ONSET OF DIFFUSE VASCULITIS (SLE) IN PREGNANCY

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Systemic lupus erythematosus (SLE) has emerged relatively recently from the realms of rarity, to a status where it can now be regarded as a common disease. Because it predominantly affects young women, the effects of SLE on pregnancy, and conversely, the effects of pregnancy on SLE, have become increasingly important. The influence of pregnancy on SLE is variable. In some reported cases, pregnancy appears to have no effect; in others, it appears to aggravate, or even initiate SLE.[1-4]

The following is a case report of a patient with diffuse vasculitis which commenced in pregnancy, persisted throughout the period of gestation and was kept under control only by large doses of steroids. A rapid and remarkable recovery occurred during the immediate postpartum period, supporting the contention that pregnancy had an unfavourable influence on the pathological process in this patient.

CASE REPORT

The patient was a 23-year-old female from Upington, who was admitted to hospital on 8 November 1965. For 3 months before admission, she was troubled by paraesthesia and intermittent dull pain in both feet; she also had a short episode of these symptoms in both hands.

Shortly afterwards, she developed painful ulcers over both ankles and a blotchy rash involving the hands, feet, legs and forearms. Just before admission, some of her toes developed a bluish-black discoloration. In addition she showed constitutional symptoms such as anorexia and weight loss.

The patient was 22 weeks pregnant at the time of admission, this being her third pregnancy. Her 2 previous pregnancies were uneventful. All the patient's symptoms therefore, commenced in the second month of her third pregnancy.

The most striking features on physical examination were the skin changes. The hands, forearms, feet and legs were covered by a blotchy, macular, erythematous rash, some areas of which blanched on pressure while others did not. There was no evidence of purpura.

The other outstanding feature was a bluish discoloration of the tips of some of the toes. These were actually areas of gangrene confined to the skin (Figs. 1 and 2). Both feet were warm, and the dorsalis pedis and posterior tibial arteries on both sides had bounding pulses. Over the lateral malleolus on each side was a dry, crusted ulcer approximately 1 × 2 in. in size (Fig. 3).

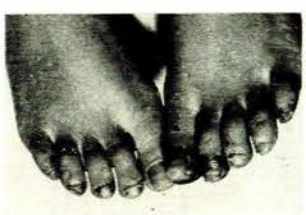

Fig. 1. See text.

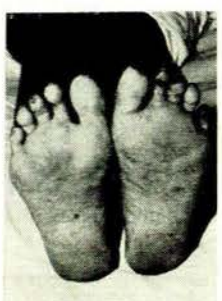

Fig. 2. See text.

The remainder of the physical examination showed nothing of note.

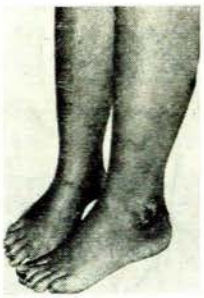

Fig. 3. See text.

Investigations

Urine—normal. Blood—Hb. 12 G/100 ml.: PCV 35%: MCHC 34%: WBC 10,000/cu.mm. Differential count normal. ESR 51 mm./1st hour (Westergren). WR negative; latex fixation test negative; LE cells negative; blood urea 29 mg./100 ml.; albumin 4 G/100 ml.; globulin 2·1 G/100 ml. Serum electrophoresis—some lowering in concentration of gammaglobulins.

Despite the lack of conclusive laboratory support, viz. the demonstration of LE cells, the diagnosis of diffuse vasculitis on the basis of SLE was made.

Course and Management

Prednisone therapy was commenced soon after admission; a daily dose of 45 mg. was chosen. Symptomatic and objective improvement soon occurred. One manifestation of this, was the shedding of the gangrenous skin from the toes (Fig. 4).

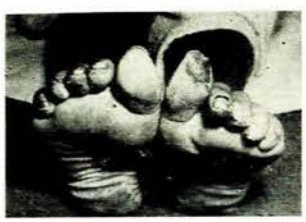

Fig. 4. See text.

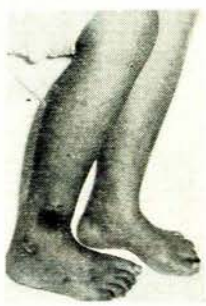

Fig. 5. See text.

After 3 weeks of steroid therapy and definite clinical improvement, the patient requested to be allowed to spend the festive season at home. Despite continued steroid therapy during the month away from hospital, the patient's condition deteriorated. She developed more pain in the feet, and on readmission, a new ulcer on the lateral side of the right leg was noted (Fig. 5). Prednisone dosage was thus increased to 60 mg. daily, but without avail, and a further increase to 80 mg. per day was administered.

Two weeks after readmission, the patient developed ischaemic neuritis resulting in a loss of sensation in the stocking distribution over both feet.

Hereafter, the disease process showed no threat of further progression. At no stage was there evidence of pre-eclamptic toxaemia. The daily dose of prednisone was maintained at 80 mg.

On 9 February 1966, the patient was delivered of a healthy male infant weighing 4 lb. 15 oz. The delivery was free of complications.

Throughout this patient's illness, the impression gained was that the vasculitis was intimately related to the

pregnancy, which appeared to be the aggravating, as well as the precipitating factor. This was in fact well demonstrated when, during the immediate postpartum period, the dosage of prednisone was reduced to 10 mg. daily over a 3-week period. During this time, the patient's condition showed marked improvement. She was free of pain, the erythematous lesions cleared, the gangrenous skin was completely shed, the ulcers healed completely, and the neurological deficit in the feet returned to normal.

The incriminating factors of the pregnancy were so over-riding that it was felt obligatory for some form of contraception to be instituted for at least some years. This was achieved by inserting a Lippes loop 6 weeks after delivery.

Four months after discharge, the patient was perfectly well. She had gained weight and was symptom free. There was no evidence of skin lesions or of any peripheral vascular abnormality.

SUMMARY

A case of diffuse vasculitis (SLE), commencing in pregnancy is presented, which required high doses of steroids to contain it during pregnancy. Dramatic improvement occurred in the immediate postpartum period, illustrating one of the effects of SLE in a pregnant patient.

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