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Original Research Paper

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A CASE REPORT OF SYSTEMIC LUPUS ERYTHEMATOSUS DURING PREGNANCY - CLINICAL PROFILE AND COMPLICATIONS

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ABSTRACT Systemic Lupus Erythematosus (SLE) is a multisystem autoimmune inflammatory disorder that frequently affects child bearing age .Disease is better tolerated in pregnancy if quiescence achieved with 6 months of prior therapy .Variable lupus flares,difficulty in assessment of different flares due to physiological changes of pregnancy,fetal and neonatal outcome, safety of various drugs in antenatal period and lactation has to be addressed while managing SLE in pregnancy .This case report discusses challenges of management of SLE in pregnancy.

KEYWORDS : SLE (Systemic Lupus Erythematosus)

INTRODUCTION Systemic lupus erythematosus (SLE) is a chronic inflammatory connective tissue disease commonly affecting women(90%).Incidence of SLE during the child bearing age is 1 in 500[2]. Women with SLE are at higher risk for spontaneous abortions, intrauterine fetal death, preeclampsia- eclampsia, preterm delivery,intrauterine growth retardation, neonatal lupus, and in extreme cases stillbirth. This paper is a case report of a pregnant woman with SLE complicated with preterm labor, preeclampsia, IUGR, Lupus flare with excellent feto-maternal outcome.

CASE REPORT: A 30 year old Mrs. X, G4P2A1L1 admitted at government Medical College, nagpur with diagnosed case of SLE since last 2 years with preterm labor at 31.4 weeks of gestation .She has previous 2 LSCS of which first was done for sever preeclampsia & IUGR while second was done for preeclampsia& preterm labor with an 2 month induced abortion in between two pregnancies. First child is 7 year old, healthy while second child died after 60 days of NICUadmission due to extreme prematurity. Patient was diagnosed as rheumatoid arthritis 2 years after first delivery and treated with NSAIDs and inj. methotrexate. Then 3 year later, she consulted dermatologist for photosensitive rash over face & hand, alopecia with oral ulcer, then SLE was diagnosed by indirect immunofluorescence test for ANA (Anti Nuclear Antibody),positive in 1:1000 titer. She was started on oral Hydroxychloroquine and Prednisolone 30mg od.Patient was booked with private hospital with regular antenatal visits and got herself registered with our institute for delivery. she visited skin opd frequently for skin flares.Patient stopped hydroxychloroquine by herself 28weeks onwards and continued with prednisolone 30 mg od although irregularly along with Aspirin, folic acid,iron,calcium,protein supplementation. Examination on admission shows, vitals were stable,blood pressure was 130/90 to 160/100 with urine albumin 2+.Abdominal examination revealed 28weeks,IUGR fetus with palpable uterine contractions.Per vaginal examination showed soft cervix at mid position, 50% effaced, 2 cm dilated and head at -2 station. A complete blood count, glucose challenge test,KFT,LFT,Coagulation profile ordered. Fundoscopy done was normal. Injection betamethasone 12 mg intramuscular given. Emergency LSCS done under spinal anesthesia and a male child delivered with birth weight 1.2 kgs with APGAR 6-8.Baby was shifted to neonetal unit for prematurity and LBW. During the intraoperative period,her blood pressure was 156-180/ 98-120 mmHg and pulse rate of 90-100/min. Postoperative period was uneventful and investigations were within normal limits. Patient received extended antibiotic cover with steroids.Her24 hr urine protein was 524mg per day for which nephrologist adviced to step up steroid therapy and follow up.Patient was discharged on day 17 th of delivery on predisone 40mg od with healthy baby of weight 1.4 kg with weekly follow-up.Baby was advice monthly electrocardiogram and 2D-Echo after 6 month. Husband was counseled and was willing to underwent vasectomy in recent future

DISCUSSION

Lupus is heterogenous autoimmune disease with complex pathogenesis that results in immune system abnormality including overactive B lymphocyte producing auto antibodies directed toward one or more cellular nuclear component causing tissue and cellular damage.[1]Infections, lupus flare, end organ damage ,hypertension , stroke, cardiovascular disease causes morbidity and mortality in SLE patients.[2] SLE is associated with decreased fertility, spontaneous abortion, preeclampsia-eclampsia, fetal growth restriction, preterm labor, anaemia, thrombocytopenia, thromboembolic episodes, sepsis.[3,4] Pregnancy outcome is best in women with 1. quiescent activity 6 months before conception 2.without renal disfunction or proteinuria 3.No evidence of antiphospholipid antibody syndrome or lupus anticoagulant 4.No development of superimposed preeclampsia.[5,6] In this case patient conceived spontaneously after bad obstetric history and progressed up to 32 weeks. Patient developed preeclampsia, IUGR, preterm labor as it is common with SLE in pregnancy. During pregnancy lupus improves in a third of women ,remain unchanged in a third and worsens in the remaining third and women having confined cutaneous lupus do not usually have adversed outcome .[7,8] Physiological changes in pregnanacy can be confused with lupus flare like pregnancy induced thrombocytopenia, facial and palmer erythema of pregnancy .Overt proteinuria is ominous sign even more so if accompanied by other evidence of nephrotic syndrome or deranged KFT.[9] NSAIDs, low dose aspirin ,corticosteroid therapy, antimalerial like hydroxychloroquine are relatively safe in pregnancy and can be used throughout pregnancy.[10,11,12].neonatal lupus and congenital heart blocks are unusual neonatal complications.[13,14]Nursing mothers can continue to take prednisolone and hydroxychloroquine. Cytotoxics such as methotrexate, azathioprine, cyclophosphamide are better avoided and can be used in severe steroid resistant disease after 12 weeks only after counseling regarding fetal risk .[15]For long term contraception, barrier method is advised while Progestin- only implant and injection are effective with no known risk of flare.[16]

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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