

Successful pregnancy outcome of a patient with ulcerative colitis and antiphospholipid antibody syndrome with recurrent pregnancy loss

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Introduction

Ulcerative colitis in pregnancy is usually uneventful and have been reported as successful pregnancy outcomes. Only one case is reported with coincidental antiphospholipid syndrome

Ulcerative Colitis (UC) is an inflammatory bowel disease presenting as recurrent abdominal pain and bloody diarrhoea. We present a case of successful pregnancy outcome with ulcerative colitis and antiphospholipid antibody syndrome.

Case report

A 27-year-old gravida 4 abortion 2 intrauterine death 1 presented to medicine department with recurrent bloody diarrhea and pain abdomen for 6 months. Colonic biopsy diagnosed ulcerative colitis. Patient was referred to us with history of previous recurrent abortions and short period of amenorrhoea. She had two first trimester (8-10 weeks) spontaneous abortions and one previous intrauterine fetal death with eclampsia and placental abruption. As history was suggestive of Antiphospholipid antibody syndrome, APLA panel was advised. APTT was prolonged, ACA was positive and dRVVT was strongly positive. Thus, APLA syndrome was diagnosed. Transvaginal sonography confirmed early intrauterine pregnancy with good cardiac activity. She was started on aspirin 75 mg per day and low molecular weight heparin 5000 IU per day. She was also on Mesalazine 750 mg per day and prednisolone 10 mg per day for the treatment of ulcerative colitis. Pregnancy was uneventful. Frequent antenatal check-ups included monitoring of fetal growth, coagulation profile and BP monitoring. Mild IUGR was noted with good amniotic fluid and good diastolic flow in umbilical artery Doppler. She had one episode of acute abdominal pain with diarrhoea and was managed conservatively. At 36 weeks, patient presented with high BP160/110 mmHg and imminent symptoms of headache and epigastric pain. Patient was taken up emergency caesarean delivery. She had taken LMWH 6 hours earlier and hence regional anaesthesia was considered. She delivered baby boy with birth weight of 2 KG. She received LMWH for one week after delivery and immediate postpartum period was uneventful.

Discussion

It is noteworthy in this case that patient had two dreadful diseases and could go home with a baby due to careful antenatal care and timely delivery.

Both diseases deserve a lengthy discussion here. Ulcerative colitis is a chronic inflammatory bowel disease and its management during

pregnancy is a challenge. Disease may aggravate during pregnancy certain times and there are studies wherein patients had to undergo bowel resection and anastomosis [1]. Our patient had few episodes of bloody diarrhoea and pain abdomen but did not aggravate further. During acute episodes, prednisolone doses were adjusted and managed conservatively. Mesalazine is the standard treatment for UC. There are studies with oral and rectal preparations. Our patient received oral preparation and there were no untoward incidents. Since drug is category B, there were no congenital malformations in fetus [2,3]. A large prospective European study with UC showed 67% remission with active disease during pregnancy [4]. A Danish study has reported 40.3% relapses during pregnancy in UC as compared to 13.6 % in the 6 months prior to pregnancy. Exacerbations of disease, particularly in the first trimester of pregnancy are often due to discontinuation of maintenance therapy [5,6]. Whether disease flares are more likely to occur in the postpartum period remains controversial, but pregnancy seems to have a beneficial effect on the disease course of IBD. A small prospective study reported a decrease in relapse rate in UC patients four years after pregnancy, in comparison with the 3 years before pregnancy. Postpartum flare seen in few patients is due to discontinuation of drugs rather than any other disease problems [7,8]. Prednisolone upto 15 mg /day is safe throughout pregnancy. Although oral clefts are reported, they are not significant [9]. However, they are inactivated once they cross placenta by 11 β hydroxyl dehydrogenase. Hence either betamethasone or dexamethasone is administered to treat fetus [10]. Our patient received prednisolone 10mg per day throughout pregnancy. She did not have any adverse effects and also received Betamethasone for lung maturity at 28 weeks.

Our patient also had antiphospholipid antibody syndrome diagnosed by positive ACA, positive dRVVT and clinical criteria. Hence, she was on aspirin and low molecular weight heparin therapy.

Many studies insist two lab values at 6 weeks' interval positivity as significant criteria, but there are also studies who are content with one. Here we have done once and took timely decision of starting heparin therapy. Sudden progression of the disease is the characteristic feature in APLA syndrome as we observed in our case of sudden imminent

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symptoms within a week, hence careful monitoring is advocated [11,12].

Hence, we conclude from this case that careful monitoring and frequent antenatal care for high risk pregnancy is the key to success.

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