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Biography

Hina Bajwa, is a Specialty Registrar in Obstetrics and Gynaecology at Somerset NHS Foundation Trust, England. She holds MBBS and FCPS qualifications in Obstetrics and Gynaecology, with MRCOG Part 1, reflecting her commitment to achieving the highest standards of clinical excellence. Prior to her current role, she gained broad NHS experience at Yeovil District Hospital and Lancashire Teaching Hospitals. Before moving to the UK, Dr Bajwa practiced extensively across government and private hospitals in Pakistan following her fellowship training.

Severe Pre-Eclampsia at the Extremes of Prematurity: Two Case Reports Highlighting Atypical Presentations and Clinical Decision-Making

Abstract

Background: Pre-eclampsia (PET) affects 2–8% of pregnancies worldwide and remains a leading cause of maternal and perinatal morbidity and mortality. Early recognition is challenging when presentations deviate from classical patterns. Ensuring compliance with national guidelines is essential to reduce complications. This case series was presented at a departmental teaching session to highlight atypical presentations of severe PET at extreme preterm gestations, promote learning from practice, and reinforce key management principles in line with RCOG guidance.

Aim: To present two cases of severe pre-eclampsia with atypical features managed at extreme preterm gestation, focusing on: (1) biomarker utility (PIGF / sFlt-1: PIGF ratio), (2) multidisciplinary escalation, (3) individualized antihypertensive choices, and (4) timing of delivery decisions. Are-audit and ongoing staff education are planned to monitor improvements in care standards.

Case 1 Summary: A 33-year-old primigravida with a background of possible essential hypertension (previously on two Antihypertensives, self-discontinued three years prior) and mild asthma. Booking BMI 33. At 29+2 weeks she presented with BP 180/112 mmHg, epigastric pain, and headache. Initial PET bloods were normal; PIGF 309 pg/mL. Management included labetalol (later stopped due to asthma), nifedipine, methyldopa, IV hydralazine, MgSO₄ (stopped at 17 hours; restarted due to ongoing headache and blurred vision), corticosteroids, and continuous CTG. Echo showed concentric left ventricular hypertrophy. CT venogram and MRI pituitary demonstrated likely physiological pituitary enlargement only. Due to uncontrolled BP and neurological symptoms, emergency Category 1 Caesarean section was performed at 30 weeks. A live male infant was born weighing 1340g (7.9th centile), APGARs 3/9/10.

Case 2 Summary: A 26-year-old primigravida (G0P1) with learning difficulties, depression, PTSD, asthma, and current smoking. Booking at 10+6 weeks, BMI 32.8, BP 120/65 mmHg. Low-risk PET

screening. Anomaly scan at 23+4 weeks (delayed due to DNA): all long bones and EFW <3rd centile; umbilical artery Dopplers normal. Patient declined tertiary referral. At 26+4 weeks: EFW 616g (0.1st centile), absent end-diastolic flow, reversed ductus venosus a-wave, reduced liquor, PlGF <12 pg/mL. Patient reported several days of vomiting, upper abdominal pain, swollen ankles and shortness of breath. On admission: BP 194/130 mmHg, HR 127. Clonus positive. Falling platelets raised concern for developing HELLP syndrome; rising creatinine noted. Labetalol avoided (asthma); IV hydralazine commenced then stopped due to hypotension; nifedipine and MgSO₄ given; benzyl penicillin and corticosteroids administered. Fluid restricted to 85 mL/hr. Emergency Category 2 Caesarean section at 26+5 weeks: live male infant 600g (0.0 centile), transferred to Newport Hospital NICU. Post-operative BP 129/73 mmHg, platelets 315, coagulation normal.

Conclusion: Both cases highlight that severe pre-eclampsia may present atypically at extreme preterm gestations, with epigastric pain, edema and rising BP even without significant proteinuria. A low threshold for investigation is essential.