Successful Pregnancy Outcome in a Patient with Chronic Renal Failure

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A 28 year old Gravida 2, para 1 presented to us with 3 months amenorrhea. She had right percutaneous nephrostomy done for bilateral hydronephrosis one month ago during pregnancy itself.

Four years back, she had been diagnosed to be a case of renal tuberculosis on being investigated for hematuria and frequency of micturition. Urine for acid fast bacilli (AFB) culture was positive. Ultrasonography (USG) showed bilateral hydronephrosis. Intravenous pylography revealed bilateral mild hydroureteronephrosis with thimble bladder. These findings were compatible with renal tuberculosis. Chest X-ray revealed only calcified deposits and sputum was negative for AFB. Kidney function tests (KFT) were in the normal range. She received antitubercular drugs for 9 months. During this period itself she had conceived and the antenatal course had been uneventful according to her. She had a normal vaginal delivery at home and there were no intrapartum or postpartum complications.

Three years after her last childbirth, she consulted a urologist as she continued to have frequency of micturition and she also developed loss of appetite. USG revealed gross hydronephrosis and KFTs were markedly deranged. To preserve kidney function, percutaneous nephrostomy was performed. During the same time, she developed amenorrhea and came to us.

On examination, she was pale. Systemic examination did not reveal any abnormality. Per vaginum examination revealed a pregnant uterus about 12 weeks in size. On investigation, hemoglobin (Hb) was 8.2gm%, blood urea (BU) 96mg%, serum creatinine 3.1mg%, Na/K 140/3.8, urine analysis showed protein 3+ and 20-30 RBC/HPF. 24-hour urine (1300 ml) revealed albumin 0.6gm/24 hour and creatinine 0.5gm/24 hour.

She continued the pregnancy against medical advice. She was advised admission but she refused. She was followed in the antenatal clinic every week. Level II USG was normal. KFT was repeated weekly which did not show any significant change. At 34 weeks, she was admitted in view of mild intrauterine growth retardation and oligohydramnios. Investigations showed, Hb 7.6gm%, BU 74mg%, Sr creat 3.3mg%, Na/K 140/5.6. On urine analysis, protein was 3+ and there were 40 RBC/HPF. 24-hour urine revealed albumin 0.7gm/24hours and creatinine 0.4gm/24 hours.

She was started on ion exchange resin for treatment of hyperkalemia. She also required glucose insulin infusion for severe hyperkalemia on two occasions. At 35 weeks, in view of IUGR and severely deranged renal function, labour was induced with oxytocin. Course of labour was uneventful and she had a vaginal delivery of a 1.9kg female baby. Postpartum renal USG revealed hydronephrosis as before.

Our case is interesting as such patients with severely deranged renal function usually do not conceive and if they do conceive there is an increased chance of abortion and intrauterine death. Successful pregnancy outcome is an exception rather than the rule in such patients.