopy.
- Confrontation test – no scotomas.

- Post operative period uneventful
- Same treatment continued
- Suture removal done on POD-7 wound healthy.
- Pt wasdischarged on POD-9

At the time of discharge:

Tab stamlobeta 10mg od

and other routine iron and calcium supplementations advised.

- On follow after one week
- No neurological sequelae found and had normal field of vision.

THANK YOU