INTRODUCTION

There have been reports that the number of circulating platelets is reduced in pre-eclampsia (Howie 1977- Schwartz et al., 1983) and it appears that the decrease in circulating platelet is secondary to an increased rate of platelet consumption (Redman et al., 1978). Whether the consumption of platelets is responsible for the intravascular coagulation, or is a part of the process itself, remains unanswered.

Gant and Worley (1980), found that the severity of thrombocytopenia was correlated with the severity of pregnancy induced hypertension. Schwartz et al. (1983), found that thrombocytopenia can occur with mild and moderate pregnancy-induced hypertension and they suggested that patients with PIH and thrombocytopenia (platelet count less than 75,000/cu mm) should be classified as having severe pre-eclampsia. Thiagarajah et al., (1984), recommended an immediate platelet count for any gravid patient with suspected PIH.

The liver has been reported as an infrequent primary target in the pre-eclamptic toxaemia syndrome, and hepatic toxaemia has generally been thought to be rare and only subclinical. Conflicting results about liver damage in pre eclampsia were reported, and while some workers could not

denote any change, others has done so (Shukla et al., 1978), Riely et al., (1981), pointed out that hepatic involvement in pregnancy toxaemia is common, but overlooked as patients have no complaints referable to the liver and liver affection is only detected by abnormal liver function tests in a toxaemic patient. Alternatively, some patients may first come to attention because of abdominal pain and tenderness located in the right, upper quadrant of the abdomen or mid epigastrium., with substernal radiation. Laboratory abnormalities are however, quite diverse. Moreover, in toxaemic patients with abnormal liver function tests, the reported abnormal liver function tests were variable in various reports.

A distinct, clinical syndrome (HELLP) occurs with pregnancy toxaemia (Weinstein, 1982),in which there is haemolysis (H), elevated liver enzymes (EL) and low platelet count (LP). The syndrome is not rare (Riely et al., 1981). Pain and tenderness in the epigastric region, associated with nausea and vomiting are the main findings in early case of HELLP syndrome and dissiminated intravascular coagulation is present in varying degrees in all cases (Goeke and Heyes, 1985). It is important to know that this syndrome may occur when the usual clinical findings to diagnose severe pre eclampsia are absent (Weinstein, 1982).The practicing

obstetrician must be knowledgable about this severe consequance of hypertension in pregnancy, and recognition of clinical and laboratory findings are important in toxaemic patients. Early and aggressive therapy is immediate caesarean section, regardless of fetal viability to prevent maternal and fetal death (Weinstein, 1982).