PREGNANCY AFTER RENAL TRANSPLANT

(A Case Report)

by

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Introduction

Renal transplant usually reverses the menstrual irregularities and abnormal reproductive function seen in hemodialysed women (Merkatz, 1981). As the number of transplanted women in child bearing age is on the increase, Obstetrician is more likely to be faced with the task of managing their pregnancies and couselling them. Pregnancy in women with renal transplant is not as common in our country as in the west where large series of such cases are published (Davidson and Lind, 1976). A case of pregnancy after renal transplant is presented.

CASE REPORT

Mrs. S.K. 30 years old woman was admitted with 35 weeks amenorrhoea and leaking for 3 hours. M.H.—4-5 days, normal flow, L.M.P. —15-11-82. 28-30

History:

Patient had acute glomerulonephritis at the age of 1 year and continued to have urinary infection off and on till the age of 3 years, which was treated with antibiotics. Then onwards she had been asymptomatic and without any treatment till 2 months after her marriage. She was diagnosed as a case of chronic renal failure and was put an hemodialysis. She became pregnant and had MTP at 6 weeks. She had kidney transplant in November 1980 and has since then been on Prednisolone 10 mgm and Immuran 25 mgm. She develops hypertension off and on for which she is given Atenalol 100 mgm S.O.S.

No other relevant history.

On Examination: General physical examination was within normal limits. Pulse 84/mm, B.P. 130/85 mm of Hg. No Oedema feet.

Height of uterus, 36 weeks, vertex presenting. Foetal heart sounds 140/mm regular. No uterine contractions. Vaginal leaking +, Urinary Sugar and Albumin—Nil.

Patient was put on conservative treatment with a view to prolong pregnancy. Same evening i.e. on 16-7-83 her B.P. went up to 160/110 mm of Hg. There was no albuminurea, other renal functions were within normal limits. She was started on Pethidine Phenergan and Reserpine. Her blood pressure was maintained with this treatment on 17-7-83. She started mild pains which subsided after Duvadilon drip. She was continued on I/M Duvadilon; On 18th July, she had slight vaginal bleeding. She went into labour and had vaginal delivery with episiotomy at IAM on 19th July. Female baby weighting 1.8 kg with Apgar score 9/10 was born.

Puerperium: was uneventful except that patient again had hypertension on 4th and 5th day and was started on Atenalol. She was asked not to feed the baby because she was on Immuron. Baby had neonatal jaundice—was

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given phototherapy and antibiotics. Both mother and baby were discharged in good condition on 29-7-83.

Discussion

Pregnancy in a women with renal transplant is considered as a high risk. Anaemia, urinary tract infection or hypertension or albuminurea can take a more grave turn. Pre-eclamptic toxaemia is seen to occur in 30% of the women. Baby is likely to be premature in 50% and small for date in 15% of such cases. In addition baby is at risk of developing leucopenia, thrombocytopenia and adrenal insufficiency (Davidson and Lind Heimer, 1978).

The risk of kidney rejection is 9% in women going upto 3rd trimester of pregnancy. This risk is the same as in non-pregnant women (Rudolph, 1979). In our patient first pregnancy after renal transplant ended in M.T.P. In the 2nd pregnancy she had no problem in 1st and 2nd trimesters. In the 3rd trimester, she had premature leaking, develop hypertension and had premature labour. Fortunately, baby did not have any major problem. She was counselled against having any more pregnancy as the functional survival after 5 years in a relative donar transplant is only 45 to 65% (Davidson and Lind, 1976).

References

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