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A Case of Diagnosed Systemic Lupus Erythematous With Antenatal Complications

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Abstract
This is a case report of SLE complicating pregnancy. During antenatal period preeclampsia was managed LSCS wasdone for IUGR with abnormal doppler. Patient discharged in stable condition and followed. Patient was continued onoral hydroxychloroquine and prednisolone throughout pregnancy and postpartum period.

Keywords: SLE (systemic lupus erythematous), IUGR (Intrauterine growth retardation), Doppler, Hydroxychloroquine, Prednisolone:

INTRODUCTION

Systemic lupus erythematosus (SLE) is a chronic inflammatory connective tissue disease commonly diagnosed after the age of 20, mostly around the age of 30 years. In 90% of cases the disease affects women, incidence of SLE during the child bearing age being 1 in 500. Women with SLE are at higher risk for spontaneous abortions, intrauterine fetal death, preeclampsia and eclampsia, preterm delivery and intrauterine growth retardation neonatal lupus, and in extreme cases stillbirth. This paper is a case report of a pregnant woman with SLE complicated with preeclampsia,IUGR and follow-up .

CASE REPORT

A 27 years old Mrs X, G4P1A2L0 came to the labor room at SMS Medical College, Jaipur in January 2016 with SLE complicating pregnancy with 38 weeks period of gestation (POG) in labor . In the past history she had photosensitive rash over face since 6 years and fever 5 years back, then SLE was diagnosed. She was started on oral Hydroxychloroquine and Prednisolone. She developed cutaneous manifestations all over the body and alopecia since 3 years. She conceived spontaneously after one year of last delivery. She continued oral hydroxycloroquine and prednisolone throughout pregnancy as advised by the rheumatologist. She was started on oral folic acid in the first trimester. The history of the patient and the antenatal card showed, she was irregular in her antenatal check-ups and last visit was 8 weeks back. The records showed her antenatal investigations and the blood pressure recordings were normal till 30 weeks period of gestation. The first trimester and second trimester ultrasound scans were corresponding to period of gestation. There was no history suggestive of impending eclampsia. The examination of the patient showed, pulse rate of 90/min, respiratory rate of 14/min and blood pressure recording of 176-188/112-126 mmHg.The abdominal examination showed a 34 weeks uterus with longitudinal lie and cephalic presentation. The per vaginal examination showed soft cervix at mid position, 40% effaced, 2 cm dilated and head at _2/3 station. The urine examination revealed a trace of proteinuria. Blood group was O+ve. A complete blood count (Hemoglobin, packed cell volume, platelet count), glucose challenge test blood urea, serum creatinine, serum bilirubin, ALT and AST, VDRL HbsAg , HIV,Thyroid profile were sent and the reports were in normal limits. Fundoscopy was normal. She was given inj labetalol 20 mg slow iv. Obstetric scan was shows 34 weeks, suggestive of IUGR . Doppler showed abnormal middle cerebral artery changes. In view of these changes Emergency LSCS was done and delivered a male child with birth weight of 2kgs with APGAR 6-8. During the intra-operative period, under general anaesthesia her blood pressure was 156-180/ 98-120 mmHg and pulse rate of 90-100/min. She was started and prophylactic schedule of injection magnesium sulphate 10 g stat i.m. (5 g in each buttock) then to be repeated every 4 h for 24 h tab nifedipine 10 mg twice a day. Immediate postoperative

period was uneventful. Preoperatively, intraoperatively and postoperatively injection hydrocortisone 100mg was given 8th hrly. She was advised not to give breast feeding. Post operatively 1 units blood was transfused and antihypertensives were continued. Patient was discharged in stable condition and followed in the post-partum period. Patient was stable and blood pressure recordings were controlled.

DISCUSSION

SLE is associated with decreased fertility and spontaneous abortion. In this case patient conceived after repeated pregnancy loss and progressed up to 38weeks gestation. Patient develops preeclampsia during antenatal period. There is increased risk of preeclampsia in SLE complicating pregnancy. As it was known that SLE is associated with IUGR, in this case IUGR was developed. The possible causes for IUGR in this case were SLE. Inspite of using drugs throughout pregnancy baby was born without any congenital anomalies. Increased SLE disease activity is expected during pregnancy because of increased levels of estrogen, prolactin, and T–helper cell 2 cytokines. Possible causes of flares during the postpartum period include decreased levels of anti-inflammatory steroid, elevated levels of prolactin , changes in the neuroendocrine axis, and estrogen and progesterone changes. High dose corticosteroids carry the risk of IUGR, premature membrane rupture, gestational diabetes, hypertension, osteoporosis etc. Hydroxychloroquine is safe in pregnancy and lupus patient who becomes pregnant should continue taking hydroxychloroquine. Nursing mothers can continue to take prednisolone and hydroxychloroquine. Cytotoxics such as methotrexate, azathioprine, cyclophosphamide and cyclosporine A are contraindicated in breast feeding mothers. Maternal and fetal outcome was good.

CONCLUSION

Even in the presence of SLE, conception is possible and with adequate antenatal and post-partum care good maternal and fetal outcome can be achieved. Doctors diagnosing and managing pregnancies with SLE should be aware of the potential complication and the genetic predisposition for early detection and proper referral and counseling regarding the prognosis of pregnancies.

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