PREEKLAMSIA: TERMINASI ATAU EKSPEKTATIF

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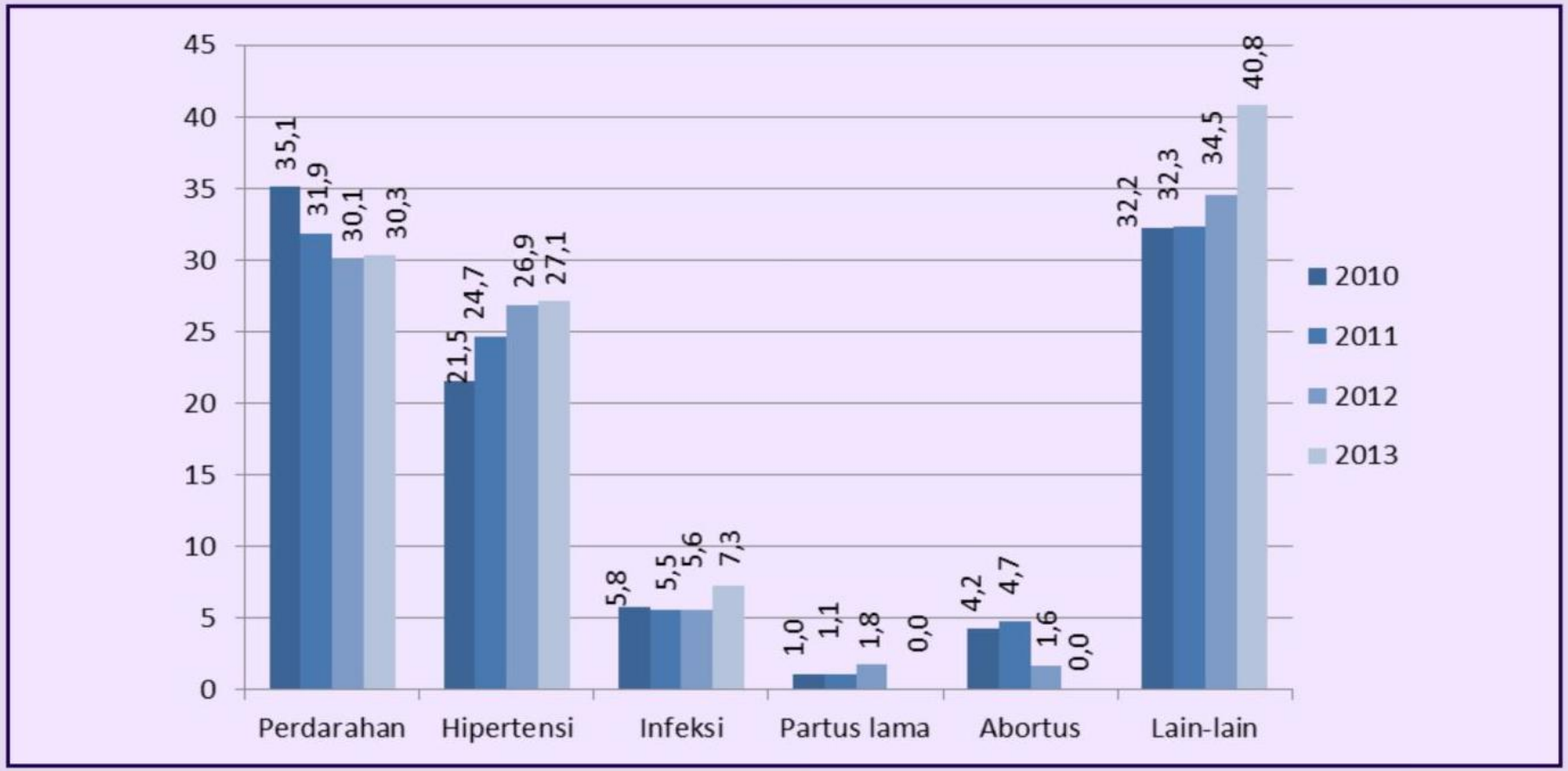
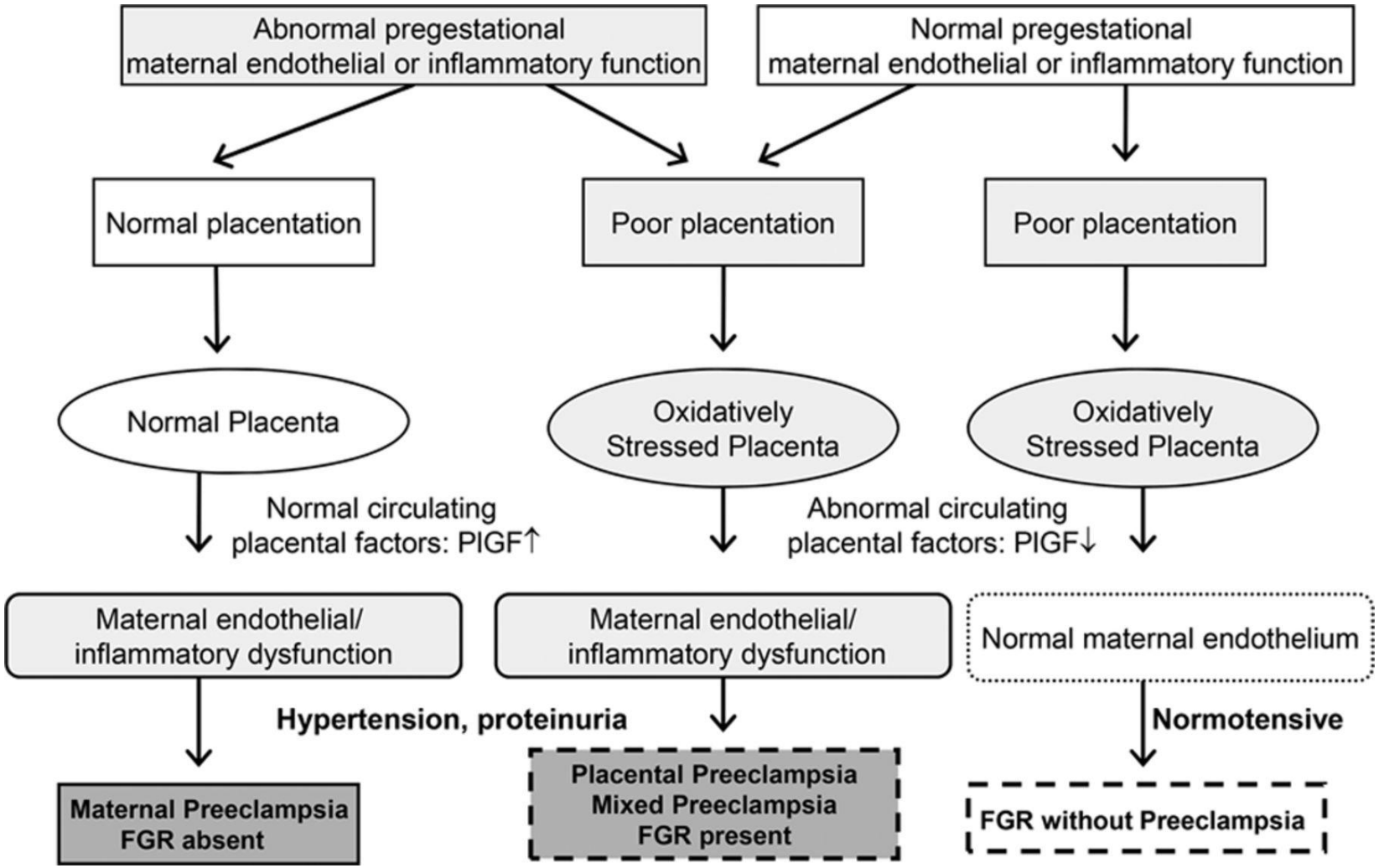
CAUSES OF MATERNAL MORTALITY @ INDONESIA

Gambar 2. Penyebab Kematian Ibu Tahun 2010-2013



Sumber : Direktorat Kesehatan Ibu, 2010-2013

A model of extended definition of preeclampsia on the basis of placenta-derived biomarkers



Anne Cathrine Staff et al. Hypertension. 2013;61:932-942

Revisi definisi preeclampsia (ISSHP 2014)

Hypertension developing after 20 weeks gestation and the coexistence of one or more of the following new onset conditions:

1. Proteinuria
2. Other maternal organ dysfunction:
   - renal insufficiency (creatinine ≥90 umol/L)
   - liver involvement (elevated transaminases and/or severe right upper quadrant or epigastric pain)
   - neurological complications (examples include eclampsia, altered mental status, blindness, stroke, or more commonly hyperreflexia when accompanied by clonus, severe headaches when accompanied by hyperreflexia, persistent visual scotomata)
   - haematological complications (thrombocytopenia, DIC, haemolysis)
3. Uteroplacental dysfunction
   - foetal growth restriction

Atypical Preeclampsia-eclampsia

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Table 1. Atypical preeclampsia (4)

Gestational hypertension plus
Mild symptoms of preeclampsia
Thrombocytopenia
Elevated liver enzymes
Proteinuria plus
Hemolysis
Thrombocytopenia
Elevated liver enzymes
Early preeclampsia at <20 weeks
Late postpartum preeclampsia/eclampsia
HELLP, ELLP, and EL syndromes

ACOG executive summary on hypertension in pregnancy, Nov 2013

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1. The term "mild" preeclampsia is discouraged for clinical classification. The recommended terminology is:
   a. "**preeclampsia without severe features**" (mild)
   b. "**preeclampsia with severe features**" (severe)

2. Proteinuria **is not** a requirement to diagnose preeclampsia with **new onset** hypertension.

3. The **total** amount of proteinuria > 5g in 24 hours has been eliminated from the diagnosis of preeclampsia with severe features.

4. **Early** treatment of **severe** hypertension is mandatory at the threshold levels of **160 mm Hg** systolic or **110 mm Hg** diastolic.

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Paradigma Kewaspadaan

- Preeklampsia sangat dinamis dan progresif
- Pasif => lebih waspada =>Aktif
- Jangan terlena dengan “preeklampsia ringan”
- TD level ringan sampai sedang (140-159 mmHg sistolik dan atau 90-100 mmHg diastolik) => EVALUASI/ PANTAU KETAT
- Konsensus Fetomaternal terapi pada tensi 140/90 mmHg => pertimbangan akses terhadap fasilitas

Do not wait when a patient has severe-range hypertension!

- Acute onset, persistent (lasting 15 min or more), severe systolic (≥160 mm Hg) or severe diastolic hypertension (≥ 110 mm Hg) or both in pregnant or postpartum women with preeclampsia/eclampsia constitutes a **hypertensive emergency*** and it is inadvisable to wait 4 hours for treatment.

*Emergent Therapy for Acute-Onset, Severe Hypertension With Preeclampsia or Eclampsia, ACOG Committee Opinion, # 514, December 2011

- Pengurangan Stres
  - komponen TD ibu adalah adrenergik
  - minimalkan rasa tidak nyaman ibu
  - beberapa komponen
    - ruangan tenang, tidak terlalu terang, terisolasi
    - protokol tatalaksana terencana dengan baik
    - penjelasan rencana dengan jelas pada pasien/keluarga
    - minimalkan rangsangan
    - pendekatan tim yang konsisten dan meyakinkan

      ✓**bidan/**perawat, obstetri, anestesi, hematolog, dr. Anak

- Penilaian Keadaan Ibu – Laboratorium
  - Hematologi
    - hemoglobin, platelet, apusan darah
    - PTT, PT(INR), fibrinogen, FDP
    - LDH, asam urat, bilirubin
  - Hepatik
    - SGPT-SGOT, LDH
    - (glukosa, amonia terhadap *R/O AFLP*)
  - Ginjal
    - proteinuria
    - kreatinin, urea, asam urat
    - Jumlah urin 24 jam

Preeclampsia early recognition tool

ASSESS	NORMAL (GREEN)	WORRISOME (YELLOW)	SEVERE (RED)
Awareness	Alert/oriented	•Agitated/confused •Drowsy •Difficulty speaking	•Unresponsive
Headache	None	•Mild headache •Nausea, vomiting	•Unrelieved headache
Vision	None	•Blurred or impaired	•Temporary blindness
Systolic BP (mm HG)	100-139	140-159	≥160
Diastolic BP (mm HG)	50-89	90-105	≥105
HR	61-110	111-129	≥130
Respiration	11-24	25-30	<10 or >30
SOB	Absent	Present	Present
O2 Sat (%)	≥95	91-94	≤90
Pain: Abdomen or Chest	None	•Nausea, vomiting •Chest pain •Abdominal pain	•Nausea, vomiting •Chest pain •Abdominal pain
Fetal Signs	•Category I •Reactive NST	•Category II •IUGR •Non-reactive NST	•Category III
Urine Output (ml/hr)	≥50	30-49	≤30 (in 2 hrs)
Proteinuria (Level of proteinuria is not an accurate predictor of pregnancy outcome)	Trace	•> +1** •≥300mg/24 hours	
Platelets	>100	50-100	<50
AST/ALT	<70	>70	>70
Creatinine	<0.8	0.9-1.1	>1.2
Magnesium Sulfate Toxicity	•DTR +1 •Respiration 16-20	•Depression of patellar reflexes	•Respiration <12

- **Penilaian Keadaan Janin**
  - **Gerakan janin**
  - **Penilaian denyut jantung janin -NST**
  - **Ultrasonografi untuk perkembangan**
  - **Profil biofisik**
  - **Indeks cairan amnion (AFI) atau AFV**
  - **Pemeriksaan Doppler arus darah : tali pusat, a.cerebri media**

Key clinical pearl

In patients with
preterm preeclampsia with severe features,
the disease can rapidly progress to significant
maternal morbidity and/or mortality.

Terminasi atau Menunda??

Expectant management in pregnancies with preeclampsia with severe features 24-34 weeks

Expectant management recommendations:

With stable maternal/fetal conditions, continued pregnancy should be undertaken only at facilities with adequate maternal and neonatal intensive care resources

Administer corticosteroids for fetal lung maturity benefit

ACOG Executive Summary: Hypertension in Pregnancy. Obstet Gynecol 2013;122:1122-31

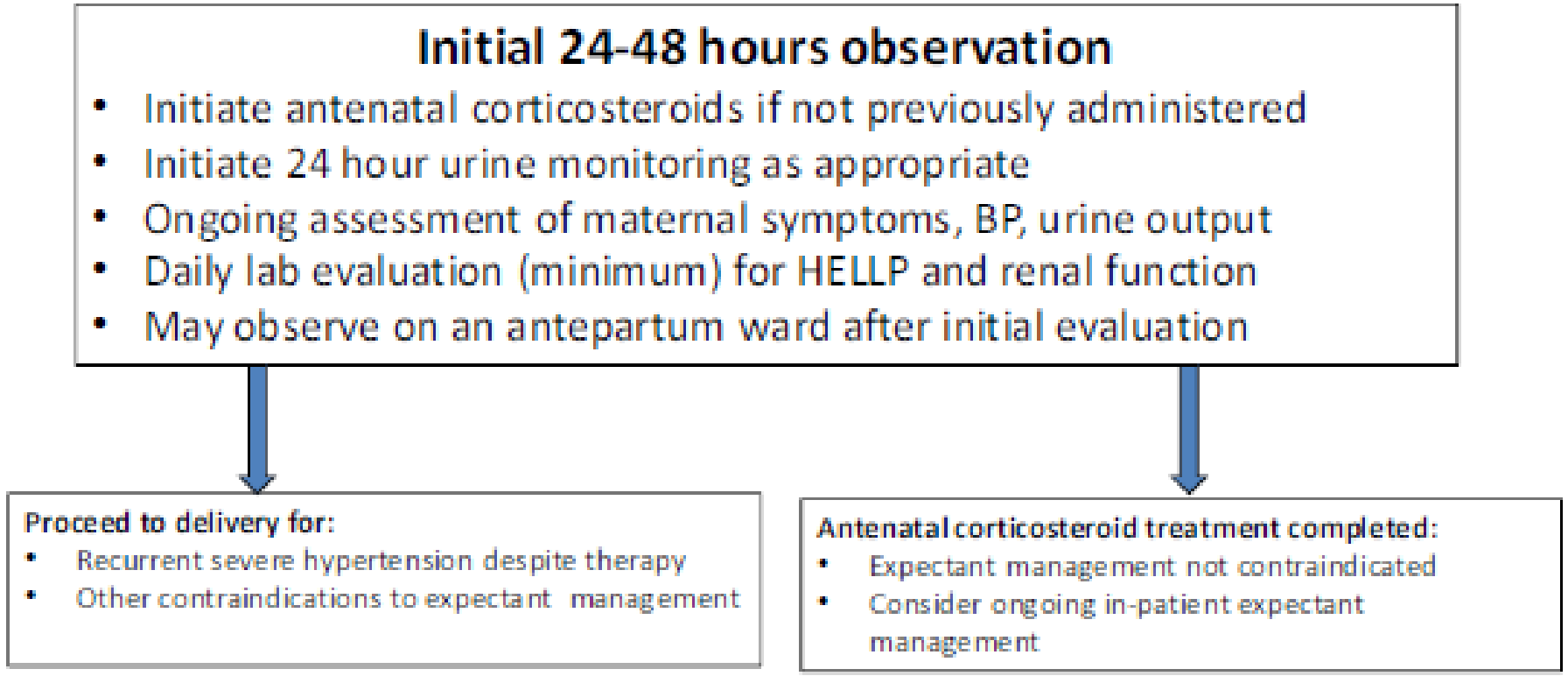
Expectant management of pregnancies with preeclampsia < 34 weeks gestation

Maternal Stabilization refers to:

- Seizure prophylaxis
- BP control
- Adequate maternal cardio-pulmonary function

- AND
  - Consultation with:
    - NICU
    - MFM
    - Anesthesia and/or
    - Critical care services

Management of suspected preeclampsia with severe features< 34 weeks gestation



Adapted from Sibai BM. Evaluation and management of severe preeclampsia before 34 weeks' gestation. American Journal of Obstetrics & Gynecology, September 2011, pg. 191-198.

- Kapan Persalinan Dilakukan
  - ≥37 minggu dengan hipertensi gestasional
  - ≥34 minggu dengan hipertensi gestasional berat
  - <34 minggu dengan:
    - TD diastolik yang sulit dikontrol dengan menggunakan obat antihipertensi
    - bukti lab (↓ platelets atau ↑ LFT, proteinuri berat), adanya keterlibatan multi-organ yang memburuk, waalupun TD terkontrol
    - dugaan gawat janin
    - kejang tidak terkontrol, berulang
    - gejala tidak responsif terhadap terapi yang sesuai

ACOG task force recommendations

- For women with gestational hypertension, less than 160/110 or preeclampsia without severe features at or beyond 37 0/7 weeks of gestation, delivery rather than continued observation is suggested.

Ref: Koopmans CM, et al. Induction of labour versus expectant monitoring for gestational hypertension or mild preeclampsia after 36 weeks gestation. (HYPITAT). Lancet 2009;374:979-88

- Persalinan- Pengobatan
  - Persalinan disaat tepat meminimalkan morbiditas dan mortalitas ibu maupun neonatal
  - Mengoptimalkan status ibu sebelum intervensi persalinan
  - Tunda persalinan untuk mendapatkan maturitas janin dan lakukan rujukan hanya jika kondisi ibu dan janin memungkinkan
  - Hipertensi gestasional merupakan penyakit progresif, manajemen konservatif potensial berbahaya bila terdapat penyakit bertambah berat atau dugaan gawat janin

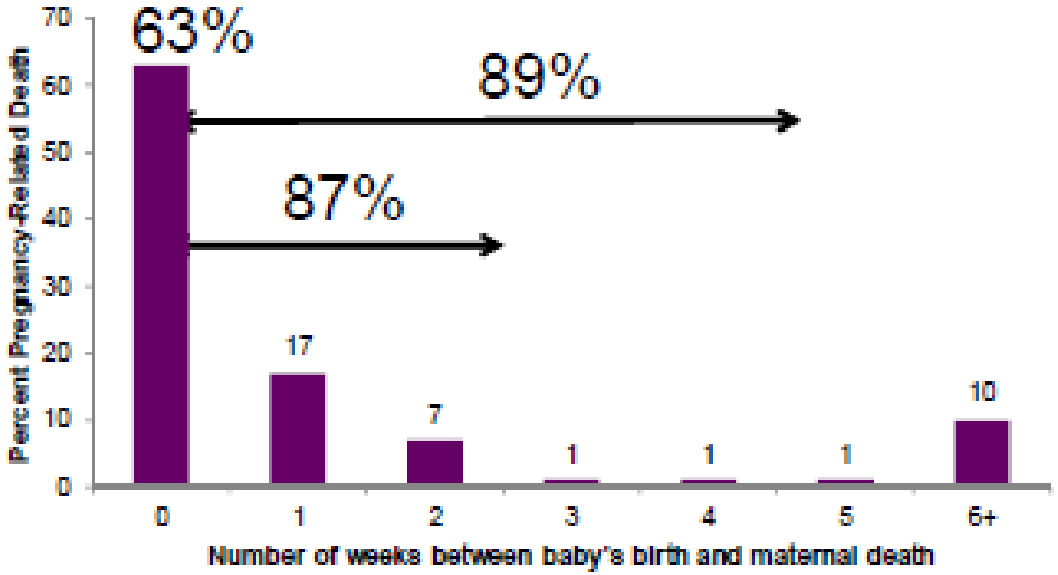
- Tatalaksana Peri- dan Postpartum
  - jangan turunkan TD terlalu rendah karena berisiko gawat janin
  - jangan berikan cairan berlebih
  - analgesi epidural lebih dipilih bila ada koagulopati atau jumlah platelet yang rendah
  - pendekatan multispesialisasi
  - pasca persalinan → pasien harus dimonitor

Eclampsia: Maternal-perinatal outcome in 254 consecutive cases over 12 years

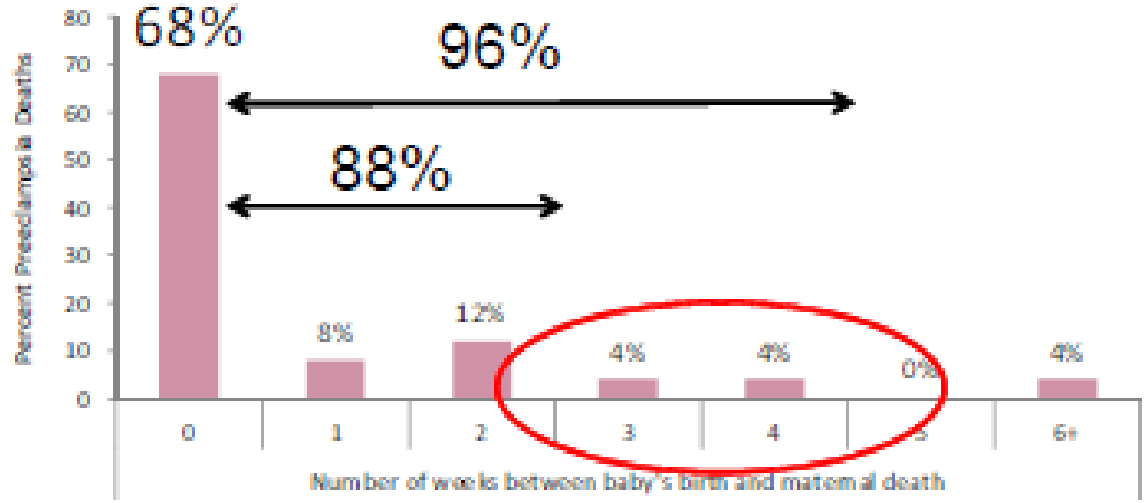
- 73 (29%) occurred postpartum.
- Over half of postpartum cases, (40 cases/16%) occurred in the late postpartum period (>48 hrs)
- 18 of these 40 cases were normotensive; all 18 had symptoms of headache or visual disturbance

Sibai BM. Eclampsia VI. Maternal-perinatal outcome in 254 consecutive cases. Am J Obstet Gynecol Sep 163(3):1049-1054; discussion 1054-1065 1990.

Timing of pregnancy-related deaths
CA-PAMR, 2002 to 2004



Non-Preeclampsia Deaths (n=129)



Preeclampsia Deaths (n=25)

ACOG task force recommendations post partum hypertension and preeclampsia

- For women in whom GHN,PE, or superimposed PE is diagnosed, it is suggested that BP be monitored in the hospital or equivalent outpatient surveillance be performed for at least 72 hours postpartum and again 7-10 days after delivery or earlier in women with symptoms.

Kesimpulan

Waktu yang tepat untuk pengakhiran kehamilan pada preeklamsia sangat tergantung pada berbagai faktor dengan target utama keselamatan ibu, dan kesejahteraan janin yang optimal.