SYSTEMIC AUTOIMMUNE DISEASE DURING PREGNANCY

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Ключевые слова: *системная красная волчанка, послеродовое осложнение, симптомы.*

Резюме. *В данной статье рассмотрен клинический случай системной красной волчанки в послеродовом периоде. Заболевание протекало под маской сепсиса, что затрудняло диагностику СКВ как первичное заболевание. Решающим стало обнаружение антиядерных антител, что помогло установить диагноз, который позволил воедино соединить все симптомы и объяснит отсутствие закономерной динамики на антибактериальную терапию.*

Key words: *system lupus erythematosus, labor complications, symptoms.*

Summary*. In this article clinical case of systemic lupus erythematosus (SLE) in the postpartum period. The disease was hiding behind the mask of systemic inflammatory response syndrome (SIRS), which made it difficult to diagnose SLE as a primary disease. Finally, anti-nuclear antibodies were detected, which helped to establish the diagnosis, and let put all the symptoms together which also explains the absence of antibacterial therapy dynamics.*

Introduction. Systemic lupus erythematosus (SLE) – is an systemic autoimmune disease of connective tissue characterized with different specificity autoantibodies hyperproduction and progression of immune-inflamatory damage of inner organs' tissues. The disease usually affects young females and develops in reproductive age, during pregnancy and postpartum period [1]. In clinical practice for the SLE diagnosis American rheumatology association lupus criteria are used, including 11 symptoms. If 4 criteria are found, the SLE diagnosis is considered as reliable. At the same time, the presence of only 1 symptom can not exclude the disease. Besides diagnostic criteria, patients with SLE also can have additional symptoms, such as trophic disorders (weight loss, excessive hair loss up to baldness), unmotivated fever.

In recent decades successful outcomes of pregnancy during SLE and healthy children births were shown. Successful pregnancy outcome with healthy child birth is possible only under the condition of fertilization in the period of remission for six and more moths, and also without kidney diseases, hypertension and circulating antiphospholipid antibodies. The suppression of immune system reactions is necessary for normal pregnancy development. During pregnancy the number of regulatory T cells increases and blocking antibodies, which suppress the activity of CD4+; lymphocytes and NK-cells, appears. Besides, among pregnant women with SLE the suppression of immune reactions due to physiological pregnancy processes is possible, which causes the remission of the disease during gestation and exacerbation of it after the delivery [3]. As usual, the exacerbation starts at first two months of postpartum period, but not days or weeks, while woman stays at maternity hospital, and can hide behind the mask of pregnancy complications, such as systemic inflammatory response syndrome (SIRS), residual nephropathy.

The problem of differential diagnosis of postpartum complications and somatic

symptoms disorders is still extremely relevant. The similarity of clinical symptoms of SLE and SIRS creates difficulties in diagnosis of somatic pathology, and the absence of proper therapy of main disease makes worsen prognosis. The differential diagnosis between atypical form of SLE and SIRS as SLE complication defines the success of treatment.

Objective. The demonstration of clinical case report of the course of SLE with atypical symptoms during the postpartum period.

Results. Patient C. 31 years old at 6th of September 2012 in an emergency order admitted to hospital ER with complaints for fever up to 39°C, weakness, painful urination, puffy face and neck, pastosity of the lower extremities, sore throat with diagnosis of pyelonephritis and kidney stone disease. She was examined by urologist. There were no suggestive data of acute urological pathology. Anamnesis: at 29th of August she had term birth (per vias naturalis) at 38-39 weeks of pregnant. She was discharged from maternity hospital at fourth day with a baby in satisfactory condition. She was recommended for outpatient treatment from a nephrologist who diagnosed chronic delitescent pyelonephritis, kidney stone disease, kidney failure (?). The antibacterial therapy started. The patient notices
recrudescence on treatment, such as weakness, fever, face, and neck and leg edema. While anamnesis data refinement with accounting of postpartum period and focusing on postpartum complications treatment, the patient was hospitalized to gynecologic department. There was no treatment response for the therapy. A multiple complaints were not usual for postpartum metroendometritis. Different diagnose versions were needed. Case conferences were conducted repeatedly due to patients' emergency condition. The regular case conference at 8th of October 2012 took place after the diagnostic results were received. The diagnosis: 18th day after the laparotomy, total hysterectomy due to postpartum metroendometritis and SIRS; acute SLE stage 3. At 10th of October 2012 the patient were transported to rheumatological department for subsequent treatment.

The patient had no classic SLE symptoms. The disease was hiding behind the mask of SIRS, which made some difficulties for diagnose SLE as the main pathology. The other symptoms were manifested differently. The typical "butterfly rash" were absent. The typical SLE rashes were interpreted as ecchymosis due to expression of breast milk (lactation suppression was recommended). Also there were complaints for soreness of the oral and nasal mucosa (as SLE aphthous stomatitis). She was examined by otolaryngologists and oral and maxillofacial surgeons, but observable ulcers were diagnosed as herpes due to postpartum immune depression. The therapy had positive dynamics. Polyserositis was florid and well-time diagnosed, but was not fit in SIRS clinics. The kidney involvement as nephrotic syndrome were appraised as pre-eclampsia consequence and kidneys disease during lifetime, and kidney failure during SIRS. Hematologic problems (pancytopenia) were observed during the hospital admission. The thrombocytopenia also were appraised as pre-eclampsia consequence, and the anemia – as postpartum complication. The appropriate correction was fully carried and weak dynamics of changes took place. The patient also had immunologic disorder, which caused facilities for transformation of metroendometritis into SIRS. During the hospitalization the patient had complaints for pain and selling of hands joints. Finally, anti-nuclear antibodies were detected, which helped to establish the diagnosis, and let put all the symptoms together

which also explains the absence of antibacterial therapy dynamics.

However, the patient had symptom complex of diagnostic criteria for SIRS, and existence of site of infection (metroendometritis), so the proper antibacterial therapy and surgery needed. The standard of care for purulent-septic postpartum complications was fully demonstrated in the treatment of this patient.

Conclusions. To sum up, the complicated diagnostic combination of SLE causes the development of purulent-septic complication, which superimposed on the patients postpartum period and caused long diagnostic search. It makes sense to aim the physicians to insert some tests to exclude systemic disease in patients with fever into diagnostic algorithm.

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