SUMMARY AND CONCLUSION

Following conclusion has been drawn from this work:-

1- Maximum fall in serum magnesium level has been observed in third trimester of pregnancy, with a greater statistically significant difference in Ist/IIInd and Ist/IIIrò trimesters than in the IIInd/IIIrò trimester.

The factors responsible for the depression in serum magnesium levels in pregnancy are still not known. Hall (1957) described this to physiological gestational hypervolaemia but of haemodilution was the cause, the level of all the blood constituents should have been lower in normal pregnancy which is not true.

2- There has been a highly significant difference in the serum magnesium levels of non-pregnant and abortion cases and first trimester pregnancy and abortion cases \( p \leq 0.01 \), whereas the difference between second trimester and abortion groups was statistically not significant except habitual abortion.

It has been observed that the level of serum magnesium is not affected by the age and parity of the patients and period of gestation in cases of abortions.
3- There has been a highly significant difference in the serum magnesium levels of nonpregnant and preterm labour cases p< 0.01 whereas the difference between normal pregnant and premature labour group was statistically not significant.

To avoid premature births intake of magnesium is recommended so that the magnesium level in serum remain within the range of 1.5 - 3.5 mg%.

It however, warns the clinician that administration of magnesium therapy may induce adverse effects on both the mother and foetus. Since it is observed that increased magnesium levels induce brady cardia and eventual cardiac arrest, the occurrence of still births may be due to high magnesium transport to the foetus through cord blood.

(a) Authors suggests magnesium therapy during pregnancy to avoid abortions and preterm labour.

(b) It is suggested that serum magnesium levels should be within the range of 1.5-3.5 mg%.