

A Case of Pregnancy Complicated with Recurrent Myelitis

Dr Amila Janalal Rubasinghe¹, Prof Athula Kaluarachchi² Dr Chandana Jayasundara² Dr Malindu Edirisinghe² Dr Sanjaya Athapaththu²

1.Post Graduate Institute of Medicine, University of Colombo, Colombo, Sri Lanka 2. De Soysa Hospital for Women, Colombo, Sri Lanka

Introduction:

Recurring (more than one episode) complete transverse myelopathy, without a specific aetiologic diagnosis (like multiple sclerosis), has been arbitrary called relapsing or recurrent myelitis.

Recurrent myelitis may be associated with optic neuritis that fit the criteria for Neuromyelitis optica (NMO) or NMO spectrum disorders. It may be associated with Sjogren’s syndrome, SLE, or sarcoidosis as well.

A very little information exists in the literature about effects of recurrent myelitis on pregnancy and effects on pregnancy on recurrent myelitis. Currently, an established guidance on the management of pregnancy complicated with recurrent myelitis isn` t available.

Case Report:

A 39-year-old lady in her third gestation with previous two vaginal deliveries, referred to tertiary level care at 9 weeks of gestation with a history of mild bilateral upper and lower limb weakness and resting tremors for 4 years, which rapidly deteriorated during the pregnancy. She also had bilateral lower limb numbness, constipation, and urinary incontinence. Mobility was severely restricted. She hasn't been assessed for her neurological symptoms in the pre-pregnancy period.

On examination, upper and lower limb motor power was 3/5 with brisk reflexes with a Left side sensory loss. Cranial nerves weren`t involved.

All the baseline investigations were normal, except neutrophilic leukocytosis and elevated ESR (65 mm/hr). CSF analysis was normal. CSF, TB-PCR was negative. MRI demonstrated multiple, short segment, non-expansile lesions with asymmetrical involvement in cervico-thoracic (C6 - T5) spinal cord consistent with myelitis. No spinal cord compressions were noted. MRI brain was normal.

She received 5 cycles of therapeutic plasma exchange which was followed by intravenous methylprednisolone 1g daily for five days. She was started on azathioprine 50 mg twice daily, prednisolone 30 mg daily and aspirin. Low molecular weight enoxaparin was commenced for thromboprophylaxis. Co-existing mild depression was diagnosed and was treated with mirtazapine. Physiotherapy and occupational therapy were commenced. She had a marked symptom improvement.

However due to social reasons, she defaulted from the follow up from 14/40 onwards and presented at 35/40 and five days of gestation with PPRM. She received standard care for PPRM, after assessment and insulin was started due to hyperglycaemia. She went into spontaneous labour after 48 hours and monitored in ICU with epidural anaesthesia. Due to pathological cardiotocograph at the dilation of 2 cm, 2kg baby (<3rd centile) was delivered via emergency lower segment caesarean section and sterilization was performed. She had an uneventful recovery. Her symptoms were improved with another cycle of methylprednisolone pulse therapy, physiotherapy, and occupational therapy.

Discussion:

- Her clinical presentation and investigation results didn`t correlate with multiple sclerosis or Neuromyelitis Optica. (However, her NMO antibody status were not known.)
- Her disease got aggravated during pregnancy and showed a relapsing nature with a partial response to immunosuppression, which wasn`t seen in previously reported cases of transverse myelitis.
- After the delivery, her symptoms markedly improved.
- Autonomic dysreflexia didn`t occur during the labor even though it was anticipated.
- Growth restriction may be multifactorial. (age, disease, and immunosuppression)

Conclusions:

- With careful multidisciplinary management, successful pregnancy outcomes are feasible in variable presentations of transverse myelitis.

Reference:

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