RECURRENT JAUNDICE OF PREGNANCY

(A Case Report)

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and

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Recurrent jaundice of pregnancy is an unusual but benign complication of pregnancy characterized by generalized pruritus and icterus. It was first noted by Hoffman in 1872 and the first case report giving details was pubilshed by Ahlfeld in 1881.

Jaundice peculiar to pregnancy had in the past been related largely to such conditions as hyperemesis, severe pre-eclampsia, yellow atrophy of the liver and sepsis. In recent years emphasis has been directed toward a type of jaundice appearing in the second half of pregnancy often preceded by or associated with generalized pruritus which disappears soon after delivery leaving no residual damage in the liver. Eppinger named this entity "Idiopathic jaundice of pregnancy" and because of the tendency of the disease to recur in succeeding pregnancies, Svanborg termed it "Recurrent jaundice of pregnancy". Thorling described 38 cases of this special form of jaundice, which he called "Endogenous hepatotoxaemia of pregnancy".

CASE REPORT

Mrs. S., aged 35 years was admitted on 4-2-75 with the following complaints:

1. Amenorrhoea seven months
2. Itching all over body—2 months
3. Yellow colouration of urine—1½ months.
4. Sleeplessness.

Menstrual History

The patient had menarche at the age of 13 years. Menstruation lasted for 3-4 days occurring at an interval of 30 days without any dysmenorrhoea.

Last menstrual period 25th July, 1974. Expected date of delivery 2nd May, 1975.

Obstetric History

The patient was a seventh gravida. She had 6 premature deliveries all ending in the seventh month. The second and fifth were hospital deliveries and the rest home deliveries. The first issue, a premature male child is alive and the rest five babies died of prematurity.

In every pregnancy patient had the same complaints itching all over the body from the fourth month, followed by jaundice and yellow coloured urine within a week or two. The symptoms gradually increased in intensity. So much so she was unable to sleep. In the seventh month there was spontaneous onset of labour pains which lasted for 4-5 hours and then delivered a premature baby. The symptoms used to disappear after few weeks of the delivery In the period between the pregnancy the patient remained free from these symptoms.

There was no history of any prodromal symptoms like nausea, anorexia, pain in abdomen or fever, no history of taking any drugs during pregnancy especially chlorpromazine and no history of toxaemia or blood transfusion.

Family History

None of her relatives suffered from such complaints.

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General Examination

The patient was well built and fairly nourished. Conjunctivae were yellow. Mild degree of anaemia was present. No oedema of feet. Heart and lungs were normal. Spleen and liver not palpable.

Pulse was 86/minute, regular, good volume. Blood pressure 120/70 mm of Hg.

Abdominal Examination

The height of the uterus was of 30 weeks pregnancy, the position was L.O.A., and small vertex was floating. Foetal heart rate was 140/minute and regular.

Vaginal examination was not done as the patient was not in labour.

Investigations

Hb.—8.6 gms%; R.B.C.—5 millions/Cu.mm. T.L.C.—6,000/Cu.mm. D.L.C.—P-78%, L-22%.

Blood urea—15 mgm%. Blood sugar—72 mgm%.

Serum Bilirubin 3.4 mgm%. Icteric Index—40 units. Vanden Berg Immediate direct +ve.

Thymol turbidity—3 units. Thymol floculation —0. Alkaline phosphatase 6.2 Bodansky unit.

V.D.R.L. was negative and Rh. was positive.

Liver biopsy—Intrahepatic cholestasis.

Radiological examination of gall bladder—No obstruction of the common bile ducts.

Bleeding time—2 minutes. Clothing time—6 minutes.

Urine: Bile salts and bile pigments—Present. Urine for urobilinogen present upto 1/100 dil.

On 5-2-75, about 8 a.m. patient started having spontaneous labour pains. She delivered a living male child at 12.45 a.m. Placenta and membranes were expelled completely and were stained yellow. The baby was normal and weighed 2 Kgm. No signs of jaundice. Investigations on the child done and were found within normal limits. The baby was kept in premature unit for 10 days and then handed over to the mother. On 15-2-75 patient was discharged with the baby in good condition.

Discussion

The exact etiology of recurrent jaundice of pregnancy is not known. The prevalent idea was a mechanical compression of the extrahepatic bile ducts by the enlarged uterus pressing on a constipated transverse colon (Mayer, 1906). Other theories on the pathogenesis of benign jaundice during pregnancy included "Nervous influences," "plethora of organs during pregnancy", "dyspepsia", "gastroduodenitis", a "mucous plug in the common bile duct" and "sudden emotions".

A similar line of thought is persued by Roumanian authors in 1957 who assume that distension of the peritoneum overlying the enlarging uterus triggers nervous reflexes which then will —modified by a terrain of hyper folliculinemia—lead to a spasm of the sphincter of oddi and perhaps to reflex inhibition of the secretion.

Early in the 20th century most authors were convinced of a causal relationship between pregnancy and recurrent jaundice (Kehrer 1905) but some still denied a connection vehemently (Schickele 1910) or believed these cases to be due to gallstone obstruction (Rissmann 1010).

The explanation for the bile stasis is unknown, but it is suggested that the bile is inspissated owing to a change in permeability related to an endocrine anomaly at the menarche or menopause or may be added in pregnancy.

The direct relationship to pregnancy more particularly as the disease often manifests itself in the third trimester, and because symptoms and biochemical and histological changes return to normal following delivery would point to a relation to placental steroids. However, whether this is special sensitivity to hormones or whether there is some biochemical injury in a predisposed individual is not known, but the histological findings resemble those seen in cases of jaundice following the administration of the anabolic steroids and have certain

similarities to those following the administration of chlorpromazine.

Brown *et al* (1963) agree that the jaundice is attributable to intrahepatic cholestasis and on the basis of electron microscopy and conventional histology they too favour the view that the cause is related in some way to hormonal changes during pregnancy.

Summary

1. A case of recurrent jaundice of pregnancy is presented.

2. Pruritus is the first symptom to occur and the main symptom during the course of the disease.

3. Apart from pruritus and jaundice there are no prodromal symptoms.

4. The intensity of symptoms during successive pregnancies remained same.

5. Each pregnancy terminated in premature delivery.

6. Recovery after delivery is complete. No permanent liver damage ensues after multiple pregnancies with jaundice.

7. The laboratory tests are those of partial obstructive jaundice, increased bilirubin, negative cephalin flocculation moderately increased alkaline phosphatase, and bile in the urine specimen associated with normal blood count.

8. The prognosis is good. The infants though born prematurely do not suffer any ill effects.

References

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