

Pulmonary edema: An intricate presentation of Pre eclampsia

Pulmonary edema is a rare but very serious complication of pre-eclampsia. The incidence of pulmonary edema in patients with pre-eclampsia with severe features is approximately 2.9%. Development of pulmonary edema in patients with preeclampsia warrants urgent treatment and expeditious delivery. If left untreated it can cause significant maternal morbidity and mortality. This case report details the course of a pre eclampsia complicated by pulmonary edema we encountered in our tertiary obstetric facility.

Case report :

Ms A was a 36-year-old primigravida at 25 weeks of gestation presented to the obstetric emergency with complaints of worsening shortness of breath and easy fatigability. She also reported severe frontal headache. There were no other remarkable symptoms. The patient was recently diagnosed as pre eclampsia without severe features and was commenced on oral labetalol. Upon assessment, she was found to be tachycardic (pulse 100/minute) and tachypneic (respiratory rate 32/min). Her BP was 170/100 mm Hg, SpO2 98 %, bilateral deep tendon reflexes were grade 2. Chest examination revealed bilateral basal crackles. Abdominal examination was normal apart from the gravid uterus. Lower limb examination revealed bilateral pitting pedal edema. Physician consultation was sought, Labetolol dose was stepped up and Nifedipine was added. Furosemide 40 mg was started. Obstetric ultrasound was reassuring. Antenatal steroids were administered. Echo was done which reported Mild septal hypertrophy, Normal LVE 57 %, Grade 1 diastolic dysfunction and moderate left atrial dilatation. Hematology and biochemistry were normal apart from raised LDH (332) . Protein creatinine ratio was also elevated (50). A repeat obstetric ultrasound was done which reported small for gestational age with AC at 4.7 percentile and umbilical artery doppler showing high indices to intermittently absent diastolic flow. A multidisciplinary team meeting involving the senior obstetricians, medical consultation team, cardiologist, anesthetists and neonatologist were held. Decision was taken to expedite delivery. Therefore, the patient had an emergency caesarean section with delivery of a live baby weighing 770 grams, Apgar 9,9 at 1 minute and 10 minutes and normal pH. The antihypertensives were changed to hydralazine. In the post op period, the BP became better controlled, and the chest symptoms resolved. The patient was discharged in stable condition on day 6 post op.

Discussion and Conclusion: Acute pulmonary edema is a life-threatening complication of pre eclampsia. It should be strongly suspected in pregnant women with pre eclampsia presenting with dyspnea. Furosemide should be promptly administered. Delivery should be expedited after the initial stabilization of the patient.