A Case of Postpartum HELLP Syndrome

A 37-year-old primigravida was referred from the antenatal clinic with a provisional diagnosis of pre-eclampsia in view of severe frontal headache, high blood pressure and proteinuria. There was no history of visual disturbance or epigastric pain. The woman was at 30 weeks gestation. She was booked at 13 weeks and commenced antenatal visits at 18 weeks gestation. She had an anomaly scan at 22 weeks, which detected no abnormalities. She was diagnosed with Gestational Diabetes at 27 weeks gestation, which was controlled with diet. On examination, blood pressure was 188/119. There was pedal oedema and peri-orbital puffiness with exaggerated reflexes. On abdominal examination, the uterine size was equivalent to 30 weeks gestation. The fetus was in longitudinal lie and cephalic presentation. Cardiotocography was reassuring. Labetalol 200mg was administered. Urinary protein dipstick revealed 3+ protein. Betamethasone 12mg IM was given. Input/output monitoring was commenced and Magnesium Sulphate (MgSO4) was given. Blood was sent for full blood count, liver function, renal function tests and clotting screen which revealed normal values. Uric acid was 388g/dl and urinary protein/creatinine ratio was 180.

In view of these symptoms, a decision for emergency caesarean section was made. A live female baby was born. The woman was transferred to Intensive care unit (ICU) for monitoring, where labetalol infusion and MgSO4 continued. She was transferred later to postnatal ward in good condition. Twenty-four hours later, she developed headache and epigastric pain. Her blood pressure increased to 200/100. Her liver enzymes showed a rapid increase with an excessive fall of her platelets. She was transferred to ICU where labetalol infusion was administered was commenced. On day two, her symptoms improved and blood pressure was controlled. Her liver enzymes decreased and platelets increased and was transferred back to postnatal ward. She was discharged on day 12 postoperatively on oral labetalol with a plan to be seen in the Gynaecology clinic again after 3 months. HELLP syndrome is a multisystem disease, characterized by haemolysis, elevated liver enzyme levels and a low platelet count1,2. The condition develops in 10%-20% of cases of severe pre-eclampsia/eclampsia and it is associated with substantial risk for the mother and her foetus. Early diagnosis and management of this condition is important. The postpartum management of HELLP syndrome is mainly supportive requiring a multidisciplinary team 3. The course is often sudden and fulminant. Usually the only symptom of this syndrome is epigastric pain as in our patient, which is assumed to be due to stretching of Glisson's capsule. However, such non-specific abdominal symptom may lead to diagnostic delay.

Very few cases of HELLP syndrome in the postpartum period have been reported. Literature review reveals one case in which a primigravida twin pregnancy developed HELLP syndrome following caesarean section which later on got complicated by DIC and she died due to multiorgan failure2. Another case has been reported where a primigravida developed HELLP syndrome after delivery and
developed acute renal failure. Fortunately our patient did not develop any complications and had a smooth recovery post ICU but timely diagnosis and multidisciplinary management is the key.

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References: