Emergency cesarean section for Antiphospholipid Syndrome pregnant women

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Antiphospholipid Syndrome (APS) is defined by the presence of antiphospholipid antibodies (aPL). These aPL are directed against cardiolipin, lupus anticoagulants, and antibodies to beta2-glycoprotein I. It clinically manifests as venous or arterial thrombosis and/or pregnancy morbidity (≥1 unexplained fetal deaths ≥10 weeks of gestation, ≥1 preterm deliveries of a morphologically normal infant before 34 weeks of gestation due to severe pre-eclampsia, eclampsia, or features consistent with placental insufficiency, ≥3 unexplained, consecutive, spontaneous pregnancy losses <10 weeks of gestation).

Diagnosis of APS is suspected when there are one or more unexplained venous/arterial thromboses in young patients, one or more adverse outcomes related to pregnancy, or otherwise unexplained thrombocytopenia or prolongation of blood coagulation. In addition, antiphospholipid antibodies are considered to be a risk factor for pre eclampsia. Severe preterm preeclampsia and Hemolysis, Elevated Liver function enzymes, and Low Platelet count syndrome (HELLP) have been particular concerns in patients with APS. There is also an association with recurrent pregnancy loss and APS where pregnancy loss occurs in higher proportion in women with aPL. Management of pregnant women with APS usually includes low molecular weight heparin (LMWH) plus aspirin (ASA). However, heparin and LMWH should be discontinued 24 hours before labor and delivery, but not stopped for more than 48 hours. ASA ideally should be stopped 7 to 10 days before delivery. If anticoagulation proves to be ineffective and patient still develops new venous thromboembolism (VTE), an Inferior Vena Filter is placed. Ideally in pregnant patients, IVC filter is placed before delivery or C-section.

The patient we are presenting is a pregnant, pre-eclamptic patient, with positivity for anticardiolipin antibodies and history of recurrent DVT’s. Patient also had developed a new VTE, discovered upon admission, despite being anticoagulated with prophylactic Lovenox and ASA. We describe successful C-section and management of this patient.