A case of severe gingival bleeding in a patient with preeclampsia

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Objective

Periodontal pathologies have been proposed to be related to preeclampsia development. Preeclamptic patients may present with dental bleeding which may necessitate oropharyngeal examination and intervention. We report a case of severe gingival arterial bleeding in a nulliparous preeclamptic patient.

Methods

A 24 year-old primigravid woman admitted to our perinatology clinic at 35 weeks with hypertension, twin pregnancy and discordant growth. She had dichorionic diamniotic spontaneous twin pregnancy with 30% of discrepance in growth. Both fetuses had normal umbilical artery doppler flows and fetal non stress test. She used 500 mg alpha-methyldopa three times per day. In the spot urine analysis, protein was above 300 mg/dl. She was hospitalized for close follow-up. Fetal surveillance was assessed with serial ultrasonography and cardiotocography. 24-hour urinary protein excretion was 3580 mg. At 36 weeks, laboratory findings revealed thrombocytopenia with a level of 101 µl and moderate dental bleeding was noticed. Thrombocytopenia was accused to be responsible for the moderate bleeding and the patient underwent cesarean section for severe preeclampsia after mgso4 prophylaxis. A female infant was born, weighing 2620 g with apgar scores of 5 and 7, at 1 and 5 minutes; and male one was born weighing 1430 g with apgar scores of 5 and 7, at 1 and 5 minutes respectively.

Results

There was not problem during operation but intraoperative massive gingival bleeding occurred between right lower canine and first premolar teeth. Tranexamic acid, 250 mg was given intravenously and tampon with tranexamic acid was applied on the bleeding gingiva. Preoperatively and intraoperatively, hemoglobin levels were 12. 6 and 8. 3 gr/dl, hematocrit levels were 36. 9% and 22. 7% and fibrinogen levels were 303 mg/dl and 143 mg/dl respectively. Two units of erythrocyte suspension, 2 units of fresh frozen plasma and 4 units of platelet suspension were transfused. Consultations by an otorhinolaryngologist and dentist were performed due to continuing severe hemorrhage. Bleeding artery was sutured by dental surgeons with 3/0 vicryl (picture 1). We used nitroglycerin postoperatively because her arterial blood pressure was 176/111 mmhg. The day following the surgery, hemoglobin was 1. 5 g/dl, hematocrit 31. 1% and her arterial blood pressure was normal. Her pregnancy history revealed that she had had gingival bleedings several times but she hasn't applied for any dental care.

Conclusion

Although the etiology of both periodontitis and preeclampsia are multifactorial and the causal relation between two is not clear, dental bleedings in patients with preeclampsia should remind periodontal pathology besides complications due to hypertensive diseases of pregnancy. As a conclusion; dental care in pregnancy is essential and the patients should be encouraged and informed about dental examination, especially in case of any dental sufferings.