

Data Said to Favor Treating Mild Preeclampsia

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SAN FRANCISCO — Experts have clashed in the past few years over whether to treat mild preeclampsia, but the data support treatment, Dr. William M. Gilbert said at a meeting on antepartum and intrapartum management sponsored by the University of California, San Francisco.

There's widespread agreement that giving magnesium sulfate to pregnant women with severe preeclampsia is beneficial. Until recently, however, studies grouped together patients with any severity of disease or focused exclusively on severe preeclampsia.

One medical journal took the unusual step in 2003 of publishing a randomized,

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controlled trial of magnesium sulfate for mild preeclampsia despite the study being underpowered to show statistical significance. The 220-patient study found no difference in outcomes (Obstet. Gynecol. 2003;101:217-20). The editors

emphasized that a large, randomized, controlled trial should be undertaken to see if treatment would benefit patients with mild preeclampsia, "which is most of the disease we see," said Dr. Gilbert, professor of obstetrics and gynecology at the University of California, Davis.

That led to a 2004 editorial in another journal saying that previous studies that had addressed either only severe preeclampsia or all levels of preeclampsia combined did not show a decrease in the risk of maternal or neonatal morbidity after magnesium sulfate treatment.

"I would disagree with that statement entirely," commented Dr. Gilbert. The editorial argued that because the significance of the 2003 study on mild preeclampsia was not clear, magnesium sulfate should not be given routinely to patients with mild preeclampsia (Am. J. Obstet. Gynecol. 2004;190:1520-6).

That editorial put clinicians in a tight spot—damned if they treated mild preeclampsia, damned if they didn't treat it and patients had strokes, seizures, or other adverse outcomes, Dr. Gilbert said.

To the rescue came a 2006 study from a hospital that gave magnesium sulfate to all preeclamptic patients for a 5-year period and then treated only severe disease in the following 4.5 years. The incidence of eclampsia more than doubled and the risk of maternal or neonatal morbidity secondary to seizures increased when patients with mild preeclampsia went untreated, compared with treating all preeclampsia (Obstet. Gynecol. 2006;108:826-32).

Among the 6,431 women with preeclampsia in the second half of the study, 1 of every 358 women treated for severe preeclampsia developed seizures,

compared with 1 of every 92 women with untreated mild preeclampsia. The study found no serious toxicity from magnesium sulfate treatment.

"Women with mild disease who did not get magnesium sulfate had a much higher risk than women with severe disease who got magnesium," Dr. Gilbert noted.

Before treating, be sure you've got a diagnosis of preeclampsia, which requires a consistently elevated blood pressure and ruling out other causes of high blood

pressure, he added. Some clinicians treat prematurely based on one reading that shows mildly elevated blood pressure, when taking a second reading between contractions or giving an epidural dose will lower the blood pressure reading to normal ranges.

On the other hand, "If I have a woman who comes in with a blood pressure of 220/120 mm Hg, I'm not going to wait 6 hours to get a second reading," but will go ahead and start magnesium sulfate, he said.

Magnesium sulfate treatment traditionally has been continued for 24 hours after delivery because about a third of women with preeclampsia will seize post partum, usually within the first 24 hours. A randomized study of 200 patients found, however, that 12 hours of postpartum treatment was as good as 24 hours in patients with mild disease—those with relatively lower blood pressures and no gestational diabetes (Obstet. Gynecol. 2006; 108:833-8). ■

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