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A preventable death

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Background & Aim: A 25 years old woman, 20 weeks pregnant, consults with her general practitioner for high blood pressure and occasional sight disorder alterations.Medical history: Non-smoker, no other toxic habits, fetal demise in the 25th week without known cause. RH A positive. Clinical examination: Good general health, blood pressure 146/95 mmHg. First trimester screen without disorders. Edema in lower limbs.
Method: Blood analysis: Haemoglobin 11.7, haematocrit 35.1%, platelets 137 x10e9/L. 24-hour urinary protein: 735mg. Anticardiolipin antibodies and anticoagulant lupic are both negative. Abdominal ultrasound and Doppler: fetal hypoxia (fetal estimate weight 236g, without telediastolic flow in umbilical artery). She was treated initially with labetalol but no decrease in blood pressure values, slight improvement of the patient and the high risk to maternal and fetal health, it was proceeded by an abortion, prior consent of the couple and subsequent prevention with labetalol and aspirin.
Results: Diagnosis: Early severe intrauterine growth restriction (IUGR) with Doppler type III/IV in the early onset severe preeclampsia context. Differential diagnosis: Pregnancy-induced hypertension, HELLP syndrome, Eclampsia.
Conclusions: Pre-eclampsia occurs in about 10% of obstetric pathology with variable clinical expression that determine prognosis. Preeclampsia usually occurs after 32 weeks; however, if it occurs earlier it is associated with worse outcomes. Therefore, routine screening is important during first trimester prenatal performed in primary care in order to prevent maternal morbidity and mortality for both and to assess cardiovascular risk of women as hypertension during pregnancy is an early marker of essential hypertension and cardiovascular disease and kidney later in life. This promotes recommendations related to healthy lifestyles, reporting recurrence risks /fetal mortality in subsequent pregnancies.