

Preeclampsia: The importance in our country

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Preeclampsia (PE) continues to be a serious complication of pregnancy, full of unknown things. It remains a pathology with unpredictable beginning and performance for both the mother and her child. However, significant advances have been made regarding the management and treatment of this disease. Due to the fact that the ultimate treatment of preeclampsia is the termination of pregnancy, the most important step in managing this disease remains the progress of the last twenty years in treating prematurely born neonates. In this context, the treatment of preeclampsia has the future in front of it, so with the improvement of results in the perinatal service, even in countries that are now somewhat behind.

In order to judge what weight preeclampsia has in the perinatal service we may mention: 10 to 15% of mother's deaths occur due to the preeclampsia;

This means that every year around the world, because of this intercourse, they lose 50,000 to 60,000 patients. As time passes, the preeclampsia frequency remains the same, complicating 5-7% of pregnant women. On the other hand, one in ten pregnant women passes a hypertensive episode during the pregnancy.

Preeclampsia is a medical cause for premature infants, a part of these children are also inappropriately-fed during pregnancy and show a retardation of physical development. In international literature, preeclampsia causes 10 to 25% of premature births. The trend over the years shows an increase of this figure, because prenatal service tends to protect the mother more, relying on the increased survival potential of newborns.

Preeclampsia is a high-risk disease, mainly related to the necessary examination and the cost of service to the newborn. However, investments made are less likely to prevent this disease or mitigate its progress. Prevention is still an investment of the future.

Preeclampsia is “changing its face” over the years. We do not see classic forms, like high albuminuria or exemplary edema, but the implications now affect more and more the melanoma, hemopoetic or coagulation system.

The preeclampsia definition remains more closely related to high blood pressure figures. The diagnosis for this disease is 140 systolic and 90 diastolic. We should pay attention to measurement techniques, because the patient should be in a state of well-being. The voltage should be measured 2 times every 4 hours. Proteinuria is assessed in favor of the diagnosis for quantities greater than 300 grams / 24 hours. It is accepted in favor of diagnosis also the fast weight gain: 300 mg / 24 hours.

It remains acceptable that preeclampsia is considered to be of severe form when it affects the function of the larynx, hepatic, pulmonary, cerebral and ultimately neuronal convulsions. Today in international literature it is acknowledged, that lack of albuminuria does not persist in diagnosis. In 10 patients with preeclampsia, there are no traces of albuminuria.

The level of proteinuria over 5-6 grams / 24 hours is no longer a criterion to distinguish between severe and light preeclampsia forms. Treatment of preeclampsia with magnesium sulphate is not recommended in any case. This drug should be used in specific cases such as: patients with history of several preeclampsia activity or those with symptomatology of the central nervous system. Preeclampsia often affects patients that have a certain risk factor. Among other things, when the mother is over 40 years old, the first pregnancy, the pregnancy from a new partner or the family preeclampsia history. Preeclampsia often occurs in patients who have given birth to low wight children, who have become fetomorous or who have become dyslexic in the placenta. Thrombophilia and more burdens are also included in the mother's dangers. Diabetes is a metabolic disease that is often associated with this complication. This happens more often in patients suffering from diabetic vasculopathy, as shown in the table below:

Piable classification according to white and preeclampsia

Class DM	% e Preeclamptic risks
Class B	1 1%
Class C	22%
Class D	21%
Class R	36%

From this table, we assess that the risk for preeclampsia triples for patients who are in the R class of the White classification.

In the international literature, attention is drawn to the risk that preeclampsia is repeated in the second pregnancy. This is related to the age when preeclampsia

has started the first time. If preeclampsia has started before the 27th week then 50% of patients will repeat these complications. Conversely, when preeclampsia begins after the week 37 in the first pregnancy, only one in five of the patients will be affected in the next pregnancy. These figures should be taken into account for preventative treatment or near follow-up of the risk-taking pregnancies.

Some of the traditional forms of preeclampsia treatment are now considered ineffective. For example, limiting salt does not lessen the risk. Bed regime offers possible, particularly thrombolytic, effects without affecting the softening of preeclampsia. The prescription of antioxidants does not reduce the risk of preeclampsia. The decision on when to stop pregnancy is the cornerstone of success or in dealing with this complication. There are a wide-ranging debates between the risk of premature mortality in terms of quality of life and risk of death. Because of this, they are more important than other motherhood complications, such as severe hyper blood pressure, placenta or "HELLP" syndrome.

Neonatal care should be included in the fetal health assessment. The more approaching system for fetal health is the biophysical profile. The mother should be aware of her situation by self-assessing the fetal movements.

The biophysical profile will be carefully evaluated in all its components, in order to have the result as closely as possible to the reality of fetal health. The fifth or sixth biophysical profile components can be used for:

- a. Acute fetal condition (NST, fetal respiratory movements);
- b. Long-term chronic fetal condition (amount of amniotic fluid, placental maturation rate).

Fetal growth evaluation should be taken in consideration as follows:

- A. It is recommended that the ultrasound be performed by the same physician and ultrasound apparatus.
- B. Retardation in fetal growth should be evaluated symmetrically, asymmetrically or mixed;
- C. Early retardation in fetal growth, the more likely it is its genetic origin. With the growth of pregnancy, genetic origin is almost excluded and emerge in the foreground of causes such as preeclampsia or infection;
- D. Must be differentiated between SGA and IUGR. Both of these forms of lack of fetal growth will provide babies with small or premature weight. SGA is a constant growth baby, but describes the trajectory at the end of the normal fetal growth area. IUGR is a normal growth baby up to a certain period of pregnancy and subsequently decreases growth, while also inhibiting it and consequently emerging from the normal fetal growth

area. This happens when there are complications and the first place for this occurrence is occupied by preeclampsia. Many advanced obstetric services, recommend that the growth area of the fetal population be renewed once a year or two years. This due to the evidence that fetal growth can change significantly in a few years. Fetal growth over the norm may be due to a complication of pregnancy, where in the first place is diabetes, mainly that induced by pregnancy. Regular measurement of arterial pressure is a non-invasive, classical and easily feasible form of observation of the preeclampsia performance.

Assessment through proteinuria of renal glomerulus damage can be done in some forms. What is considered most useful is the amount of urine for 24 hours and the protein eliminated for the same period. The patient is advised that the diet and especially the amount of fluids taken should not change 24 hours before the diuretic evaluation. The amount of urine along with the weight of the patient is the traditional way, but still valid as a precursor to the possible deterioration of mother and child health. The advice is:

- weigh the patient every day,
- measure the amount of urine,
- measure the protuberance of the kidney every 24 hours and the arterial blood pressure 2-4 times per day.

Preeclampsia in most cases can be treated ambulatory. Patients need no absolute bed regime, should not stop the salt and you shouldn't recommend medications for arterial blood pressure up to 160/90 figures. Medication treatment should be started at figures above this level and can be continued out patiently.

In medicament treatment should be present the fact that:

- a. Treatment should be started with a medication. If for some days we do not accomplish the goal, another should be added;
- b. Blood pressure should not be reduced immediately, but gradually;
- c. Blood pressure should be maintained between the figures 130-140 for the systolic. Adhering to these principles primarily protects the health and the fetal life, from a major risk of placental hypovolemia and fetal hypoxia.

In cases where arterial tension is rebellious or manifests pre-stroke complications, patients should be hospitalized. Magnesium should be chosen the prevention and treatment of the ecliptic crisis. The first time usage was done in 1906 and over the

years this drug carries the country deserving of this pathology. Magnesium should not be used in all preeclampsia patients, but only in complicated cases, especially for patients with cerebral symptoms such as headache, appearance, dizziness, vomiting and vomiting. Magnesium is the first line medication selected for the treatment of preeclampsia, from the beginning up to 24 hours postpartum.

The confrontation with preeclampsia requires a group work of health care workers from the family doctor, midwife, and obstetrician and in some cases nephrologists, cardiologists, neurologists and others.

Preeclampsia In SUOGJ Mbreteresha Geraldine Hospital- Observation

Every year there are hospitalized 120-370 cases of preeclampsia in the SUOGJ “Mbreteresha Geraldine” hospital. Almost half of these cases are from the city of Tirana, although the city’s population is bigger than the village. It’s been around 20 years that in every three patients, one comes from outside Tirana and among them are the most complicated patients.

TABLE I. Preeclampsia distribution Tirana / village / town.

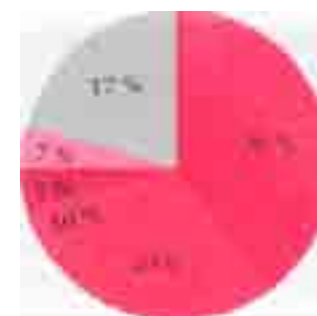
Year	Total	Tirana		Rural		District	
			%		%		%
1995	277	164	59	76	27	37	13
							8
1997	219	78	36	85	39	56	26
1998	164	71	43	53	32	40	24
1999	130	58	45	45	35	27	21
2000	123	63	51	34	28	26	21
2001	103	62	60	28	27	13	13
2002	132	44	33	43	33	45	34
2003	173	56	32	56	32	61	35
2004	129	42	33	56	43	31	24
2005	369	130	35	116	31	123	33
2006	195	69	35	74	38	52	27
2007	216	95	44	83	38	38	18
						49	21
2009	192	72	38	82	43	38	20
2010	227	83	37	77	34	67	30

2011	234	92	39	73	31	69	29
2012	206	75	36	57	28	74	36
			29				

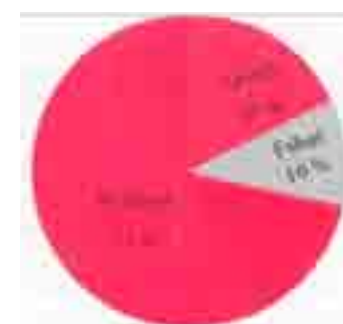
National mortality in the SUOGJ “Mbreteresha Geraldine” hospital in the last 20 years it has had constant decrease. From 1995-2014 we have lost 30 patients in this hospital, of whom 1/3 because of the preeclampsia and in the second place is hemorrhage.

GRAF 1. Local mortality (1995 – 2014)

- Preeclampsia Hemorrhage
- Heart disease
- IRA
- Other Leucosis



GRAF 2. Local mortality (where do this patients come from)



It’s been years since we started involving the patient and spouse in decision-making. This desire and obligation of doctors in our hospital is also improved because of the following reasons:

- cultural growth of the population;
- the ability of the population to be informed,
- the opportunity to choose the doctor and service he wants, public or private healthcare system.

In the future, this trend will have the necessary ground to be furtherly improved.

Preeclampsia remains a disease which requires many actresses and factors to improve the results in its treatment. At the local level, it would also be beneficial for the treatment of the preeclampsia to organize a reference system.

In this way, they would find a more accurate and more relevant response to any obstetric service, in the following questions:

- A. Which type of patients do we have to treat? (Every service should be determined based on the results and the possibilities it has, to what extent a patient should be treated by him. This assessment should be made for the mother, but mainly for the future of fetal maternity.
- B. Each service should determine what level of complications a pregnant patient should be transferred.
- C. The third step in the referral system is where to transfer a patient. Generally, transference is performed in a parallel or higher level service.
- D. Finally, how should transportation be performed and whose responsibility is it. This transfer is related to the selection of the staff that will accompany the patient and the means of transport. In a preliminary agreement, transportation may be the responsibility of the hospital where the patient or the hospital he/she will go to. Here is not excluded the possibility of personal car transports.

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Coexistence of Psychiatric Symptoms and Chiari Type I Malformation - A Case Report

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Abstract

Introduction: Chiari type I malformation has been described infrequently in association with defined psychiatric syndromes. **Method:** There is a limited literature about obsessions in comorbidity with Chiari malformation. It is described a case of an adolescent with obsessive compulsive disorder and Chiari I malformation and it is reviewed the literature regarding Chiari I malformation and psychiatric disorders. The child came to the attention of child psychiatrist at the age of 7 years old when he manifested developmental delay and various kinds of behavioral symptoms. He was followed up at the age of fifteen when he developed obsessions and upon MRI was identified a Chiari malformation type I. **Discussion:** This paper discusses the likely under recognized co-occurrence of Chiari malformation and psychiatric symptoms. Currently available data from case reports associate Chiari I malformation with a variability of psychiatric symptoms: autism spectrum disorder, bipolar disorder, seizures, developmental delay, generalized anxiety disorder, panic attacks, Tourette's syndrome, OCD, ADHD, cognitive disorder NOS and psychosis. It is concluded that mixed psychiatric symptoms and developmental delay might be a more common finding in comorbidity with Arnold Chiari type I malformation.

Keywords: case report; obsessions; Arnold Chiari type I malformation; coexistence