J Obstet Gynecol Ind Vol. 53, No. 6 : November/December 2003 Pg 589-590

Pemphigus Vulgaris in Pregnancy

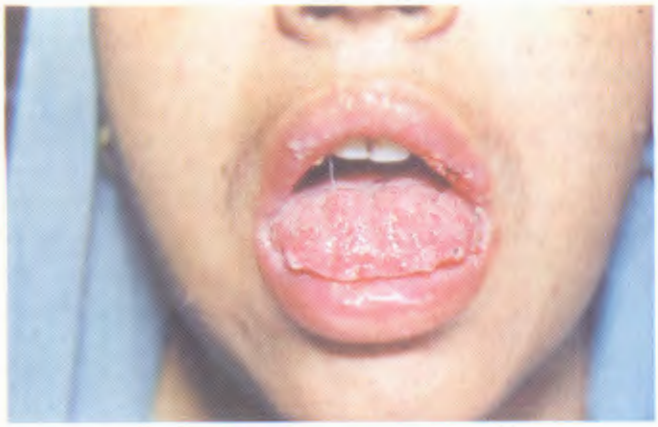
Singhal *Savita Rani*, Sangwan *Krishna*, Sharma *Neeraj*
Department of Obstetrics and Gynecology PGIMS, Rohtak – 124 001.

Key words : pemphigus vulgaris, pregnancy

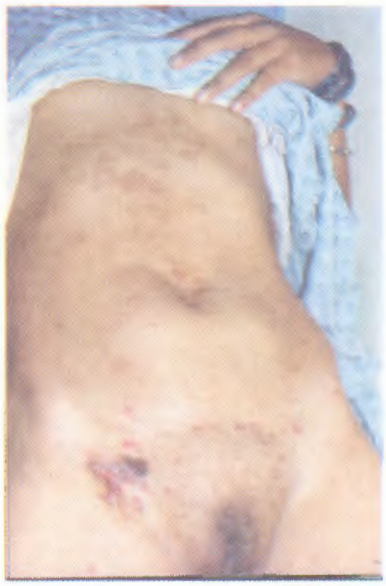
Pemphigus vulgaris (PV) is a rare autoimmune bullous dermatosis. Clinical manifestations include numerous skin vesicles on scalp, face, axillae, groins and pressure points[1]. Diagnosis is made by lesion biopsy showing acantholysis and suprabasal cleft formation in deep layer of epidermis. PV associated with pregnancy is very rare and only 27 cases have been reported in literature[2]. We report a patient who conceived during the active phase of the disease. Her lesions were not improving inspite of vigorous treatment but markedly improved after termination of pregnancy.

Case Report

A 26 year old $G_4P_3A_0$ with 18 weeks of pregnancy with pemphigus vulgaris was referred by her dermatologist for medical termination of pregnancy (Voluntary termination of pregnancy under Medical Termination of Pregnancy Act, 1971) and tubectomy. Detailed history and previous records revealed that she had multiple vesicular lesions on the face, oral mucosa, abdomen and back for last 6 months which were not controlled inspite of the treatment. Her younger child was 9 months old and she was in lactational amenorrhea when she consulted the dermatologist, 4 months back. She was diagnosed as PV by lesion biopsy and was put on pulse therapy (corticosteroids + cyclophosphamide). She took three courses of treatment but had no improvement. On feeling fetal movements, she consulted a private practitioner and to her surprise came to know of having 4 months pregnancy. She was not willing to continue the pregnancy as she had taken antineoplastic drugs in first trimester and was having three living children. She was depressed and was having multiple vesicular lesions on oral mucosa (Photograph 1), abdomen (Photograph 2) and vulva (Photograph 3). Few of the lesions were infected. Abdominal examination revealed a pregnancyof 18 weeks which was confirmed by ultrasonography. She was admitted and the pregnancy was terminated by instilling 150 cc of ethacridine lactate extra-amniotically under cover of broad spectrum antibiotics. She aborted within 24 hours of induction and the fetus was apparently normal. Her request for tubectomy was deferred due to active lesions on the abdomen. Cu-T was inserted. She came for follow up after one month. The lesions were markedly improved. Pelvic examination was normal.



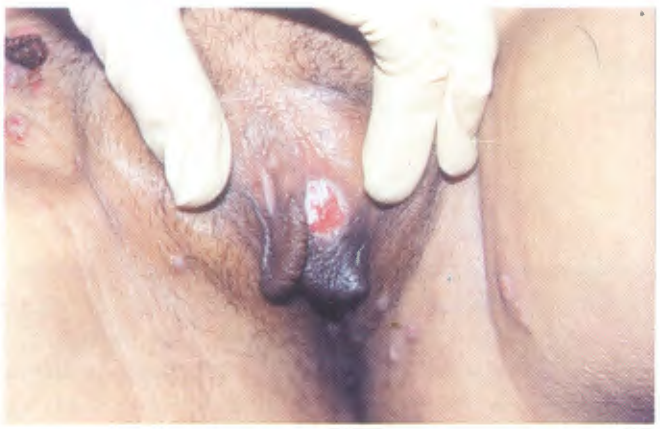
Photograph 1 : Vesicles on lips and oral mucosa.



Photograph 2 : Abdomen having multiple healed and active vesicles.

Paper received on 4/9/02 ; accepted on 25/2/03

Correspondence :
Dr. Savita Rani Singhal
Department of Obstetrics and Gynecology PGIMS,
Rohtak - 124 001.



Photograph 3 : Lesion seen on labia minora.

Discussion

Pregnancy may precipitate or aggravate PV like other autoimmune diseases[3]. The same was observed in the present case also and the lesions were not improving inspite of vigorous treatment. PV is associated with infertility during its active phase and has adverse neonatal outcome like prematurity, intrauterine growth restriction and fetal death[2]. Skin lesions on the new born are also reported[3] but in our case the fetus was normal. Management for PV is corticosteroids which are usually not associated with increased risk of congenital malformation[4]. In the present case pregnancy was not known, so the patient was put on cyclophosphamide and corticosteroids. During active lesions on the abdomen, an abdominal incision should be avoided. Hence, the tubectomy was deferred to a later stage.

References

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