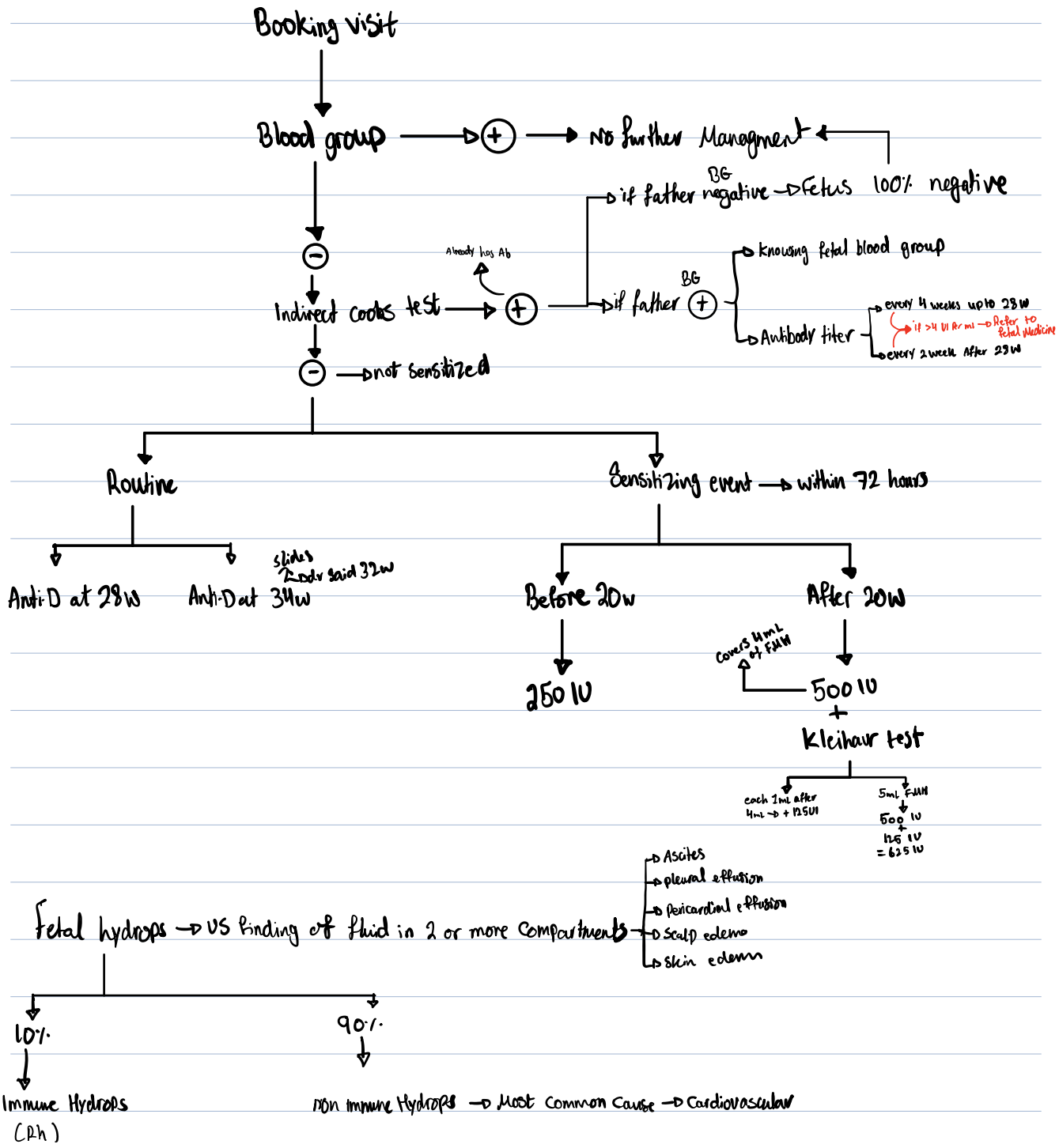
Rh Isoimmunization



will increase

Most Autoimmune disorders ↓ in Pregnancy except SLE ↑ → known safe drugs in Pregnancy and drugs to avoid (Table in slides)

SLE → ANA, Anti DSDNA, Anti-Ro or La → Could cause → Cutaneous neonatal lupus → Transient; Congenital heart block → Permanent

APS → vasospasm, Thrombosis → placental infarction + fetal loss
- lupus anticoagulant
- anticardiolipin
- anti B_2 glycoprotein

2 occasion 12w Apart

one Clinical + One laboratory to diagnose

Managment: 1. APL Antibodies, no thrombosis, no Pregnancy loss	Aspirin or Nothing
2. previous Thrombosis	LMWH (Therapuetic dose) + Aspirin
3. Prev. recurrent (>3) miscarriage (<10w)	Aspirin + LMWH (Prophylactic dose)
4. Fetal loss or severe preeclampsia	Aspirin + LMWH (Prophylactic dose)

Thrombocytopenia → Plasma vol. 50% ↑; Red cell 25% ↑; Platelets unchange or 6% ↓

Differential diagnosis of Thrombocytopenia in Pregnancy important → slide → Memorize it well

Most important is to differentiate between gestational Thrombocytopenia (75%) and ITP.

Gestational Thrombocytopenia (75%)	ITP
* Physiological reduction, 6% dilution	
* only during pregnancy after preg. normal	* usually has platelet disorder outside preg.
* Third Trimester	
* doesn't affect fetus	* May Affect the baby because its Autoimmune IgG Ab
* doesn't drop below 70	* Can reach 20, 10, 5

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if patient presented with thrombocytopenia
- count < 20
- symptomatic

→ Tx: first and Second Trimester give Platelets if

Near delivery

Accepted for vaginal or CS → >50

Accepted for spinal or Epidural → >75

first line: Corticosteroids → Prednisolone → 20 mg

other lines: IVIG

Thyroid - common during Pregnancy

3 main changes → ↑ TBG → Total T_3, T_4 increase but active form unchanged
- ↑ TSH
- Iodine deficiency

before (Gestational) 12 w or said low T_4 crosses placenta and used for normal fetal brain development

After 12w T_3, T_4, TSH DO not cross the placenta

know Symptoms and differential diagnosis of Hyperthyroidism → graves (90%)
- Rule out
  - Hyperemesis gravidarum
  - Molar preg.

→ 5% chance of neonatal graves

Graves → Autoimmune, 90%.

↳ decrease during pregnancy and increase after delivery

How to assess potential Hyperthyroidism
- → Maternal perception of fetal movement
- → Standard growth assessment
- → Fetal tachycardia >160
- → US to exclude fetal goiter

Management: Propylthiouracil (PTU), Carbimazole

① BB → to control Sx, short duration due to small baby

Hypothyrodism → Most common Hashimoto (USA)
Iodine (worldwide)

Postpartum Thyroiditis → Start as Hyper then hypo, can occur up to 1 year after delivery → 90%. Anti peroxidase

Anemia → Iron deficiency Anemia

Any patient → CBC at booking and at 28 w

to say pt is Anemic, → IV iron Contraindicated in first trimester

1st Trimester: <11
2nd Tri: <10.5
Post delivery: <10

100 - 200 mg per day elementary oral iron, repeat CBC after 3w

Good response when Hb ↑ 0.8 per week → keep giving for 3 month after normalization of CBC

When to give blood? <7 or symptomatic

mcv ↑ normally in preg → mcv can mask IDA

to diagnose IDA : Serum Ferritin only

Read Summary in Slides.

GI → N/V → Hyperemesis gravidarum (H.g)
→ Cholestasis

H.g: Severe form of N/V characterized by → intracable vomiting
→ Read in slides

8-12 w, 0.5-2%, most Sx stop 16-18 w

Read Complication. Rule out other causes (found in slides)

Admission → intracable emesis
→ Electrolyte imbalance
→ severe hypovolemia

Managment: ensure adequate hydration 0.9 saline + KCL

don't give dextrose → may excacerbate wernick

Cholestasis → diagnosis of exclusion → See what you should exclude in slides

3rd Trimester → Itching over whole body without Rash

↑ALT, Multip Preg., Hepatitis virus

check Risk in slides ↓vitK deficiency → PPH
(or Preterm (iatrogenic) → cause ↑risk of IUFD

check management in Slides

Vit. K should be given, no method of surveillance prevent IUFD

Recurrence in subsequent preg 90%.

Respiratory → cystic fibrosis important.