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## ORIGINAL RESEARCH

# A clinical study on maternal and fetal outcomeinpreeclampsiawith thrombocytopenia

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**ABSTRACT**

**Background & objectives: Class II and III mortality Class I deliveries werevaginal (62.5 percent). Thrombocytopenia in pregnancy causes hypertension in both motherand foetus. Associated causes include abruption, dead foetus, septicaemia, and DIVC worsenthe thrombocytopenia consequence. For both mother and foetus, thrombocytopenia is morecommon with early pregnancy induced hypertension.Study of pre-eclampsia withthrombocytopeniainhypertensivepregnantwomen.**

**Material andMethods:From the records of pregnant women admitted to the Osmania Medical College's ModernGovernment Maternity Hospital, Petlaburz, from November 2020 to November2021.**

**Results:In this study, 120 women were followed for two years, and 70.58 percent ofthem developed pregnancy-induced hypertension. It was prevalent in the 21-30 age range(31%), with 54.17 percent primigravida. There were 45.45% LSCS in severe PIH withthrombocytopenia between 34-37 weeks for foetal indications including severe IUGR andoligohydramnios. In 8 cases of eclampsia with thrombocytopenia, vaginal birth was morecommon in 34-37 weeks gestation (60 percent). Cesareans were more common in the 37-weekgestationperiod(75percent).MaternalMortalitywas7.69%,followedby42.30%and 20.9 percent of cases with eclampsia and PPH, 19.23 percent with renal failure, and 15.38percent with DIC. Pre-eclampsia is a primary cause of thrombocytopenia in pregnancy. Thisincreasesmaternal and foetal mortality and morbidity.**

**Keywords:severePE;mildPE;HELLP,thrombocytopenia,LSCS.**

## INTRODUCTION

Thrombocytopenia is a condition that can complicate up to 7-8 percent of all pregnancies. Thecomputerised Complete blood count, which typically includes platelet count, is largely responsiblefor the present detection of the illness. The majority of this drop takes place during the thirdtrimester and is connected with a shift in the histogram of platelet count distribution throughoutthistimeperiod.

It can be caused by a range of conditions, ranging from benign illnesses such as pregnancythrombocytopenia to life-threatening syndromes such as HELLP syndrome (Haemolysis, ElevatedLiver Enzymes, Low Platelet Count), which is characterised by low

platelet counts and hemolysis.Thrombocytopenia is characterized as a low number of platelets in the circulatory blood that isbelownormal.[1]

The discovery of thrombocytopenia during pregnancy is an intriguing problem for obstetricians todeal with on a daily basis. It is estimated that roughly 20% of all occurrences of thrombocytopeniaduring pregnancy are caused by hypertensive disorders of pregnancy, which are responsible forapproximately 20% of all cases.Preeclampsia is associated with mild to moderate thrombocytopenia,however it is possible to develop severe thrombocytopenia. Patients with eclampsia were at an evenlarger risk of having severe thrombocytopenia than those without the condition. In addition, womenwhoare pregnantaremore likelytodevelopHELLPsyndrome, whichisasubtypeofpreeclampsia.

Thrombocytopenia is a critical and required component of this condition, and it must be treated.Four processes contribute to thrombocytopenia: artifactual thrombocytopenia, insufficient plateletgeneration, rapid platelet breakdown, and platelet pooling. Which is defined mostly by bleedingfromsmallbloodvessels asitshallmark.[2,3]

The period of onset of many problems during pregnancy, as well as their clinical symptoms,frequently coincide, making the diagnosis of individual disorders challenging. Thrombocytopenia is aconcern for both the woman and her unborn child, and it has been connected with significantmaternalorneonatalmorbidity andmortalityin several studies.[4-5]

Specialized treatments, on the other hand, have been shown to improve the outcomes of affectedpatients and their progeny when implemented quickly and effectively In order to determine theprevalence of thrombocytopenia in pregnant women with pregnancy-induced hypertension, as wellas the consequences of this condition on maternal and foetal outcomes, a retrospective study wasconducted.

## AIM&OBJECTIVES

- Clinicalstudyof maternalandfetaloutcomeinpre-eclampsiawiththrombocytopeniainhypertensivepregnantwomen.

## METERIALSANDMETHODS

### SOURCESOFDATA

FromtherecordsofpregnantwomenadmittedintheDepartmentofObstetricsandGynaecology,ModernGovernmentMaternityHospital,Petlaburz,OsmaniaMedical College,Hyderanbad, Telangana–from November2020toDecember2021.

### METHODOFCOLLECTIONOFDATA

### STUDYDESIGN

Prospective

### SAMPLESIZE

120

From the records / case sheets of pregnant women with pregnancyinduced hypertensionadmitted in labour to the department of obstetrics and gynaecology, Modern GovernmentMaternityHospital,Petlaburz,OsmaniaMedicalCollege,Hyderanbad,Telangana

Details will be entered in the proforma regarding the detailed history of period of gestation,highriskfactors,complications-duringpresentandpastpregnancy,likepregnancyinducedhypertension,diabetesmellitus,APLA, intra uterine death, abruption, hepatitis.Pasthistoryofpregnancyinducedhypertension,hypertension,diabetesmellitus&haemor

rhagicdisorders.

**INCLUSIONCRITERIA**

1. Third trimester pregnant women with BP measuring more than 140/90mmHgwiththrombocytopenia.
2. PregnantwomenwithHEELPsyndrome.
3. Pregnantwomenwithdiagnosedpre-eclampsiaandeclampsiawiththrombocytopenia.

**EXCLUSIONCRITERIA**

1. PatientswithestablishedITPdisease.
2. Patientswithhypertensivedisorderbeforepregnancy.
3. PatientsestablishedwithHIVdisease.
4. Patientswithhistoryofviralfever.

**PROCEDUREOFTHESTUDY**

Pregnant women who are admitted to OsmaniaMedical College associated hospital in thethird trimester with BP >140/90 will beselectedaccordingto inclusion and exclusioncriteria.Awrittenconsent istaken inthosewhosatisfytheseinclusioncriteria.
Bloodpressuremeasurementsandfullbloodcounts,renalfunction,liverfunctiontestsand peripheralbloodsmearstudyaredone.Thiswillexclude any known cause ofthrombocytopeniasuch as ITP, Leukaemia, and or lympho-proliferativediseases.
Studyisaboutmaternalandfetaloutcomerelatedtomodeofdelivery(vaginal/instrumental / CS), maternal and fetal morbidity and mortality, complicationslikerenalfailure,pulmonaryoedema,cerebralvenous thrombosis, disseminated intravascularcoagulation,postpartumhaemorrhage, multiorganfailure.
Blood specimen will be withdrawn with minimal stasisfromtheante-cubital vein usingadrysteriledisposablesyringeandneedle.3mlofbloodisdispensedintoEDTAanticoagulant tubes. The specimens are labelled with subject‟s age, sex and identificationnumber. The EDTA sampleswill be keptat room temperature until processed within 4hoursofcollection.
Laboratory analysis – Platelet countwillbeperformedusingmanual methodandautomatedhaematologymethod.

**RESULTS**

**Table1:EtiologyofThrombocytopenia**

| Etiology | Noofsubjects | Percentage |
|---|---|---|
| MildPIH | 32 | 26.66 |
| SeverePIH | 48 | 40 |
| Eclampsia | 10 | 8.34 |
| HELLP | 29 | 24.16 |
| **Total** | **120** | **100** |

In the above table, out of 120 cases included in the study, 32and 48 cases presented withmild and severe pregnancy induced hypertension, 8 cases were diagnosed as eclampsia and29cases presented withHELLP syndrome.

**Table 2: Age distribution of Subjects of Pregnancy induced Hypertension withthrombocytopenia**

| Agegroup | Frequency(n) | Percentage(%) |
|---|---|---|
| <20years | 31 | 25.84 |

| | | |
|---|---|---|
| 21-25years | 47 | 39.16 |
| 26-30years | 27 | 22.5 |
| >30years | 15 | 12.5 |
| **Total** | **120** | **100** |

Majorityofthestudysubjectsinourstudywere agedbetween21-25years (39.16%)followedby<20 years (25.84%) . 22.5 % of the cases were between the age group 26-30 years and 12.5 % wereagedabove30yearsof age.

**Table3:GravidityindexofpatientswithpregnancyinducedhypertensionwithThrombocytopenia**

| Gravida | Frequency(n) | Percentage(%) |
|---|---|---|
| Primigravida | 65 | 54.17 |
| Multigravida | 55 | 45.83 |
| **Total** | **120** | **100** |

Inourstudy,65ofthecaseswereprimigravidaand55ofthemweremultigravida.

**Tale4:Analysisofmodeofdelivery andgestational ageinmildpregnancyinducedhypertensionwith thrombocytopenia**

| GestationalAge | Modeofdelivery | MILDPIH | Percentage |
|---|---|---|---|
| | ID | 2 | 22.23 |
| | LSCS | 3 | 33.33 |
| | VD | 4 | 44.44 |
| 28-34weeks | TOTAL | 9 | 100 |
| | ID | 2 | 11.76 |
| | LSCS | 5 | 29.41 |
| | VD | 10 | 58.82 |
| 34-37WEEKS | TOTAL | 17 | 100 |
| | ID | 3 | 33.33 |
| | LSCS | 1 | 11.11 |
| | VD | 5 | 55.55 |
| >37WEEKS | TOTAL | 9 | 100 |

Outofthe120casesofthrombocytopenia35casespresentedwithmildPIH.Out ofthetotal 35cases the 9of them were between the 28-34 weeks of gestation, 17 were between 34-37weeks and 9wereover the 37weeks ofgestation.

Amongthe28-34weeksofgestation,4(33.33%)hadnormalvaginaldelivery,3(33.33%)underwentLSCSandremaining2cases(22.23 %)hadinstrumentaldelivery.

Nearly10(60%)casesoutof17inthe34-37weeksofgestationalagehad vaginaldelivery,5(29.41%) underwentLSCS and 2(11.76%) hadinstrumentassisteddelivery.

Out of 9 cases between the gestational age greater than 37 weeks, 5 (55.55 %) , 1(11.11%)and2(22.23%)deliveredthroughnormalvaginal,LSCSandinstrumentaldeliveryrespectively.

**Table 5: Analysis of mode of Delivery and Gestational age and Severe PregnancyInduced Hypertension withandwithout thrombocytopenia**

| GestationalAge | Modeofdelivery | Thrombocytopeniapatients | Percentage |
|---|---|---|---|
| | ID | 0 | 0 |
| | LSCS | 3 | 37.5 |

| | | | |
|---|---|---|---|
| | VD | 5 | 62.5 |
| 28-34weeks | TOTAL | 8 | 100 |
| | ID | 3 | 13.63 |
| | LSCS | 10 | 45.45 |
| | VD | 9 | 40.9 |
| 34-37WEEKS | TOTAL | 22 | 100 |
| | ID | 2 | 13.33 |
| | LSCS | 8 | 53.33 |
| | VD | 5 | 22.72 |
| >37WEEKS | TOTAL | 15 | 100 |

Out of the 120 cases of thrombocytopenia 40 cases presented with Severe PIH .Out of thetotal45casesthe8(17.77%)ofthemwerebetweenthe28-34weeksofgestation,22(48.88%)were between 34-37 weeks and 15(33.33%) were over the 37 weeks of gestation.Among the28-34 weeks of gestation, 3 (37.5 %) had normal vaginal delivery,5 (62.5%) underwentLSCS. Nearly9(40.9%)casesoutof22inthe34-37weeksofgestationalagehadvaginaldelivery,9(40.9 %)underwent LSCS and10 (45.45 %)had instrument assisted delivery.

Out of 15cases with the gestational age greater than 37 weeks, 5 (22.72 %) , 8 (53.33%)and2(13.33%)deliveredthroughnormalvaginal,LSCSandinstrumentaldeliveryrespecti vely.

**Table6**:**ModeofDeliveryinMildandSeverePregnancyInducedHypertensionwithThrombo cytopenia**

| Modeofdelivery | MildPIH | SeverePIH |
|---|---|---|
| VD | 17(58.62%) | 15(36.58%) |
| ID | 5(17.24%) | 7(17.03%) |
| LSCS | 7(24.13%) | 18(43.90%) |
| TOTAL | 29(100%) | 41(100%) |

Chi square=3.69 df=2p=0.169

Outofthe29casesofMildPIH,16(57.2%)hadNormalVaginalDelivery,4(14.3%)wereinstrumenta ldeliveryand8(28.5%)underwentLSCS.

Outofthe40casesofSeverePIH,14(35%)hadnormalVaginalDelivery,6(15%)hadinstrumentassis ted deliveryand20(50%)weredeliveredthrough LSCS.

TheassociationbetweenthemodeofdeliveryandthevariantsofPIHwasfoundtobestatisticallynot significant

**Table 7: Analysis of Mode of Delivery and Gestational age in Eclampsia withThrombocytopenia**

| | Eclapsia | | | |
|---|---|---|---|---|
| | Modeofdelivery | | | |
| Gestationalweeks | NVD | ID | LSCS | Total |
| 28-34WKS | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| 34-37WKS | 3(60.0%) | 2(100%) | 1(25%) | 6(54.5%) |
| >37WKS | 2(40%) | 0(0%) | 3(75%) | 5(45.5%) |
| TOTOAL | 5(100%) | 1(100%) | 4(100%) | 11(100%) |

Fishersexact test=0.46p>0.05(notsignificant)

Outofthe11casesofeclampsiawiththrombocytopenia,6(54.5%)wereinthe34-37weeksofgestationand 5 (45.5%) above37weeks ofgestation.

Out of 5 cases which had normal vaginal delivery, 3 (60 %) were in the 34-37 weeks ofgestation and 2 (40 %) was above 37 weeks of gestation. There was only one case whichwas delivered through the assist of instrument was in the 34-37 weeks of gestation. Among3 cases delivered through LSCS, 1(25 %) was in 34-37 weeks and 3(75 %) above 37weeksofgestation.

TheAssociationbetween Modeofdeliveryandgestationweeksamongthe eclampsiacaseswasfoundto be not significant.

**Table8**:**Distributionofsubjectsaccording totheclassificationofHELLP**

| Class | Frequency | Percentage |
|---|---|---|
| CLASSI | 14 | 52 |
| CLASS II | 7 | 28 |
| CLASSIII | 5 | 20 |
| **Total** | **25** | **100** |

HELLPwasclassifiedintoClassI(52%),ClassII(28%) andClassIII(20%).

**Table 9: Distribution of subjects according to the Complications andclassificationof HELLPsyndrome**

| Complication | HELLP | | | |
|---|---|---|---|---|
| | ClassI | ClassII | Class III | Total |
| Maternalmortality | 0(0%) | 1(12.5%) | 1(20%) | 2(7.69%) |
| Eclapsia | 9(60.0%) | 2(25%) | 0(0%) | 11(42.30%) |
| PPH | 2(13.33%) | 2(25%) | 2(40%) | 6(23.07%) |
| Renalfailure | 2(13.33%) | 2(25%) | 1(20%) | 5(19.23%) |
| DIC | 2(13.34%) | 1(12.5%) | 1(20%) | 4(15.38%) |
| **TOTAL** | **15(100%)** | **8(100%)** | **5(100%)** | **26(100%)** |

Among all the HELLP patients, Maternal Mortality was 7.69 % followed by 42.30 % and20.9%ofcasespresentedwitheclampsiaandPPH,19.23%forRenalFailure,15.38%withDIC.

Maternal Mortality was seen each among class II and Class III of HELLP. Out of 15casesamongclassI,9(60.0%)eclampsia,2(13.34%)PPH,2 (13.3%)Renalfailureand2(13.3%)DICwerePresent.

8cases of HELLP class II was seen in our study out of the 8 cases 1 (12.5%)MaternalMortality,2 (25.0%) eclampsia,2(25.0%)renalfailureand one(12.5%)caseofPPH.

HELLPclassIIIhad5cases,1(20%)hadmaternalMortalityandrenalfailure,2(40%)hadPPHand 1(20%)hadDIC.

**Table10:AnalysisofModeof Delivery AndGestational ageAmongClassIHELLP**

| Gestationage | Modeofdelivery | | | Total |
|---|---|---|---|---|
| | VD | ID | LSCS | |
| 28-34WKS | 0(0%) | 1(25%) | 0(0%) | 2(12.5%) |
| 34-37WKS | 6(60%) | 3(75%) | 2(40.00%) | 8(50.0%) |
| >37WKS | 4(40.0%) | 0(0%) | 3(60.0%) | 6(37.5%) |
| **TOTAL** | **10(100%)** | **4(100%)** | **5(100%)** | **16(100%)** |

Outof14casesofHELLPclassI,8caseswerevaginaldelivery(60%in34-37weeksand40%in>37weeks),4caseswereinstrumentaldelivery(25 %in28-34weeksand75%in34-37weeks),and5caseswereLSCS(40 %in34-37weeks and60 %in>37weeks).

TheAssociationbetweenModeofdeliveryandgestationweeksamongtheHELLPClassIcases was found to benot significant.

**Table11:Analysis ofModeofDelivery And GestationalageAmongClassIIHELLP**

| Gestation age | Modeofdelivery | | | Total |
|---|---|---|---|---|
| | VD | ID | LSCS | |
| 28-34WKS | 1(25%) | 1(33.34%) | 0(0%) | 2(28.72%) |
| 34-37WKS | 3(75%) | 2(66.63%) | 0(0%) | 4(57.14%) |
| >37WKS | 0(0%) | 0(0%) | 2(100%) | 1(14.28%) |
| **TOTAL** | **4(100%)** | **3(100%)** | **2(100%)** | **7(100%)** |

Outof6casesofHELLPclassII,4 caseswerevaginaldelivery(25%in28-34 weeksand66.7%in 34-37weeks),2caseswereinstrumental delivery(50%in 28-34weeksand50%in34-37weeks),and1caseswereLSCSSeeninthe>37weeksofgestation.

The AssociationbetweenMode of delivery andgestationweeksamongtheHELLPClassIIcaseswas foundto benot significant.

**Table12:AnalysisofModeof Delivery AndGestational ageAmongClass IIIHELLP**

| Gestation age | Modeofdelivery | | | Total |
|---|---|---|---|---|
| | VD | ID | LSCS | |
| 28-34WKS | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| 34-37WKS | 1(33.34%) | 1(100%) | 0(0%) | 2(33.34%) |
| >37WKS | 2(66.66%) | 0(0%) | 2(100%) | 4(66.66%) |
| **TOTAL** | **3(100%)** | **1(100%)** | **2(100%)** | **6(100%)** |

Out of 6 cases of HELLP class III, 2 cases were vaginal delivery 33.34 % in 34- 37 weeksand 66.66 % in > 37 weeks), 2 cases was instrumental delivery in 34-37 weeks, and 2 casesofLSCSin the>37 weeks of gestation.

The Association between Mode of delivery and gestation weeks among the HELLP ClassIIIcases was found to benot significant.

**Table13:AnalysisofModeofDeliveryandGestationalageamongEclampsiaandpatientswith HELLP**

| Modeofdelivery | | | Total |
|---|---|---|---|
| | WithHELLP | Witheclampsia | |
| VD | 14(53.84%) | 5(50%) | 19(52.78%) |
| ID | 7(26.92%) | 2(20%) | 9(25.0%) |
| LSCS | 5(19.23%) | 3(30.0%) | 10(27.77%) |
| **TOTAL** | **26(100%)** | **10(100%)** | **36(100%)** |

Outof36caseswithHELLPandEclampsia,14cases(53.84 %)deliveredthroughvaginal , 9 (25%) delivered using instruments and 10 (27.77 %) through LSCS.

Outof10caseswitheclampsia,5(50%)deliveredthroughvaginalroute,2 (20 %) throughinstrumentaland3(30 %) throughLSCS.Theassociationbetweenmodeofdeliverywitheclampsiaand HELLPwasalsofoundto be statisticallynot significant.

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**Table14:AnalysisofFoetalMortalityandMorbidity inAllcasesadmittedwithThrombocytopenia**

| GestationalAge | Fetaloutcome | Thrombopenia | | | |
|---|---|---|---|---|---|
| | | Modeof delivery | | | Total |
| | | VD | ID | LSCS | |
| | Healthy | 7 (75%) | 2(66.7%) | 2(50%) | 11(63.64%) |
| | Perinatalmortality | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| 28-34 wks | PerinatalMorbidity | 2(33.33%) | 2 (33.33%) | 2(33.34%) | 6(33.3%) |
| | Total | 9(100%) | 4(100%) | 4(100%) | 17(100%) |
| | Healthy | 23(76.66 %) | 8(72.72%) | 12(70.58%) | 41(100%) |
| | Perinatalmortality | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| | PerinatalMorbidity | 7(25.54%) | 3(27.28 %) | 5(29.41%) | 15(25.9%) |
| 34-37 wks | Total | 30(100%) | 11(100%) | 17 (100%) | 56 (100%) |
| | Healthy | 11(78.57%) | 3(60%) | 12(80%) | 24(72.72%) |
| | Perinatalmortality | 0(0%) | 0(0%) | 0(0%) | 0(0%) |
| | PerinatalMorbidity | 3(27.27%) | 2(40%) | 3(20%) | 9(27.27%) |
| >37wks | Total | 14(100%) | 5(100%) | 15 (100%) | 33(100%) |

Foetaloutcomeisgenerallyinfluencedbygestationalageandmodeofdeliveryinthepresentstudythe abovefactors wereconfirmed bythe tablegiven above.

In the group with thrombocytopenia gestational age between 28 to34 Weeks (n=17), livebirths were 100 %, perinatal mortality was nil, Perinatal morbidity 33.3% and 63.64 % werehealthy. The association between the mode of delivery and foetal outcome was found to bestatisticallyinsignificantin this group.

In gestation between 34 to 37 weeks (n=56) live births were 100%, perinatal mortality waszero, Perinatal morbidity 25.54 % and 27.28 %, 29.41 % were healthy. The associationbetweenthemodeofdeliveryandfetaloutcomewasfoundtobestatisticallyinsignificanti nthis group.

Morethan37Weeksofgestation(n=33)livebirthswere100%,perinatalmortalitywaszeroand Perinatal morbidity 27.27 % and 67.2% healthy infants. The association between themodeofdeliveryandfoetaloutcomewasfoundto bestatisticallyinsignificantinthisgroup.

## DISCUSSION

Thrombocytopeniacomplicatinghypertensivedisordersofpregnancyareapproximately10%.Pree clampsiaaffects approximately6%of allpregnancies.[2]

Inourstudyof120casesofthrombocytopenia,70.58%ofthecaseshadPregnancyinducedhypertensi on.

Intheotherstudiesdone byRobertSEgerman (7-10%)[6],wastheoverall incidenceofPIH.

TheprevalenceofthrombocytopeniaamongthePIHwas21%inthestudydonebyRayJG[7], 21%in Bob and Burrow[8], 20%inJohn G Kelton[9], 28.5%inJoshiet al.[10]

Thefindingsof ourstudywasmuchhigherwhencompared to otherstudies.

## INCIDENCEOFHELLPSYNDROME

HELLPsyndromeispartofthisspectrumofplateletconsumptionandcoagulationactivationinpregn ancy.Incidenceofthrombocytopeniaamongpatientswithseverepihandeclampsiaaround20%[11].

In the present study, 24.16%patients had HELLPsyndrome.

## INCIDENCEOFMATERNALMORTALITY

Patients with severe pre-eclampsia, eclampsia and HELLP have a significant

maternalmortalitywhichcanrangefrom1-3%asaresultofmultisystemorganfailure[12].Inourstudythemortality was2% among theHELLP. This compareswith others asfollows

## INCIDENCEOFFOETAL MORBIDITY

IUGR is a most common fetal morbidity associated with PIH and thrombocytopenia. In thepresentstudy incidenceofFoetal Morbidity was28 %.This compareswith thefollowing

## CONCLUSION

Thrombocytopeniainpregnancy-inducedhypertensionisassociatedwithadangerforboththe mother and the foetus, according to the American Heart Association. The concomitantcausesofthrombocytopenia,includingasabruption,retentionofadeadfoetus,septicae mia,and disseminated intravascular coagulation, exacerbate the complication of the disease.Thrombocytopenia is more common among women who have experienced the onset ofpregnancy-inducedhypertensionearlyon,anditisassociatedwithsubstantialmorbidityforboththemother and the foetus.

HELLP syndrome continues to be a source of concern for obstetric health care providers.The nonspecific signs and symptoms of many illnesses early in the disease process makecorrect identification difficult, and delaying early treatment, which has the best prognosisforbothmaternalandfoetaloutcomes,furthercomplicatesthesituationanddelaystreatme nt. The presence of thrombocytopenia per se has no effect on the mode of delivery.Mild thrombocytopenia was frequent in the third trimester, and it had a benign course afterdelivery.Administrationofcorticosteroids–dexamethasonerescuetothemothershouldbedoneassoonaspossibletoincreasetheplateletcountan dtoenhancelungmaturity,aswellas to reduce the risk of intraventricular haemorrhage and necrotising enterocolitis between28 and 34 weeks of pregnancy, thereby reducing maternal and perinatal morbidity andmortality,as well as maternal andperinatal morbidity and mortality.

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## CONFLICTOFINTEREST

None

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