EAS Journal of Anaesthesiology and Critical Care
Abbreviated Key Title: EAS J Anesthesiol Crit Care
ISSN: 2663-094X (Print) & ISSN: 2663-676X (Online)
Published By East African Scholars Publisher, Kenya

OPEN ACCESS

Volume-7 | Issue-5 | Sep-Oct-2025 | DOI: https://doi.org/10.36349/easjacc.2025.v07i05.012

Original Research Article

Management of Eclampsia in Resuscitation Department in Sub-Saharan Africa

Kane MM[1*], Ntab SO[2], Sambou P[1], Barboza D[1]

[1]Anaesthesia-Resuscitation Department, Peace Hospital, Training & Research Unit - Health Sciences, University Assane Seck Ziguinchor Senegal

[2]Gynecology-Obstetrics Department, Peace Hospital, Training & Research Unit - Health Sciences, Assane Seck University Ziguinchor Senegal

Article History
Received: 23.08.2025
Accepted: 09.10.2025
Published: 15.10.2025

Journal homepage:
https://www.easpublisher.com

Quick Response Code

Abstract: ***Introduction***: Eclampsia, a serious neurological complication of pre-eclampsia, is manifested by convulsions and/or impaired consciousness during pregnancy or postpartum. It is a major public health problem in Senegal and in sub-Saharan Africa. It is associated with a high maternal-fetal morbidity and mortality. ***Objective*****:** Evaluate the management and prognosis of eclampsia in intensive care unit. ***Patients and Method*****:** A descriptive and analytical retrospective study was conducted in an intensive care unit from January 1st, to December 31th, 2024. All patients admitted for eclampsia were included. The epidemiological, clinical, therapeutic and evolutionary data were collected via standardized survey sheets and analyzed with the Sphinx software. ***Results***: Pre-eclampsia affects 16.58% of admissions, mainly among young primiparas. Prenatal monitoring is limited (11.1% without consultations) and seizures most often occur before childbirth (61.1%). Severe arterial hypertension (33.3%) and significant proteinuria (94.4%) are common. The treatment is based on magnesium sulfate (100%), antihypertensives (75%) and cesarean section (86.1%). Maternal complications (38.9%) include renal failure and HELLP syndrome while prematurity was the most common fetal complication (55.5%). The rate of maternal deaths is 8.3%, two thirds of which are due to acute kidney failure and the perinatal rate is 8.1%. ***Conclusion*****:** Eclampsia remains an obstetric emergency of concern in sub-Saharan Africa, particularly in Senegal, strongly increasing maternal-fetal morbidity and mortality. To remedy this, it is essential to strengthen prenatal monitoring for early detection, improve the training of professionals with standardized protocols, raise awareness among communities about warning signs and optimize infrastructure for easier access to essential care. A multisectoral approach is needed to sustainably reduce this burden.

Keywords: Eclampsia, Management, Acute Kidney Failure, Resuscitation.

INTRODUCTION

Eclampsia is defined as the occurrence of generalised convulsions and/or changes in consciousness during pregnancy or postpartum, in the context of pre-eclampsia, which cannot be related to any pre-existing neurological damage. It is a serious complication of severe pre-eclampsia, which is the combination of hypertension after the 20th week of LMP (last menstrual period) up to 42 days after delivery with systolic blood pressure (SBP) ≥ 160 mm Hg and/or diastolic blood pressure (DBP) ≥ 110 mm Hg and associated with proteinuria > 0.3g/24h [1]. Eclampsia is associated with significant maternal and fetal morbidity [2]. It can be associated with serious complications such as acute renal failure, HELLP syndrome, DIC (disseminated intravascular coagulation), strokes that worsen the prognosis [3]. Eclampsia leads to significant mortality, causing approximately 50,000 maternal deaths each year globally [4] with a marked prevalence in developing countries [5]. In Senegal, the maternal mortality ratio increased from 392 to 153 per 100,000 live births between 2010 and 2023 (EDS 2023). The vascular-renal pathologies during pregnancy relegated hemorrhages to the background regarding mortality [6]. Between November 2015 and November 2016, a study in the intensive care unit (ICU) of a hospital in Senegal revealed a high frequency of eclampsia of 29.58% [7]. The lack of recent resuscitation data on this pathology

***Corresponding Author:** Kane MM
Anaesthesia-Resuscitation Department, Peace Hospital, Training & Research Unit - Health Sciences, University Assane Seck Ziguinchor Senegal

led us to conduct this study whose general objective is to reassess the therapeutic management of eclampsia.

PATIENTS AND METHODS

This retrospective, descriptive and analytical study was conducted over a 12-month period from January 1st, to December 31th, 2024. The study included all patients admitted to the ICU who had experienced eclampsia during the antepartum, perpartum or postpartum periods. Women whose convulsions were due to another cause, such as epilepsy, meningitis, a hemorrhage or a brain tumor, were excluded from the study. The data was collected from the medical records and registers of patients hospitalized in ICU. The variables analyzed in this study include:

- The frequency of eclampsia;
- The sociodemographic characteristics of patients;
- The medical and gynaecological-obstetric history of the patients;
- The patients' medical history;
- The type of pregnancy;
- The onset period of eclampsia;
- The diagnostic elements to confirm eclampsia, namely seizures, the context of pre-eclampsia and the absence of other causes;
- The clinical manifestations of eclampsia;
- The mode of delivery;
- Complications arising during eclampsia: maternal and fetal;
- The therapeutic aspects;
- The monitoring elements;
- Evolution;
- And the number of days of hospitalization

RESULTS

During the study period, we collected 36 cases of eclampsia out of a total of 217 patients, representing a frequency of 16.58%. The average age of the patients was 22.53 years with extremes of 15 and 37 years. The most represented age group was that of those under 20 in 50% followed by those between 20 and 35 in 44.4%. Patients over 35 years old accounted for 5.6%. They were mostly from Ziguinchor (72.2%). The rest came from the regions of Sedhiou, Kolda and neighboring countries such as Gambia and Guinea. Patients referred by other structures represented 88.9% of cases. A history of pre-eclampsia had been found in 2.8% of the patients. The average gesture of the patients was 2 with extremes ranging from 1 to 6. Primiparas were more numerous with 50% of cases. Prenatal consultations were well attended in 41.67%. The gestational age at diagnosis was between 36 and 40 weeks of LMP in 75% of patients. The mean SBP was 158.84 mm Hg with extremes of 88 and 230 mm Hg. The DBP was 85.8 mmHg with extremes of 54 and 130mmHg. The hypertension was severe in either 33.3%. More than two thirds, or 69.4%, of the patients had tachycardia with an average of 107.23 and extremes of 73 and 124 beats per minute. The majority of patients, 94.4%, had a preserved diuresis. Proteinuria was greater than 2 crosses in 94.4% of patients with massive proteinuria in 8.33%. Edema localized to the lower limbs were noted in 75% of patients. Only one case of generalized edema was found. The Glasgow score was between 8/15 and 12/15 in 36.1% of the patients. We had noted the presence of headaches in 80.6%. All patients had an average of 2.2 episodes of generalised tonic-clonic seizures. These convulsions mainly occurred during preparation in 61.1%. We noted cases of postpartum seizures in 16.7% of the patients. We had observed hepatic cytolysis in 30.5%. Renal function was impaired in 16.7% of the patients. Magnesium sulfate was administered to all patients. Benzodiazepines had been used in 11% of patients. Calcium channel blockers were used intravenously in 47.2% of cases compared to 27.8% orally. The analgesic treatment was systematic. It consisted of a combination of paracetamol and tramadol in 63.9% of cases and that of paracetamol and nefopam in 22.2%. Among our patients, 80.6% had benefited from a preventive dose of low molecular weight heparin anticoagulation. Corticosteroid therapy was initiated in 19.4% of patients. Uterotonic treatment with oxytocin was prescribed in 88.9% of the patients. The majority of patients had a cesarean delivery in 86.11%. Maternal complications were noted in 38.9% of women. Acute renal failure was found in 16.7% followed by the state of convulsive illness and recurrent hematoma in 8.3% each and uterine rupture in 5.6%. Fetal complications were dominated by prematurity in 27.7% and acute fetal suffering in 22.2%. A case of fetal death in utero was noted. The majority of patients (91.7%) had a favorable outcome. We had deplored 3 maternal deaths, or 8.3%, the causes of which are: acute renal failure in 2 cases (66.7%) and hemorrhagic shock in 1 case (33.3%). Moreover, 3 neonatal deaths by asphyxia, or 8.3%, were recorded. The duration of hospitalization was on average 2.81 days. biology anemia was noted in 44.4% of patients and thrombopenia in 24.95%.

DISCUSSION

The study focuses on a small sample of 36 patients, which limits the statistical weight of the results obtained. The results may not reflect the situation in other rural or urban areas of Senegal, particularly in terms of access to care and medical practices. The study does not cover the long-term evolution of patients and newborns (sequelae, post-eclampsia morbidity, etc.), which is crucial for assessing the full impact of the pathology. These limitations highlight the need for multicenter studies with larger samples, longitudinal follow-up and more comprehensive data collection to strengthen the validity of conclusions. In our study, eclampsia accounted for 16.58% of ICU admissions highlighting its significant impact in this context. This prevalence is comparable to that reported in a previous study conducted in Ziguinchor which revealed a prevalence of 29.58% in 2016 in the ICU [7]. In Ivory Coast, Bekoin-Abhé found a prevalence of 12.1% in a

study conducted over four years from 2014 to 2018 [8]. However, the frequency of eclampsia is still higher than those found in developed countries. In France and the United Kingdom, the prevalences are respectively 6.2% [9], and 2.7% [10]. This rate, which remains high in developing countries, can be explained by the relatively low level of education among patients but also by social beliefs. It can also be attributed to economic precariousness limiting access to quality medical care. The average age of patients with eclampsia in this study was 22.53 years with extremes of 15 and 37 years. The most represented age group was that of those under 20 in 50% which is in agreement with previous studies conducted in Africa. In Senegal, the average age in the study conducted in Ziguinchor was 23 years [7]. This trend is also observed in the study by Brouh Yapo in Ivory Coast, who reported an average age of 22.7 years in 2008 [11]. Nearly half of the patients, or 47.2%, had completed one to three prenatal care (PNC). No PNC was done in 11.1%. Nearly half of the patients, or 41.7%, had completed the eight recommended PNC. Another study conducted in Ziguinchor in 2017 showed that only 8.4% of women admitted for eclampsia had properly followed up [7]. The implementation and quality of PNC is a key factor in ensuring early detection of at-risk pregnancies, particularly pre-eclampsia causing eclampsia and initiation on aspirin. The absence of PNC can also be attributed to economic precariousness which limits access to quality medical care often relegated to the background in the face of other necessities but also by ethnic beliefs. Primiparas accounted for half of the cases. It has been established that pre-eclampsia is 4 to 5 times more common in primiparous than in multiparous with a generally more severe form. This phenomenon is linked to the first maternal exposure to villous trophoblasts containing antigens of fetal origin, therefore paternal [12, 13].

In our series, 83.3% of patients had no reported history. We found a history of pre-eclampsia in 2.8% of women. This result is in agreement with the study conducted in Ziguinchor which reported 1.41% pre-eclampsia in the medical history [7]. This low proportion, including hypertension or pre-eclampsia suggests that eclampsia can occur unpredictably even in women without apparent risk factors. The concordance between the two studies highlights the importance of rigorous prenatal monitoring, including in patients considered at low risk, to detect early warning signs and prevent serious complications. Our cases of eclampsia seizures occurred in the antepartum phase in the majority of patients, i.e. in 61.1%, in the pertum in 22.2% and in the postpartum phase in 16.7%. This result reveals a clear predominance of the occurrence of eclampsia seizures in the antepartum phase, which is consistent with data from the literature, particularly in the studies by Diouf [7], and Moujahid [15], who had found 57,7% and 67.7% of occurrence of eclampsia in prepartum. This trend confirms that the period before childbirth is the most critical time for the onset of eclampsia. Overall, these data show the importance of close monitoring from the pre-partum phase to the immediate post-partum to prevent serious complications related to eclampsia.

At the admission, nearly two thirds (63.9%) of the patients had a Glasgow score between 13 and 15 with extreme values of 8 and 15. Our results are similar to the results of the studies by Moujahid [15], and Diouf [7], which found 58.8% and 74.65% respectively. This can be explained by the fact that mild coma is more common in eclamptic patients due to the paroxysmal and brief nature of convulsions often followed by a rapid return to consciousness. Early management with anticonvulsants such as magnesium sulfate also helps to limit the depth of coma. In our study, 80.6% of patients presented with headaches, 8.3% of which were associated with epigastric pain. At admission, hyperreflexia (muscle stretch reflexes) were observed in 19.4% of patients. These results are consistent with those of Olsen [16], and Moujahid [15], who found headache in 59% and 60%, respectively, of the patients in their series. This confirms that headaches are a predominant symptom in clinical presentations of eclampsia. The association with epigastric pain, although less frequent, remains an important warning signal that may be related to liver damage or HELLP syndrome. These signs are alert indicators requiring rapid management. We had found severe hypertension in 12 patients, or 33.3%. These results are similar to those of Diouf with 39.43% [7], Olsen with 28.2% [16] and Bonkoungou with 39.7% [17]. According to Martin, the current hypothesis of the pathophysiology of the eclampsia crisis establishes a direct link with hypertensive outbreaks. The rise in blood pressure in eclampsia results from numerous mechanisms, some of which are still poorly understood. It is notably associated with placental ischemia reperfusion and maternal endothelial dysfunction. These alterations contribute to high blood pressure by inhibiting natriuresis and altering peripheral resistance [18]. Edema was present in 77.8% of patients and was most often localized to the lower limbs in 75% of cases. Edema is frequently observed, although it is not specific to eclampsia. However, their persistence can be considered as a factor of poor prognosis that may reflect a worsening of proteinuria. The latter was positive in 94.4% of patients and it was massive in 8.3% of patients. Eclampsia occurs on a diagnosed or undiagnosed pre-eclampsia field. This explains why, at admission, the majority of patients presented with proteinuria of this intensity. Anemia was observed in 44.4% of patients. These biological anomalies are frequently reported in studies on eclampsia in Africa: Thiam had found 51.36% of cases of anemia [19], Olsen 56.4% [16], and Moujahid 50.5% [15]. This high prevalence can be explained by several factors including pre-existing nutritional deficiencies, blood loss related to obstetric complications or even hemolysis in the context of HELLP syndrome. Thrombocytopenia less than 100 000 elements/mm^3 was observed in 24.95% of the patients in our study compared to 25.35% in the one involving Diouf [7]. Thrombopenia

in the context of eclampsia is often a reflection of severe endothelial involvement and platelet consumption that can lead to serious hemorrhagic complications. Its early detection is therefore essential to adapt the management and prevent maternal risks. We had also found hepatic cytolysis in 30.6% of the patients. Our results are similar to those of Diouf who had recovered 35.21% and are higher than those of Olsen who had recovered 25.6% [16], and Moujahid 13.4% [15]. This hepatic cytolysis can also be part of the complications of severe pre-eclampsia, namely HELLP syndrome. A difference in the handling times can explain the difference in the incidence of cytolysis between the different series. Complications associated with eclampsia were found in 38.9% of cases and were dominated by renal failure in 42.9%, followed by seizure disorder in 8.3%, placental abruption in 8.3% and uterine rupture in 5.6%. The decrease in the incidence of these complications could be achieved by a better awareness of the population on the warning signs of obstetric pathologies. Similarly, better access to quality care with improved roads and development of pre-hospital medicine (EMS or emergency medical services) would allow earlier patient management to prevent the occurrence of complications. We had recorded fetal complications in 55.5% of cases. These complications were prematurity which represented 27.7%, acute fetal suffering in 22.2% of cases and stunting in 5.6%. This result is similar to those of the work of Diouf who had found a prematurity rate of 23.94% and Baye who had found 25.4% [20]. Moujahid [15], had found 31.9% of cases of acute fetal suffering. This high incidence of fetal complications (55.5%) illustrates the severity of eclampsia on perinatal outcome, probably reflecting later management or more severe clinical forms. These results highlight the urgency of early detection and enhanced obstetrical support to improve neonatal prognosis in contexts of eclampsia. The management of eclampsia in this study was primarily based on the use of magnesium sulfate in all patients. Our results are comparable to those of DIOUF who had used magnesium sulfate in 97.18% of the patients. BEYE [21], in Dakar, had administered magnesium sulfate to all patients, except those sedated with fentanyl and diazepam. It is the reference treatment for eclamptic convulsions. Its use reduces the risk of recurrence with greater effectiveness than other anticonvulsants, which leads to first-line recommendation in this indication [22]. The loading dose relieves cerebral vasospasm by its calcium inhibitory effect [23]. It also reduces the release of acetylcholine at the neuromuscular junction, thus acting against convulsions.

All women who had high blood pressure figures received monotherapy antihypertensive treatment with mainly nicardipine. This use of nicardipine is found in the studies of BEYE [21], Moujahid H [15], and Diouf [7], with a use in 100%. It is indeed the currently recommended antihypertensive agent and can be used in combination with magnesium sulphate provided that appropriate monitoring is carried out. [24]. Monitoring should therefore be adequate as authors have reported cases of secondary heart failure with concomitant administration of the two products [25]. Only 4.2% had an association with atenolol. Nicardipine is indeed a source of tachycardia, which an association with beta-blockers can help resolve. Corticosteroids were administered to 19.4% of patients. These were mainly patients with thrombocytopenia in the context of a HELLP syndrome. Corticoids would have a beneficial effect in resolving the thrombocytopenia of HELLP syndrome [26]. The mechanism of this effect would be related to a decrease in interactions between vascular endothelium and circulating cells responsible for an inhibition of platelet activation and consumption [27]. There are however other sources questioning the effectiveness of corticosteroids in the management of HELLP syndrome [28]. All patients in our study were admitted to ICU during the postpartum period. The majority of our patients, namely 86.1%, had a cesarean delivery. Our results are close to those of DIOUF [7], Moujahid [15], and Olsen [16], who had reported respectively rates of 94.36, 69% and 66.7% of cesarean section. This high rate of cesarean could be due to the presence of various maternal-fetal complications associated with the diagnosis. These complications make vaginal delivery more risky, which can alter the maternal and fetal prognosis. The cesarean section is therefore often preferred for its speed in order to manage the emergency. Our mortality rate was 8.3%. Two thirds of the deceased patients were due to acute kidney failure. Our death rate is lower than that of Diouf which was 12.68%, of BONKOUNGOU which was 31%, of BEYE which was 23.3% and of OTIOBANDA which was 19.56% [7-29]. This difference can be explained by the seriousness of the cases observed in these other series but also by the good care through the application of protocols in mother-child centers and by the continuous training provided by the mother and child health department of the Health Ministry. Our mortality rate remains higher than that of BOURRET [30], in France which is 2.5% and of DUCARME [31], who had no deaths. This disparity is probably due to an early and regular follow-up of pregnancies as well as a better availability of therapeutic means. The perinatal mortality rate observed in our series (8.3%) is relatively low compared to those reported by Diouf [7]. (11.26%), Moujahid [15]. (27%) and especially Beye [21]. (42.8%) reflecting probably more effective obstetric and neonatal care. This difference can be explained by a better anticipation of complications, close monitoring during critical periods, or even an improvement in neonatal resuscitation conditions related to the availability of a neonatology unit in the mother and child pole. These results highlight the importance of a multidisciplinary strategy to reduce perinatal mortality related to eclampsia.

CONCLUSION

Despite the many advances noted in recent decades thanks to the Sustainable Development Goals,

challenges remain to be addressed in the field of maternal and child health. The early and adapted management of severe pre-eclampsia and its complications such as eclampsia and the availability of hemodiafiltration in ICU would reduce maternal-infant mortality and morbidity in Senegal and Africa.

BIBLIOGRAPHY

1. Prise en charge multidisciplinaire des formes graves de pré-éclampsie : Recommandation formalisée d'experts communes SFAR/NGOF/SFMP/SFNN :27 / O1 /. 2009.
2. Fischer C. Pré-éclampsie sévère. Le Praticien en Anesthésie Réanimation, 2022;26(4):198-205.
3. Édouard D. Pré-éclampsie-Éclampsie. Encyl.Med. Chir Anesthésie-réanimation. 2003;36-980-A10, Obstétrique:5-071-30 1-15.
4. Sawle G, Ramsey M. The neurology of pregnancy. J Neurol Neurosurg Psychiatry. 1998;64:717-25.
5. Réanimation des formes graves de pré-éclampsie. J Gynecol Obstet Biol Reprod (Paris. 2001 ; 30 121-32.
6. Agence Nationale de la Statistique et de la Démographie (ANSD) [Sénégal], et ICF. 2024. Sénégal : Enquête Démographique et de Santé Continue (EDS-Continue 2024).
7. Barboza D, Coulibaly S, Traoré MM, Diouf E. Prise en charge de l'éclampsie en réanimation dans un hôpital périphérique. RAMUR 2018, 23 (1) : 40-46
8. Bekoin-Abhé CM, Kohou-Koné LL, Goulai Bi YE, Mobio M, Coulibaly KT, Tetchi YD. Caractéristiques epidemiocliniques, thérapeutiques et évolutives de l'éclampsie grave en réanimation au chu de Cocody (Abidjan - cote d'ivoire).
9. Masson E. Pré-éclampsie, éclampsie, HELLP syndrome : définitions, éléments de diagnostic et de prise en charge. EM-Consulte n.d. https://www.emconsulte.com/article/226337/preeclampsieeclampsie-hellpsyndrome definitions (accessed May 12, 2022).
10. Knight M. Eclampsia in the United Kingdom 2005. BJOG. 2007;114 1072-8.
11. Brouh Y, Ndjeundo PG, Tetchi D, Akpo AA, Peter Y,Yapobi Y. Les éclampsies au centre hospitalier universitaire en Côte d'ivoire: prise en charge, évolution et facteurs pronostics. CAN J Anesth 2008; 55(7): 423-8.
12. Duckitt K, Harrington D. Risk factors for pre-eclampsia at antenatal booking: systematic review of controlled studies. BMJ 2005;330:565. https://doi.org/10.1136/bmj.38380.674340.E0.
13. Lie RT, Rasmussen S, Brunborg H, Gjessing HK, Lie-Nielsen E, Irgens LM. Fetal and maternal contributions to risk of pre-eclampsia: population-based study. BMJ 1998;316:1343–7. https://doi.org/10.1136/bmj.316.7141.1343.
14. Diouf AA, Diallo M, Mbaye M, Sarr SD, Faye-Diémé ME, Moreau JC. Profil épidémiologique et prise en charge de l'éclampsie au Sénégal: à propos de 62 cas. Pan Afr Med J 2013;16. https://doi.org/10.11604/pamj.2013.16.83.3101.
15. Moujahid H. Prise en charge de la prééclampsie sévère et de l'éclampsie en réanimation chirurgicale (à propos de 97 cas. Thèse Med FES. (024/07).
16. Ngompe T, Olsen J. Aspect épidémiologique et pronostic maternel de l'éclampsie en réanimation du centre hospitalo-universitaire Gabriel Touré. 2022. Thèse de doctorat. Université des Sciences, des Techniques et des Technologies de Bamako.
17. Bonkoungou PZ, Bako YP. L'éclampsie en Réanimation : épidémiologie et pronostic au CHU Yalgado Ouédraogo. RAMUR, 2014 ; 19 : 28-32
18. Staff AC, Halvorsen B, Ranheim T, Henriksen T. Elevated level of free 8-iso-prostaglandin F2alpha in the decidua basalis of women with preeclampsia. Am J Obstet Gynecol. 1999 Nov;181(5 Pt 1):1211-5
19. Thiam M. Eclampsie aspects epidemiologiques, diagnostiques, therapeutiques et pronostiques au centre hospitalier regional de thies a propos de 146 cas. Journal de la sago (Gynécologie – Obstétrique et Santé de la Reproduction) [Internet]. 2020 [cité 26 mars 2025];21(2). Disponible sur: https://jsago.org/index.php/jsago/article/view/75.
20. Baye S. Eclampsie, première cause de décès maternels dans le service de gynéco-obstétrique de l'hôpital Fousseyni Daou de Kayes. Thèse Méd ; Bamako 2018, N°148.
21. Beye MD, Diouf E, Kane O, Ndoye MD, Seydi A, Ndiaye PI, Sall BK. Prise en charge de l'éclampsie grave en réanimation en milieu Tropical africain. A propos de 28 cas. Ann Fr Anesth Réanim 2003; 22:25-9
22. Kayem G. Utilisation du sulfate de magnésium en obstétrique. Gynécologie obstétrique et fertilité, 2012 ; 40(10) : 605-613
23. Dubar G, Rackelboom T, Tsatsaris V, Mignon A. Pré-éclampsie-Éclampsie. Anesthésie-Réanimation. 2012 ; 36-980-A-10, 18.
24. Diemunsch P. Principe généraux de la prise en charge hospitalière de la pré-éclampsie. Annales Françaises d'Anesthésie et de Réanimation, 2010 ; 29(4) : 51-58.
25. Carles G. Complications de l'association sulfate de magnésium et nicardipine au cours de la pré-éclampsie : à propos de deux cas. Gynécologie obstétrique et fertilité, 2012 ; 40(10) : 614-616.
26. Martin J. Better maternel outcomes are achieved with dexamethasone therapy for post-partum HELLP syndrome. Am J Obstet Gynecol, 1997;177:1011-7
27. O'Brien JM. Impact of high-dose corticosteroid therapy for patients with HELLP (hemolysis, elevated liver enzymes, and low platelet count) syndrome. Article and reviewm J Obstet Gynecol, 2000; 183(4) : 921-924
28. Matchaba P, Moodley J. Corticosteroids for HELLP syndrome in pregnancy. Cochrane Database Syst Review 2004:CD002076

29. Otiobanda GF, Itoua C, Ossou PM, Nguiet PM. L'éclampsie en réanimation polyvalente au CHU de Brazzaville : aspects épidémiologiques, cliniques et évolutifs. Rev. Cames sante, 2013 ; 1(2) 2423-7243.
30. Bourret B, Compère V,Torre S, Azhougagh K, Provost D, Rachet B, Gillet R,Rieu M, Marpeau L, Dureuil B. Évaluation de l'utilisation du sulfate de magnésium dans la prévention secondaire de l'éclampsie : étude rétrospective de 39 cas. Annales Française d' Anesthésie et de réanimation (2012) ; 31 : 933-936.
31. Ducarme G, Herrnberger S, Pharisien I, Carbillon L, Uzan M. Éclampsie : étude rétrospective de 16 cas. Gynécologie Obstétrique Fertil. 2009;37(1):11 7.

Cite this article: Kane MM, Ntab SO, Sambou P, Barboza D (2025). Management of Eclampsia in Resuscitation Department in Sub-Saharan Africa. *EAS J Anesthesiol Crit Care, 7*(5), 135-140.