# Obstetric Management in a refractory case of Systemic Lupus Erythematosus with Lupus Anticoagulant.

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Systemic Lupus Erythematosus (SLE) is an immunological disorder that derives its name from the antiphospholipid antibody Lupus Anticoagulant (LAC). However it is a misnomer, as LAC is present in only 30% of cases with SLE, but its presence is associated with disasterous obstetric outcome repeated abortions, growth retardation, fetal death, severe pregnancy induced hypertension, arterial and venous thrombosis in almost 90-100% cases.

The management of such a patient is both a medical and an obstetric challenge. Various therapeutic drugs aspirin, corticosteroids, heparin have been used with about 80% success. Recently high dose Intravenous Immunoglobulin (IVIG) therapy has also been used for refractory cases.

*Case report* : A 28 year old third gravida was referred to the All India Institute of Medical Sciences at 22 weeks of pregnancy. She had previous 3 mid - trimester missed abortions at 5-6 months. In the third pregnancy, she had severe hypertension, and on investigation, she was found to have SLE.

At AIIMS the Lupus Anticoagulant was found to be strongly positive, but there were no Anti cardiolipin Antibodies. The Karyotype of the patient and her husband were normal.

At booking, her blood pressure was 160/110mm Hg, the fetus was severely growth retarded. Prednisolone 15 mgm/d and aspirin 75 mgm/d along with methyldopa was started. However, the fetus had intrauterine death after 1 week. In the fifth pregnancy, she was started on prednisolone 60 mgm/d and aspirin 75 mgm/d at 11 weeks. Prednisolone was reduced to 40 mgm/d after 1 week. At 34 weeks, she had spontaneous preterm premature rupture of membranes. Emergency caesarean Section (C.S) was performed for fetal bradycardia, and a 2.1 kg healthy baby was delivered. Steroid therapy was tapered off.

In the sixth pregnancy., she did not want high dose corticosteroid therapy as she had gained excess weight and developed Cushingoid features. IVIG 100 mgm/kg/d for 5 days was given at 15 weeks and again at 19 weeks of gestation. Prednisolone 15 mgm/d and aspirin 75 mgm/d were also started from 10 weeks of pregnancy. At 34 weeks, she developed imminent eclampsia and caesarean section was performed with birth of a 2.315kg. healthy baby.

In the seventh pregnancy, with 2 living issues, the patient again reported at 10 weeks of pregnancy. She refused termination of pregnancy with ligation. IVIG (100 mgm/kg/d x 5 days), was given at 14 weeks and 18 weeks of gestation, along with predonisolone (15 mgm/d) and aspirin (75 mgm/d) from 10 weeks. The patient returned to her home town for follow up and was advised admission at AIIMS at 34 weeks. Unfortunately, she reported at 32 weeks with loss of fetal movements. She had developed sudden severe pregnancy induced hypertension, the blood pressure was 180/120 mm Hg. The fetus was dead and there was a large retroplacental clot. She was advised ligation.

Thus, the management of LAC in patients with SLE requires aggressive therapy and intensive feto-maternal surveillance for optimal obstetric outcome.