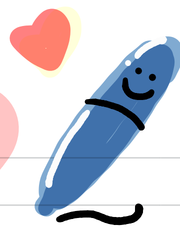
notes Dr. Abdelfattah



Convulsions

→ **Eclampsia**: if pregnant. should be considered as eclampsia till aproved othe-wise

* if controlled → ABC, decrease BP (labetelol 250 mg)

نستخدم 50 بعد 10 m نستخدم 50 ... للسيطرة عليه

or (hydralazine 10 mg) (IV) ✗ ما نعطي بكمية ضخمة

--- 5 or less ← 10m بعد 5mg نعطي

* if fulminating → fits

1st choice → MgSO4 (always give lowest dose)

if still Not responding → 4 g very slowly (5-10 m)
→ increase the dose (don't give all 6g دفعة وحدة 😵)
(1g / h) → وبنعطي ال 24h بعد الولادة او بعد ال fit ✓

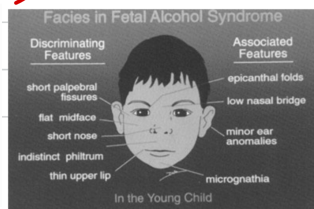
don't forgive follow-up (urine output .... etc) #

→ **epilepsy**:

① مشكلة: أغلب الأهل عارفين وبحكو او مابحكو
② ما فيه anti-epileptic drug مبرأ من العيوب :
(all cross placenta → affect baby)

Phenytoin syndrome
(anti-epileptic syndrome)
└ IUGR, cleft lip palate, cardiac anomalies ...

P — Cleft Palate, Cleft lip
H — small Head, Hypoplastic face, Hirsutism, Heart defects
E — Embryopathy, Anti Epileptic use
N — Hypoplastic nails and digits, Neurologic defects



* اذا كانت المريضة More than one drug توخذ
يلزم أمشيها على نوع داله فقط
لتفادي المشاكل

* to control the fit → Phenytoin أفضلهم الـ

20mg/kg/day (IV) → cause necrosis in vein (very high alkaline)

1. should be given w/o dilution
2. slowly
3. in average 50 mg/min
4. arrthmya on ECG

groups

enzyme inducing

Phenytoin

1. should be continue follow-up to prevent → fits
2. during pregnancy → (w/ N&V) // ↑ plasma volume → تقبلها للدوا بقل

, so we should do adjustment for dose #

3. all cross placenta
4. last 4 weeks you should give vit K (لازم)

1 mg و أول ما ينولد البيبي نعطيه

5. here, if you want to give combined OCPs → لازم نزود الـ dose (نعطي عيار أعلى)

ex: 50 Microgram ethinyl estradiol.

ex: Medroxy progesterone acetate (every 12 w.) 3 شهور
every 10 w. بصير أعطيها مثلاً

بما انه قلت الـ efficacy

so, هنعدل أحسن طريقة الهم نعطيهم Mirena (IUD) → avoid passage -- local فبشتغل

Non-enzyme inducing

Sodium valporate → ادوش دواء (cause neural tube defect)

* folic acid (5Mg) decrease the effect of Phenytoin

- There is tendency for early epilepsy in fetal & Maternal 3% & Congenital anomalies 3%

Management Tips for Pregnant Women with Epilepsy

- **Monitoring phenytoin levels**: Regular monitoring ensures therapeutic levels are maintained, preventing breakthrough seizures despite folic acid supplementation.
- **Folic acid supplementation**: Women on phenytoin are advised to take **higher doses of folic acid** (e.g., 4-5 mg/day) to reduce the risk of congenital anomalies.
- **Risk-benefit balance**: The benefits of controlling seizures during pregnancy often outweigh the risks associated with AED use, but careful monitoring is essential.

→ **Multiple sclerosis** : Not auto-immune disease

→ ttt : Cortisol

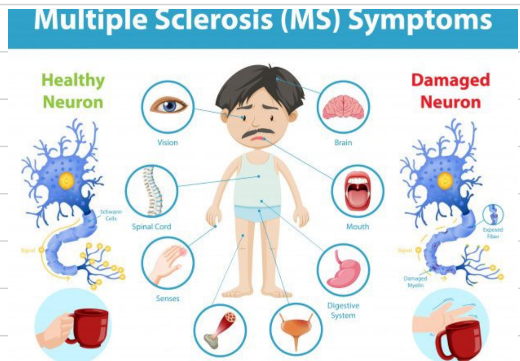
in Pregnancy → ↑ Cortisol ٿ

(so, Mostly flare up Not occur in Pregnancy #

* Cortisol decrease in 3rd trimester

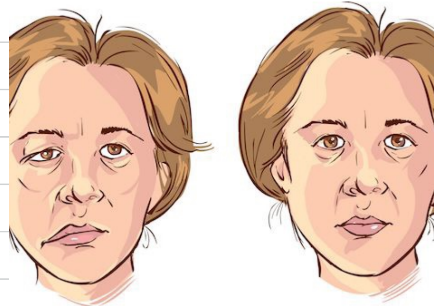
* Beta interferon :- بتظل مستمرة عليه حتى مع الحمل

safe ٿ
↳ during Pregnancy & Breast feeding



→ **Myasthenia graves** : auto-immune disease

- 2 organs Not affected (heart & uterus)
  - one Pace Maker (heart), 2 Pace Makers (uterus)
  - ↳ both has Pace Makers
- anti-bodies cross Placenta
  خاصًا ال Thymus بتهم كبيرة



ttt : Cholenestrase i (neostigmine)
↳ if you give overdose → رح يقلب الموضوع
pupile Constrict ← atropine نعطي ال
(Miosis)

for diagnostic : Edraphonium
لأنه → short acting
- IV
وبتكون تحسن في ثواني

لازم نستخدم forceps or vacuum بنفس مش ان تقدر straining اثناء ال 2nd stage

headaches :

Table 35.1 Characteristics of headaches in pregnancy

Headache type	Onset	Location	Character	Duration	Worsened by	Other symptoms	Course with pregnancy	Diagnosis
Tension type	Gradual	Bilateral	Constant, pressing/ tightening, mild/moderate	30 minutes to 7 days	–	Pericranial tenderness, minimal photophobia	No change	Symptomatology and history
Migraine	Progressive, may be preceded by aura	Unilateral, frontotemporal	Pulsating, moderate/severe	4–72 h	Exertion	Nausea, vomiting, photo/phonophobia ↑ stress	Majority improve	Requires at least 5 attacks to fulfill definition
Cluster	Sudden, up to 8 times per day	Unilateral, periorbital	Severe, constant	15–180 minutes	–	Ipsilateral tearing, sweating, congestion, edema, miosis, agitation	Rare	Symptomatology and history
Pre-eclampsia/ eclampsia	Gradual	Bilateral	Pulsating	Persists intermittently until delivery	Exertion	Scotomata, right upper quadrant and epigastric pain	Occurs during pregnancy after 20 weeks gestation and up to 7 days post partum	Typically blood pressure >140/90 on 2 instances 6 hrs apart and proteinuria >300mg/24hrs
Hypertensive crisis	Gradual	Bilateral	Pulsating	Resolves within 1 hour of normalization of blood pressure	Exertion	–	Increased incidence in women with chronic hypertension	Blood pressure >160/120
Cerebral venous thrombosis	Progressive	Diffuse	Severe	Weeks, until dissolution of thrombus by anticoagulation	–	Neurologic deficits, seizures, loss of consciousness, increased intracranial pressure	Increased incidence	MR or CT angiography
Subarachnoid hemorrhage	Abrupt	Unilateral	Incapacitating, worst ever	Days	Exertion	Nausea/vomiting, altered consciousness	Unchanged	CT, MRI, LP
Idiopathic intracranial hypertension	Progressive	Diffuse	Constant	Resolves within 72 h of normalization of ICP	Coughing, Valsalva	Papilledema, visual field defects	Unchanged	LP to measure ICP (>200mm H20)
Postdural puncture	Progressive within 5 days of dural puncture	Diffuse	Constant	1 week or 48 h after epidural blood patch	Upright position	Neck stiffness, tinnitus, hypacusia, photophobia, nausea	Associated with epidural and spinal analgesia	Symptomatology and history
Neoplasm	Progressive	Localized	Worse in morning	Indefinite, unless surgically resected	Cough or bending forward	Focal neurologic signs	Unchanged	CT, MRI
Caffeine withdrawal	Within 24 h of last caffeine intake	Bilateral	Pulsating	1 h if caffeine ingested, 7 days if not	–	–	Frequent in first trimester	Symptomatology and history
Meningitis	Progressive	Diffuse	Constant	Up to months after resolution of infection	–	Fever, stiff neck, nausea, photo/phonophobia	Unchanged	LP
Sinus headache	Gradual	Frontal, facial	Constant	7 days	–	Acute sinusitis	Unclear	CT, MRI

* Migrain ttt :- Paracetamol + caffeine (maybe IV)

Preventive :- ergotamine (absolute CI during Pregnancy)

بدائل ؟؟؟

CCB

$MgSO_4$

ββ (may cross placenta)

Table 15.5 Common neuropathies seen in pregnancy and the pueperium

Neuropathy	Neurologic symptoms/signs	Etiology	Treatment
Bell's palsy (facial nerve or cranial nerve VII palsy)	Asymmetric facial droop and unilateral weakness of eye closure Taste on anterior third of tongue may be impaired and there may be an increased sensitivity to noise from the ear on the affected size	Edema of facial nerve In women of reproductive age 17/100,000 versus 57/100,000 in pregnancy. Most cases occur in third trimester or peripartum and in patients with pre-eclampsia [84,85]	Prednisone (1 mg/kg/day for 7 days) may improve recovery which is generally good but may take up to 6 months. Antivirals to not appear to affect recovery [86] If eye does not close at night, it may need to be patched shut with gauze compressed by tape
Meralgia paresthetica (lateral femoral cutaneous nerve palsy)	Burning, numbness of tingling over the upper outer thigh. Symptoms made worse by standing or extending leg. Improve with sitting or lying. May be bilateral	Compression of lateral femoral cutaneous nerve at groin by gravid abdomen and edema	Usually resolves in weeks to months following delivery
Carpal tunnel syndrome	Numbness, tingling or pain of the thumb, index finger and middle fingers. Often awakes patient at night and relieved by shaking hand. Pain may radiate into forearm. Often bilateral	Edema within the carpal tunnel at the wrist causes compression of median nerve Present in 5–10% of pregnant women [87]	Splints that hold wrist in neutral position may help decrease nerve compression. Most cases resolve in months following pregnancy
Obturator nerve palsy	Medial thigh pain and adductor weakness causing a circumducting wide-based gait	During vaginal delivery the nerve is compressed against the lateral wall of the pelvis as it crosses the upper margin of the obturator internus muscle	Most cases resolve in months following pregnancy [88]
Femoral neuropathy	Weakness of quadriceps ("knee buckling") with sparing of thigh adduction, sensory loss overy the anterior thigh and most of the medial thigh	Lithotomy positioning (with sharp flexion of the hip) can compress the nerve at the inguinal ligament. Excessive hip abduction and external rotation can cause additional stretching of the nerve. This is a particular risk when the patient has had an epidural anesthetic during labor because the anesthetic allows prolonged sharp flexion and external rotation that would otherwise be limited by pain and muscular resistance	Usually treated with physical therapy, avoiding hip abduction and external rotation. Knee bracing can be used to prevent buckling of the knee Recovery typically occurs over 3–4 months
Peroneal nerve compression	Foot drop with tenderness and paresthesias of the dorsum of the foot and anterolateral leg. Often not apparent until 24–48 hours post partum	Prolonged squatting, sustained knee flexion or pressure on the fibular head from stirrups or palmar pressure during pushing	Usually self-resolving within 8 weeks. May require short leg brace for a few weeks

are not affected. Myasthenic crisis is a term used to describe weakness associated with MG that is severe enough to require endotracheal intubation or delay extubation following surgery. It is often accompanied by bulbar muscle weakness that causes dysphagia and potentially aspiration.

Like most autoimmune conditions, MG affects women under 40 years more often than men (3:1). Myasthenia is also associated with other autoimmune diseases, in particular hypothyroidism. More than 80% of women who develop MG before 40 years of age also have hyperplasia of the thymus or a thymoma [90]. It is the thymus that is the source of anti-AchR antibodies and the likely origin of the type of autoimmune MG most commonly seen in pregnancy.

It has been estimated that MG affects one pregnancy in 20,000. Most women who become pregnant with MG are aware of their diagnosis before conception. A prior diagnosis of MG makes management during pregnancy easier, as long as the clinician is aware of specific problems [91]. Particular to pregnancy is the concern that maternal anti-AchR autoantibodies cross the placenta and cause fetal or neonatal myasthenia in up to 20% of pregnancies (see below).

Diagnosis

A new diagnosis of MG is suggested by clinical examination when there is early muscle fatigue and weakness.