



Addison's Disease in Pregnancy: A Case Report

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Introduction

Addison's disease is a rare endocrine disorder in pregnancy. Incidence is 4 to 11/100,000 cases. Nontreated primary adrenal insufficiency reduces fertility. Addisonian crises is life threatening and can accompany stressful conditions like labour, puerperium, infection, hyperemesis gravidarum or surgery. Maternal mortality has reduced with introduction of glucocorticoid therapy.

Here we describe the multidisciplinary management of an Addisonian patient that resulted in successful maternal and foetal outcome.

Case Presentation

A 27 years old female, G3P1L0A1, 14 weeks of gestation, previous LSCS, last child birth two years back, with LMP: 10/03/2018 and EDD: 15/12/2018 known case of Addison's disease on treatment for the past 6 months with T. Hydrocortisone 10 mg BD came for routine antenatal check-up.

Ultrasound showed intra uterine gestation corresponding to 14 weeks with a small sub chorionic bleed 1x 0.8 cm. Serum electrolytes were normal. Urine ketones were negative. Serum

DHEAS was 30 microg/L (NV 35 -40), Serum Cortisol was 7 micro g/dl (NV 8-30). ACTH was 90pg/ml (NV 1-40).

Endocrinologist opinion was got and T. Hydrocortisone was increased to 10 mg TDS and T. Fludrocortisone 50 mcg OD was added in view of increased demand during pregnancy.

At 20 weeks patient underwent an Anomaly scan which was normal. Oral Glucose Tolerance test done was normal. Serum Cortisol done was 10 micro g/dl and ACTH was 45pg/ml. Serum electrolytes and Blood pressure were normal during the entire period of gestation.

Growth scan with doppler done at 34 weeks of gestation was normal. Serum Cortisol and DHEAS were also within normal limits.

Patient underwent Elective LSCS at 38 weeks of gestation. The new born was a male baby of weight 2.8 kg with APGAR 8/10 and 9/10. Hydrocortisone 1 gram IV was given 24 hours before and after the Caesarean section. Breast feeding was given for the baby.

At follow up after 6 weeks both the mother and baby are not having any problem. The mother was advised to continue T. Hydrocortisone 10mg TDS and T. Fludrocortisone 50 mcg OD for 6 months

and thereafter follow up with Endocrinologist for dosage modifications.

Discussion

Prior to the introduction of steroid therapy, Addison's disease was associated with a high mortality rate. However, if it is diagnosed and treated adequately before the pregnancy adverse effects are uncommon and there is good maternal and foetal outcome. It is important to increase the dosage of steroids during pregnancy in view of higher demand. Serum electrolytes and blood pressure must be monitored carefully to avoid Adrenal insufficiency. As both vaginal delivery and Caesarean section are stressful situations additional dosage of hydrocortisone must be given. Patient must also be made aware of symptoms of adrenal insufficiency so that she can seek help earlier.

Conclusion

Pregnant women with Addison's disease must be thoroughly monitored. Early detection and multidisciplinary action are necessary to prevent complications and to get a successful outcome.

References

1. Caterina cosimo and cirofranco, Journal of Prenatal medicine, ncbi. Nlm.nih.gov.in
2. Albert E, Dalaker K, Jorde R. Addisons disease and pregnancy. Acta Obstet Gynecol Scand. 1989;68:185-187
3. Osler M. addisons disease and pregnancy. Acta Endocrinol.1962:41:67