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CONNECTIVE TISSUE DISORDERS IN PREGNANCY: CASE SERIES

Gynaecology

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ABSTRACT

BACKGROUND: Connective tissue disorders are caused by deposition of immune complexes or inherited as disorders of bone, skin, cartilage, blood vessels and basement membrane. T hese pregnancies are always considered as high risk.

CASE SERIES: We present five cases of successful pregnancy outcomes in patients diagnosed with connective tissue diseases . Three cases diagnosed with Antiphospholipid antibody syndrome were on aspirin ,heparin, progesterone supplements antenatally and postnatally on heparin have successful outcome. One case diagnosed with Systemic lupus erythematosis was on Tab Azathioprine, Tab Chloroquine, steroids antenatally and postnatally had successful outcome. One case diagnosed with Sjogren syndrome was on steroids before and after delivery had successful outcome.

CONCLUSION: Pregnancy with connective tissue disorders are associated with increased maternal and perinatal complications. Preconceptional counseling, appropriate medication, multidisciplinary care, delivery in tertiary care hospital with specialist can result in favourable outcome.

KEYWORDS

INTRODUCTION

Connective tissue disorders are caused by deposition of immune complexes or inherited as disorders of bone, skin, cartilage, blood vessels and basement membrane. Prevalence of autoimmune disease ranges from 7.6 to 9.4%.[1] All autoimmune diseases, to some extent, have implications for fertility and obstetrics.[2-6] Currently, due to available treatments and specialized care for pregnant women with autoimmune disease, the prognosis for both mother and child has improved significantly[2-5] However these pregnancies are always considered as high risk.

CASE SERIES

Case 1

32 year old G6A5 at 6week 6day period of gestation was diagnosed as a case of Antiphospholipid Antibody Syndrome with positive Antiphospholipid antibody (APLA) IgM and Anticardiolipin antibody (ACL) IgM.She has a history of 5 spontaneous 1st trimester abortions with 1.5 to 2 years of gap in between pregnancies. She was started on Tab.Ecosprin 75mg and Inj Enoxaparin 60mg subcutaneously once daily in the 1st trimester . She underwent elective LSCS (Indication-Oligohydramnios with Bad obstetric history) at 35wk 5day period of gestation and gave birth to a female baby of 2.25Kg with normal APGAR score. Postnatally Inj .Enoxaparin 6omg subcutaneously was continued for 6 weeks

Case 2

33 year old G3P2L0 was diagnosed as a case of Antiphospholipid Antibody Syndrome with positive Anticardiolipin antibody (ACL) IgM. 6yrs back she has a history of stillbirth at 9 months of amenorrohea, delivered a male baby of 3kg. She was diagnosed as gestational diabetes postnatally and was on insulin for 4 months. 2nd pregnancy was an intra uterine death expulsion at 7 months of amenorrohea .In the 3RD pregnancy she was diagnosed antenatally as gestational diabetes at 6 months of amenorrohea and was started on insulin .She was started on Tab.Ecosprin 75mg once daily from 1st trimester and Inj Enoxaparin 60mg subcutaneously at 23wk period of gestation. She underwent elective LSCS (Indication-Oligohydramnios with Bad obstetric history) at 36wk 4day period of gestation and gave birth to a female baby of 2.13Kg with normal APGAR score. Postnatally Inj .Enoxaparin 6omg subcutaneously was continued for 6 weeks. Postnatally her sugars were normal

Case 3

26 year old G7P1L0A5 was diagnosed as a case of Antiphospholipid Antibody Syndrome with positive Lupus anticoagulant .9years back she has a history of stillbirth at 7 months of amenorrohea, delivered a female baby of 1.5kg. She was diagnosed as gestational hypertension and managed with antihypertensives. She has a history of 5 spontaneous 1st trimester abortions with 1.5 to 2 years of gap in between pregnancies. She is a known case of Lupus nephritis and was on Tab Cyclophosphamide for 1 year and later changed to Tab Hydrochloroquine. She was started on Tab.Ecosprin 75mg and Inj Enoxaparin 60mg subcutaneously once daily in the 1st trimester . She underwent elective LSCS (Indication-Bad obstetric history) at 36wk 6day period of gestation and gave birth to a male baby of 2.3Kg with normal APGAR score. Postnatally Inj .Enoxaparin 6omg subcutaneously was continued for 6 weeks

Case 4

26 year old primigravida was diagnosed as a case of systemic lupus erythematosis.She is a known case of systemic lupus erythematosis since 2 yrs on Tab.Azathioprine 50mg once daily, Tab. Hydrochloroquine 200mg twice daily, Tab.Wysolone 2.5mg once daily. She underwent emergency LSCS (Indication-PPROM>24hrs) at 36wk 4day period of gestation and gave birth to a male baby of 2.25Kg with normal APGAR score. Postnatally patient was continued on Tab. Wyslone, Tab. Azathioprine, Tab.Hyd rochloroquine

Case 5

30 year old G2 P1 L1 was diagnosed as a case of Sjogren syndrome. Since 4 yrs she was on Tab.Wysolone 10mg once daily. 6years back patient has undergone full term vaginal delivery with no complications.In 2nd pregnancy patient underwent Preterm vaginal delivery at 36weeks period of gestation.She delivered a male baby of 2.5Kg with normal APGAR score. Postnatally patient was continued on Tab. Wyslone.

DISCUSSION

Connective tissue diseases predominantly affect young women between 20 and 40 years of age .The fertility of patients with connective tissue disorders is not reduced. Several prospective studies observed fertility rate of 66% to 85% in patients with connective tissue disease[7]. These patients are at increased risk for foetal loss in the first trimester, preeclampsia/eclampsia, intrauterine growth restriction, placental insufficiency, pre-term birth, caesarean delivery and low birth weight. In present study all 5 patients had preterm delivery with a mean birth weight of 2.3 kg, when compared to a study by Vengetesh

PM et al. out of 30 patients 7 patients had preterm delivery with a mean birth weight of 2.5 kg.

CONCLUSION

Pregnancy with connective tissue disorders are associated with increased maternal and perinatal complications. Preconceptional counseling, appropriate medication, multidisciplinary care, delivery in tertiary care hospital with specialist can result in favourable outcome.

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