AICOG 2025
Mumbai
67th All India Congress of Obstetrics & Gynaecology
FOGSI celebrates 75 years – Diamond Jubliee
8-12 January, 2025 | JIO World Convention Centre

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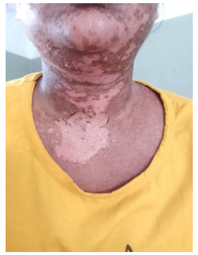
Title: SUCCESSFUL MANAGEMENT OF NEW ONSET LUPUS FLARE IN EARLY PREGNANCY

CASE REPORT:
A 23-year-old primigravida presented at 12.6 weeks gestation with newly diagnosed Systemic Lupus Erythematosus (SLE). She presented with severe anemia (Hb 6.8 g/dL), lupus flare and renal involvement.

INTIAL PRESENTATION:
The patient's pregnancy was diagnosed at 8 weeks, following which dating scan and antenatal profile was done which came out to be normal. Later at 9 weeks, she had fever for which Laboratory Investigations were done outside which were suggestive of typhoid fever with urinary tract infection (UTI) for which she was managed conservatively .



DIAGNOSIS OF SLE:
Despite treatment, patient's fever persisted,she also developed mouth ulcers with skin rashes. ANA profile was sent, which came out to be positive, confirming the diagnosis of SLE. So she was started on hydroxychloroquine (HCQ) and dexamethasone

The patient presented to our hospital at 12.6 weeks of gestation with high-grade fever,joint pain, rashes, fatigue, oral ulcers and pedal edema. She was started on injectable antibiotics (ceftriaxone and clindamycin), HCQ and methylprednisolone.

Laboratory investigations:

- Severe anemia (Hb 6.8 g/dL)
- Elevated CRP (14.9)
- Raised ESR
- Proteinuria (+1)
- Decreased complement levels (C3 and C4)-0.26 AND 0.09
- Antiphospholipid antibodies IgG AND IgM 1.04 AND 1.08 WHICH WAS NEGATIVE

Decision Dilemma :
All the high risk factors regarding risk of flaring of disease in pregnancy which can lead to multi organ system involvement ,risk of developing congenital anomalies in fetus and need for close feto-maternal monitoring with continuation of medication were explained to patient and their relatives. Following which they decided to continue pregnancy.

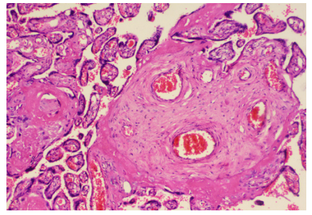
FETAL CLOSE MONITORING DONE VIA REGULAR ANC VISITS AND ADMISSION WITH

- Dating scan, NTNB scan , NIPT , Early anomaly scan ,Fetal echo

Management:
The patient was managed with a multidisciplinary approach, including rheumatology, nephrology, and obstetrics.

- Hydroxychloroquine (HCQ) 300mg OD
- Methylprednisolone
- Azathioprine
- Fetal monitoring and growth scans

Outcome:
The patient's condition improved with treatment, She remained asymptomatic throughout the pregnancy, with no lupus flares. At 37 weeks, she developed pre eclampsia and delivered a healthy 2.9 kg female via elective cesarean section. Placenta was small in size and sent for histopathology , it suggestive hyalinized blood vessels and umbilical vein thrombus.



Discussion:
Pregnancy with SLE is considered high risk due to potential adverse effects on maternal and fetal outcomes.

SLE's clinical manifestation vary including rashes, arthritis, anemia, thrombocytopenia, nephritis, seizures, psychosis.

Risk of flares increases with gestational age as

- 13%in 1st trimester
- 14%in 2nd trimester
- 53%in 3rd trimester
- 23% during the puerperium

Our patient presented with new-onset lupus in pregnancy, primarily affecting the mucocutaneous and renal systems. She received injectable antibiotics, methylprednisolone, and hydroxychloroquine (HCQ).

HCQ is considered safe in pregnancy and reduces disease activity and flares. Azathioprine and low-dose corticosteroids can be used for mild manifestations.

Differentiating preeclampsia from lupus nephritis can be challenging due to shared symptoms. Falling or low complement levels and high or increasing anti-dsDNA along with active urinary sediment and urinary cast can help differentiate between the two conditions.

Regular monitoring, including dating scans, NTNB scans, NIPT, early anomaly scans, and fetal echos, is essential. Four-weekly fetal doppler and interval growth scans can help diagnose intrauterine growth restriction (IUGR) earlier.

Postpartum women on HCQ, azathioprine, and/or steroids for immunosuppression should continue these medications, as the puerperium is a high-risk period for lupus flares.

Conclusion:

SLE with pregnancy is a high risk pregnancy especially if patient has lupus flare and antiphospholipid antibodies and anti Ro ana Anti La antibodies are positive. These pregnancies should be handled and taken care of at multi-speciality clinic. Proper counseling for flare symptoms, explaining of high risk condition, and necessity of continuation of treatment is must for successful maternal and fetal outcome. Frequent fetal monitoring with sonography and fetal echo is required for early detection of IUGR, doppler changes and first and second degree heart block respectively in fetus.

Inter-professional team care and close surveillance during pregnancy and in puerperium can lead to successful maternal and fetal outcome.

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