

Case Report

Eclampsia with retropharyngeal edema: A rare presentation

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Case report

A 20 year old unbooked primigravida with 37 weeks amenorrhea was referred to us on 25th May, 2006 at 07.15 hours with six episodes of eclamptic fits since early morning. She was disoriented and restless with a blood pressure of 150/110 mm Hg, had generalized edema, grade 2 retinopathy, and albuminuria +++. She had one more fit after admission. Her hemoglobin was 12g/dL while platelet count prothrombin time, and liver and kidney function tests were within normal limits. She was given standard magnesium sulphate doses besides other supportive measures. In view of nonfavorable cervix, cesarean section was done under general anesthesia at 12.30 hours after the fits were controlled. There wasn't much difficulty in intubation despite some laryngeal edema. A live baby weighing 2.7 kg with good apgar score was

delivered. Intra operative and immediate postoperative period was uneventful. At about 16.30 hours she developed 102^oF temperature. Soft nontender swelling in the neck region which was observed at admission had increased and kept on increasing extending bilaterally to parotid, submandibular and submental regions. Her deteriorating condition prevented her shifting for CT scan and we have no MRI facility. Besides, the diagnosis of retropharyngeal edema was obvious on ultrasound. By 19.00 hours she became quite restless and developed respiratory discomfort. Sonography of the neck showed features suggestive of retropharyngeal and retrotracheal cellulites and edema. X-ray neck showed widened retropharyngeal and retrotracheal space. While the patient was being investigated for high fever (x-ray chest and neck, sonography and blood test), she developed breathlessness and stridor which worsened on putting ultrasound probe on the trachea suggesting tracheal compression. ENT surgeon strongly suspected retropharyngeal abscess and took the patient for drainage of suspected abscess under general anesthesia at 21.30 hours. A wide bore needle aspiration of retropharyngeal space by intraoral route did not drain any pus or blood but little amount of clear edema fluid. In view of respiratory difficulty

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the patient was shifted to ICU with endotracheal tube which could be removed only next morning. She was given broad spectrum antibiotics and injection hydrocortisone. She had an uneventful recovery. Both the mother and the baby were discharged on seventh postoperative day.



Figure 1. Bilateral neck swelling.



Figure 3. X-ray neck after 2 days.

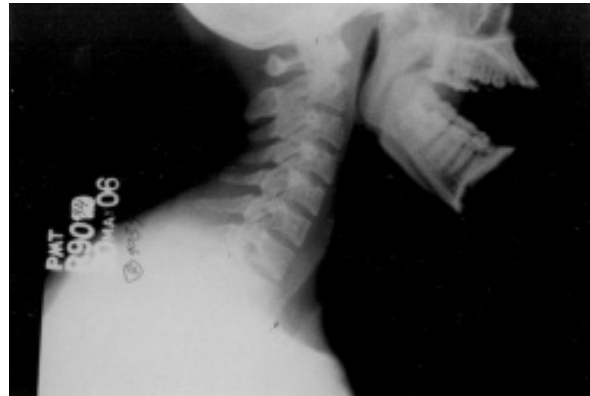


Figure 2. X ray neck on first day.

Discussion

Retropharyngeal space is limited above by the base of the skull, while below it extends behind the esophagus into the posterior mediastinal cavity of the thorax. Above the hyoid bone, it is in continuity with parapharyngeal space. It contains the retropharyngeal nodes superiorly and fatty tissue elsewhere². Being a closed space it can cause pressure symptoms in case of collection or infection. Retropharyngeal abscess is a common occurrence in children. Besides infection, swelling of this space can occur because of congenital conditions like brachial cyst and ectopic thyroid, neoplasms like cystic hygroma and neuroblastoma, traumatic conditions like hematoma, foreign bodies, and hypothyroidism³. Tuberculosis of the vertebral bodies can also cause abscess formation in this space. Laryngeal edema is a common finding during intubation in cases of preeclamptic toxemia but with severe edema with respiratory embarrassment is uncommon. Postoperative neck swelling can also be because of tracheal injury^{4,5} in difficult intubation. In this case however sonography and x-ray picture ruled out any surgical emphysema. Retropharyngeal space measuring greater than 7 mm and retrotracheal space greater than 22 mm in adults are abnormal and suggestive of a pathological process⁶. In this case measurements were 28 and 24 mm respectively. The swelling subsided with 48 hours. This is probably the first reported case of this kind where edema due to preeclampsia caused so much of pressure effects. Symptoms and signs especially high temperature, increasing neck swelling, respiratory discomfort, development of stridor, and x-ray and sonography findings mimicked an emergency condition

like retropharyngeal abscess. There was no option but to take her for drainage of supposed abscess - a life threatening emergency, with potential for airway compromise and other catastrophic complications⁶. She had to be kept on endotracheal intubation for fear of further deterioration till she recovered and swelling subsides.

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