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Title: SLE with Secondary APS in Pregnancy

INTRODUCTION

- SLE is a multisystemic autoimmune inflamatory disease which primarily affect women in their reproductive age group. Out of all SLE patients 90% ore women.' 90% of them ore within 20-40yrs oge
- Pathogenesis of SLE involves auto antibody production d/t overactive B lymphocytes, impaired T cell regulation & subsequent deposition of immune complexes which result in tissue & cellular damage.
- May affect any organ system, joints>skin >lungs>nervous system> kidneys>heart are mostly affected.
- Fertility is generally unaffected in SLE, except in women with active disease, signiflcant impairment of renal function or high dose corticosteroid or cyclophosphomide therapy which con result in ovarian dysfunction.
- Steroids are usually safe& l st line drugs during exacerbation or Lupus flares
- Continuing HCQ in pregnancy appears to reduce the risk of lupus flares during & after pregnancy.

CASE REPORT

A 28 yrs,G3PlLOAl at GA 32 wks 3days with SLE with 2° APS with nephritis, severe Preeclampsia , hypothyroidism was admitted to LR on 09/08/23 with c/o Pain & swelling of b/1 legs & hands, palmoplantar rash & bodyache for l5days. Patient had anti Ro/SS A(+), ANA Hep 2-3+ patient was on Tab. prednisolone, Tab. HCQ, Tab. Thyroxine since 1ST TM. On Admission pt was conscious, oriented, afebrile, BP-160/90, P+l-E+++, urine alb-3+. Her P/A showed Ut. 28-30 wk size, Cx long, soft, os closed, FHR-1 32/min on doppler. Pt. was kept on lnj.f/b oral antihypertensives (labetalol, nifedipine), lnj.Dexona, Inj . MgS04 neuroprotection dose started, Tab.HCQ, tab. thyroxine continued, Inj. LMWH put on hold. LSCS decision was taken In view of Severe Preeclampsia with uncontrolled htn with BOH. LSCS/male/2kg/ l l.55AM/Vx.

Postoperatively pt. had uncontrolled HTN-+ lnj. labetolol Infusion given along with Inj. Lasix. Daily Rheumatology review done with advice to start lnj. LMWH (0.4cc S/C) from POD-3 & SLE medications (Tab.HCQ & lnj. Hydrocortisone) continued as before. pt transferred to HRW after BP control, rest postoperative period was uneventful. Pt. discharge on POD-8 with advice to attend Rheumatology OPD for further management of SLE .

DISCUSSION

Diagnosis

CLINICAL :

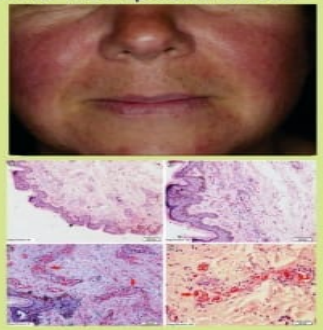
ACR (American College of rheumatology) diagnostic criteria for SLE-->

D - Discoid Rash
O - Oral ulcers
P - Photosensitivity
A - Arthritis(nonerosive)
M - Malar Rash
I - Immunological d/o
N - Neurological-neuropathy, seizures, psychosis, myelitis
E - elevated ESR
R - Renal impairment-nephritis, proteinuria, casts
A - ANA positive
S - Serosal- pleural/pericardial effusion, Pericarditis
H - Hematological - leucopenia, thrombocytopenia, autoimmune hemolysis

SCREENING :

by detection of antibodies in SLE

- Antinuclear Ab.(ANA)-best screening test, found l almost all pts of SLE
- Anti DS DNA ab.-In a preg. SLE pt signifies' increased chances of Nephritis, vasculitis
- Anti Smith Ab-most specific for SLE



CONCLUSION

- No permanent cure of SLE.
- Only symptomatic t/t done
- Give low dose Aspirin throughout the pregnancy for preg with SLE & 2°APS with no BOH.
- If h/o RPL with APS Combination of Low dose Aspirin+ s/c UFH/LMWH in prophylactic doses
- MILD CASES If c/o arthralgia/serositis DOC- NSAIDS upto 32 wks (CAUTION- Don't use for prolonged period/large intermittent dose l/t Oligohydramnios/premature closure of Ductus arteriosclerosis in fetus)
- SEVERE CASES DOC-PREDNISOLONE (dose-1-2mg/kg/day)' S/E- may l/t GESTATIONAL DIABETES
- In pts resistant to steroids Doc-AZATHIOPRINE
- If pt was on antimalarial before preg. & her SLE was controlled with it continue antimalarial in pregnancy
- SLE can l/t Preterm Labor
- Timing of Delivery Continue pregnancy till TERM unless PIH/IUGR/PTL
- In certain cases of SLE which are resistant to Steroids & immunosuppressives Intravenous Immunoglobulins (IVIg) can be given

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