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SLE (Systemic Lupus Erythematosus) Complicating Pregnancy – A Case Report

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***Abstract**: This is a case report of SLE complicating pregnancy. During antenatal period anaemia was managed and LSCS was done for IUGR with abnormal doppler. During surgery atonic PPH was developed and managed with medical methods and B- lynch application. In the postpartum period she developed hypertension and antihypertensives were started. Patient discharged in stable condition and followed. Patient was continued on oral hydroxychloroquine and prednisolone thru out pregnancy and postpartum period.*

***Keywords:** SLE (systemic lupus erythematosus), Anaemia, IUGR (Intrauterine growth retardation), Doppler, Atonic PPH, B-Lynh, Hydroxychloroquine, Prednisolone*

I. Introduction

Systemic Lupus Erythematosus (SLE) is one of the most common autoimmune disorders that affect women during their childbearing years. The prevalence of systemic lupus erythematosus (SLE) is 14.6-50.8 cases per 100,000 general population. Lupus exacerbation during pregnancy occurs in about 20-30% of pregnant lupus patients. Flares of SLE are uncommon during pregnancy and are often easily treated.

SLE increases the risk of spontaneous abortion, intrauterine fetal death, preeclampsia, intrauterine growth retardation and preterm birth. Prognosis for both mother and child are best when SLE is quiescent for at least 6 months before the pregnancy and when the mother's underlying renal function is stable and normal or near normal. The mother's health and fetal development should be monitored frequently during pregnancy.

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.

II. Case Report

A 27 year old Mrs X, Primigravida with 7th month period of gestation came to Metro Superspeciality hospitals, suryapet, Vijayawada with SLE complicating pregnancy for antenatal check up.

In the past history she had photosensitive rash over face since 4 years and fever 3 years back, then SLE was diagnosed. She was started on oral Hydroxychloroquine and Prednisolone. She developed cutaneous manifestations all over the body (Fig 1) and alopecia (Fig 2) since 2 years.

She conceived spontaneously after 8 months of marriage. She continued oral hydroxycloroquine and prednisolone thru out pregnancy as advised by the rheumatologist. She was started on oral folic acid in the first trimester. She attended this hospital in 7th month period of gestation and she was investigated.

Investigations showed Hb% - 5 gm%, ESR is elevated, platelet , WBC , RBC count were normal, peripheral smear showed microcytic hypochromic anaemia, renal function tests and liver function tests were normal, thyroid profile is normal, HIV , HBsAg, VDRL were normal, blood group is O+ve, glucose challenge test was normal, urine complete examination was normal. Obstetric scan was done and fetal anamolies were ruled out and it was normal.Total abdominal scan was normal. In view of anaemia she was given 3 units packed cell transfusions. At 35weeks period of gestation IUGR was diagnosed. NST was abnormal and 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 surgery she developed atonic PPH, injection 20 units oxytocin drip, injection 10 units oxytocin intramuscularly, injection methergine intrvenously, injection prostadin intramuscularly and intramyometral were given. As the bleeding was not controlled B-Lynch (Fig 4) was applied. Then bleeding was controlled. Placenta was succentuirate placenta (Fig 3).Preoperatively, intraoperatively and postoperatively injection hydrocortisone 100mg was given 8th hrly. She was advised not to give breast feeding. Post operatively 2 units blood was transfused. On the 5th post operative day she developed high blood pressure recordings and was started on oral labetalol and nefidepin. Investigations were done and all were normal. Antihypertensives were continued up to 5weeks post partum period. Patient was discharged in stable condition and followed in the post partum period. Patient was stable and blood pressure recordings were controlled.

Figure 1: Cutaneous manifestations in SLE

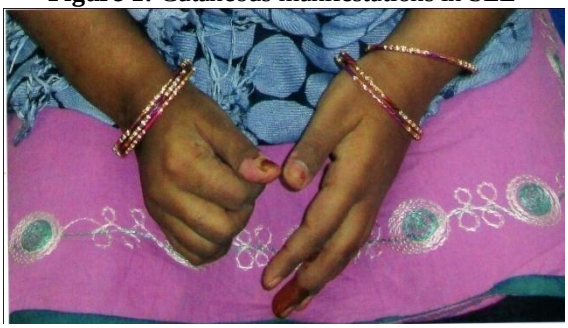


Figure 2 : Alopecia

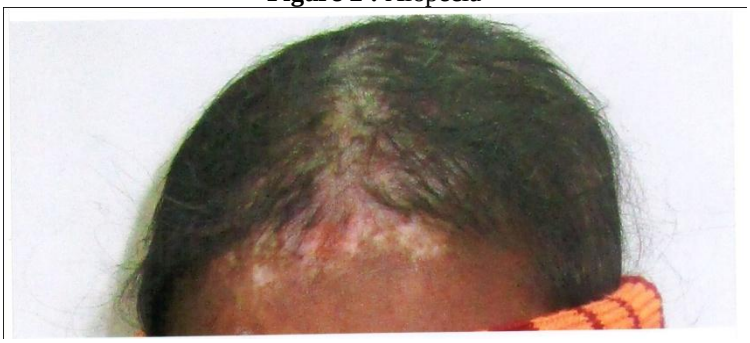


Figure 3 : Succenturiate placenta

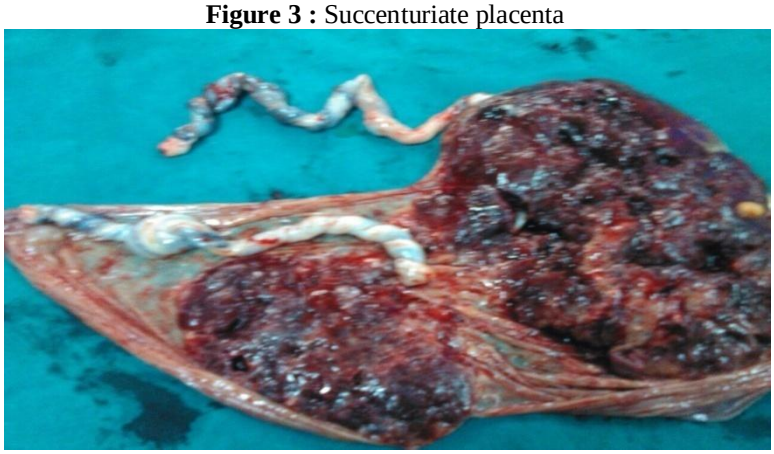
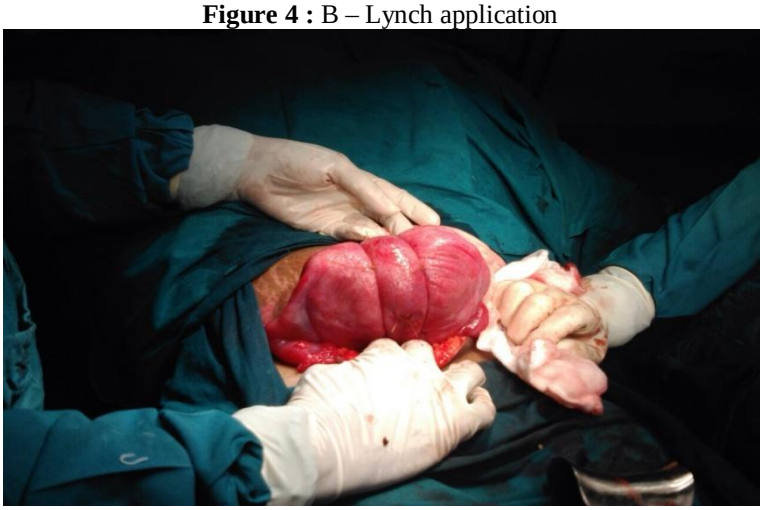


Figure 4 : B – Lynch application



Discussion

SLE is associated with decreased fertility. But in this case patient conceived spontaneously and progressed up to 35 weeks gestation. 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, anaemia and drug induced. Inspite of using drugs through out pregnancy baby was born with out any congenital anamolies. Patient did not develop any complications during antenatal period but intraoperatively patient developed atonic PPH which was managed effectively. In the post operative period she developed hypertension. There is increased risk of preeclampsia in SLE complicating pregnancy. She was advised to avoid breast feeding as she continued on hydroxychloroquine.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.

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