Case Report

Rare cases of pregnancy with SLE

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ARTICLE INFO

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1. Introduction

Systemic lupus erythematosus (SLE) is an autoantibody mediated multisystem autoimmune disease, with considerable female predominance.¹

Women with SLE are at higher risk for exacerbations of the disease during pregnancy, spontaneous abortions, intrauterine fetal death, pre-eclampsia and Eclampsia, preterm delivery and intrauterine growth retardation, fetal heart block.

However, over the past few decades, there has been a trend towards more favorable outcomes.

This case report summarizes the management in a parturient with SLE who underwent emergency caesarean section (LSCS) for massive accidental hemorrhage.

2. Case Presentation

2.1. Case 1

A 27 years old 6th month primi gravida, was a known case of SLE with CRF and Chronic H.T., admitted with c/o hemoptysis with fever with chills with nausea and admitted under nephrologist, physician and intesneivist. Treatment given²

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https://doi.org/10.18231/j.ijogr.2020.064
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CGA maturity of 32 weeks. EFW: 1712 gms MCA PI 1.6, Umbilical Artery PI: 1.0 CPR>1
Umbilical Artery PI:1.8.
The following chart presents the detailed hematological report.

Renal function test= S CREATININE 2.9 G/DL, GFR=21 ml/min/1.73m²
S. Sodium 133, S. Pottosium 5.0, S. Chloride 96, Urine
Showed 78.2 PUS Cell Count.
Liver Function Test = SGPT 27, SGOT 17, S. Alubumin
3.2, S. Globulin 2.6, A/G Ratio 1.2
ANA (BY I.F.) DILUTION 1:100 = POSITIVE (++++)
Profile = ANTI DsDNA Strong Positive
ACA = Negative
ANCA C & P = Negative
CBC = HB : 6.6 G/DL WBC : 10530 PLATELET : 2,80,000
CRP = 29.3 MG%
D-DIMER = 0.21
MNPT = 4.1
Renal biopsy: focal sclerosing glomerulonephritis
Maternal: Electrophysiological study of (23-06-2018)
facial nerves revealed evidence of mild moderate right facial
axonal neuropathy.
The patient came with massive accidental haemorrhage on
26-6-2018 at 9:00 pm.
Emergency LSCS was done. The neonate weighing 1.6
kg with Apgar score 4 was shifted to NICU.
Total 8 unit of RCC and 2 unit of FFP were given.
Persistant hypertension was aggravated severely after
surgery.
Inj. Labetalol iv stat given followed by inj. Betaloc given.
Cap. Depin continued S.L.
Inj. NTG started in 250 ml NS for uncontrolled BP with
above treatment.
Top Nitro patch kept for 24 hours, inj. Lasix given after
every 2nd RCC and Calcium Gluconate after every 3rd unit
of RCC.
Inj. Peperacillin with tazobactum 2.5 mg in 100 ml NS.
And inj. Metrogyl iv every 8 hourly continued for five days
after LSCS With other supportive treatment. On 3rd day tab
Hydralazine started orally BD.
Patient developed big prolapsed piles (due to? Vascu-
lopathy) which reduced manually through Rectum.

2.2. Case 2
Female 23 years old has came with 26 weeks of pregnancy
for expert usg at our center for opinion.
Fetus has fetal Brady cardia around 96 bets per minute
constant and was advices by another Gynec for termination.
We have done detail usg and counseling and taken
opinion with endocrinologist and done her SLE profile.
Reports are positive and started HCQ twice a day and
tablet betamethasone 2mg tice a day and continue pregnancy

with risk of above all complications.
Regular follow up with usg shows fetal bradycardia
continue 96-100 bpm.
Fortunately patient went 33 weeks of pregnancy, and we
have done nothing plan LSCS under steroid cover.
Female child of 2.250 Gm cried son after birth with
bradycardia of 96 bpm
Baby kept under observation for 24 hrs at neonatal unit
and send for pediatrics consultancy at Ahmedabad CIMSs
hospital and echo was normal with bradycardia and no
intervention of pace maker was advised.
Follow up till date baby is fine with bradycardia and
weight gain also about 4.00 kg.
Mother is on tab HCQ once daily.

3. Discussion
The peak incidence of SLE occurs between the ages of 15
and 40 years, with an estimated female-to-male incidence of
9:1.
It is characterized by autoantibody production and a dys-
functional immune system resulting in organ inflammation
and consequent damage.
Positive antinuclear antibody test is the characteristic
laboratory test used to help diagnose lupus.
Pregnancy outcome is influenced by placental dys-
function, the presence of antiphospholipid antibodies, preconceptional lupus activity, the severity of renal
involvement, and the course of SLE during pregnancy. SLE
may be associated with secondary APS (anti-phospholipid
syndrome) that is a multisystem disorder characterized by
recurrent systemic arterial and venous thrombosis, recurrent
abortion, thrombocytopenia and neurological disorders.
Clotting factors are also affected but tests such as partial
thromboplastin time can be falsely elevated because the

Fig. 1: A): Fetus with good Apgar score; B): Placental
haemorrhage; C): Mother with moon face showing Bell’s Palsy

A
B
C
Fig. 2: Baby

Fig. 3: Echo

Fig. 4:

Fig. 5: Baby ECG

Fig. 6: Mother lupus positive
lupus antibodies react with phospholipids used to determine PTT.

A more serious and rarer complication is the reaction of antibodies with factors VIII, IX, XII that leads to bleeding. Complete coagulation profile (BT, CT, PT, APTT) and prophylactic precautions against DVT are indicated. The risks for other serious complications, such as pre-eclampsia, hypertension, bleeding and serious infections, are also raised two-fold to eight-fold Musculoskeletal manifestations and mucocutaneous symptoms occur frequently.

Respiratory complications include restrictive lung disease, myopathy affecting diaphragm or chest wall muscles and interstitial infiltration secondary to treatment with cyclophosphamide and azathioprine, which may potentiate need for post-operative mechanical ventilation.

Cardiac lesions include pericarditis, myocarditis that may lead to CHF and cardiac valvular lesions (Libman-Sachs endocarditis) that are usually asymptomatic. So, ECG and echocardiogram should be done.

Prophylactic antibiotic is indicated for labor and delivery, as they are prone for infections.

Nephritis is a known complication of SLE as in our case and is a strong predictor of poor outcome. Hypertension, proteinuria and nephrotic syndrome often accompany lupus nephritis. Urine analysis, BUN, serum creatinine, electrolytes and blood sugar should be performed frequently.

Neurologic complications like peripheral neuropathy, cranial nerve palsies, psychosis, intracranial bleeding may be due to vasculitis or due to steroid therapy.

The fetal complications are higher rates of fetal loss, preterm birth, intra-uterine growth restriction (IUGR), and neonatal lupus syndromes (NLS). Maternal antibodies cross the placenta and lead to fetal manifestations.

Patients who are on HCQ before pregnancy are more likely to develop fetal heart block during pregnancy. The présences of SSA and SSB anti bodies Can lead to fetal heart block and neonatal lupus. Which can be managed with betamethasone OR I/V Immunoglobulin. Treatment of patients with antiphospholipid antibody-associated recurrent pregnancy loss with heparin and low-dose aspirin have been shown to improve live birth rates, while patients with positive antinuclear antibodies failed to show any improvement in implantation and pregnancy rates but not proven yet and further studies going on.

Anesthetic management of pregnant patients with SLE depends on the multisystem nature of the disease, the severity of the organ involvement and adverse effects of drugs used in treatment.

Sjograns syndrome is a disorder of immune system identified by its two most common symptoms — dry eyes and a dry mouth.

4. Source of Funding

None.

5. Conflict of Interest

None.

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Cite this article: Pandya D, Pandya D, Pandya MR, Pandya R. Rare cases of pregnancy with SLE. Indian J Obstet Gynecol Res 2020;7(2):292–295.