

A CASE REPORT OF ATYPICAL PRESENTATION OF DENGUE HEMORRHAGIC FEVER IN THE THIRD TRIMESTER

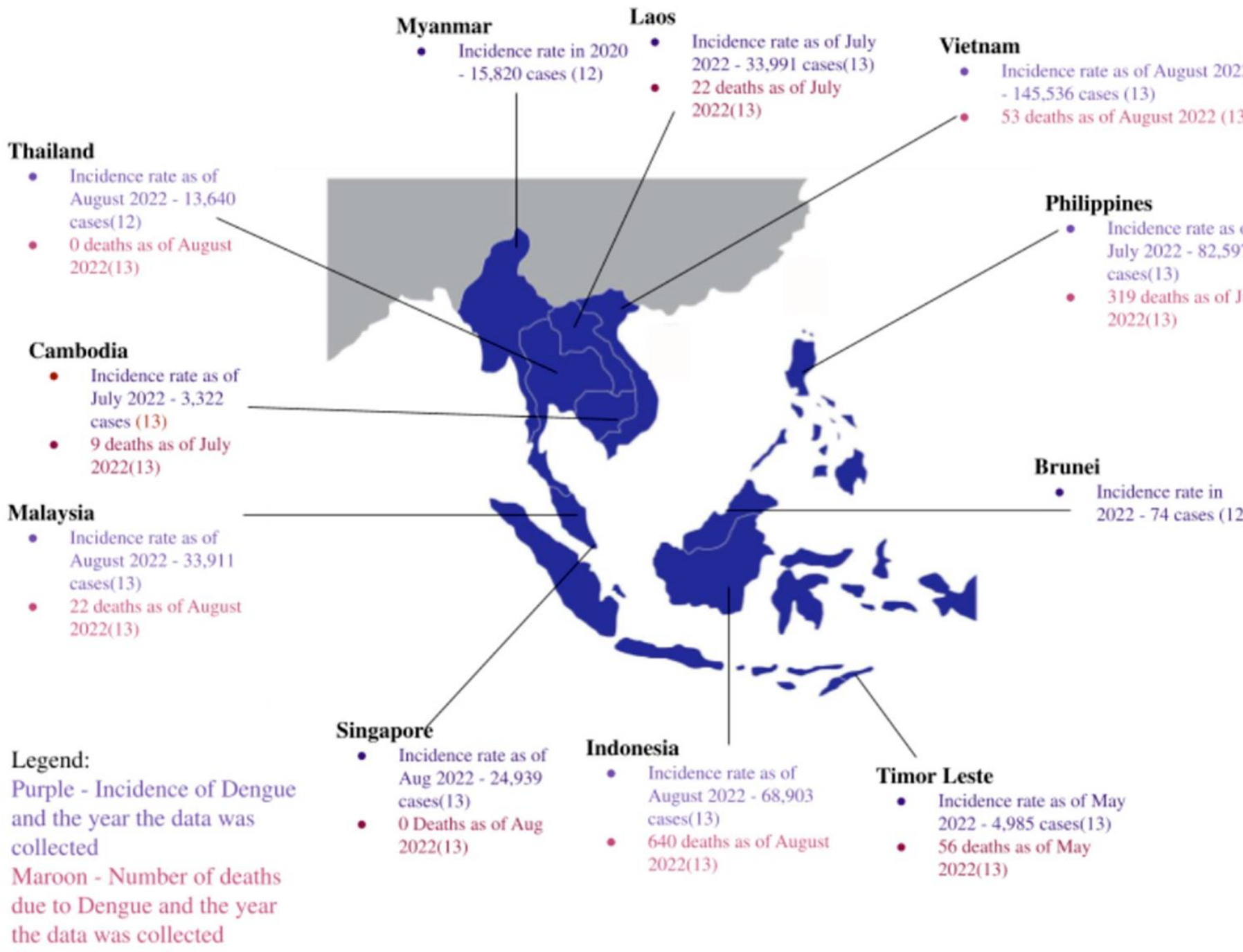
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INTRODUCTION

Dengue infection is considered one of the leading indirect causes of maternal death in South Asian countries before the Covid Infection outbreak. The more severe form known as Dengue Hemorrhagic Fever (DHF) occurs in pregnant women when compared to non-pregnant women with dengue infection. DHF in late pregnancy causes more fetal complications due to maternal hemodynamic deterioration and requires surgical interventions to deliver. Early detection and meticulous management warrants better outcomes in DHF. Complication in DHF such as hepatitis and acute kidney injury management is challenging in pregnancy, there is no national or international level guidance. Only individual case assessment treatment according to clinical evaluation gives better outcomes.

CASE REPORT

A 42-year-old pregnant woman at 35 weeks of gestation presented with fever acute onset of fever and later managed as DHF. As the emergence of warning symptoms and signs and rapidly dropping platelet and rising liver enzymes, she was been managed with the help of a medical team.



Source: <https://www.mdpi.com/2414-6366/8/2/86>

DISCUSSION

Dengue is the most significant mosquito born disease in Sri Lanka. It Is a leading indirect cause of mater death in the Country before Covid. The clinical assessment, diagnosis, treatment, and monitoring of dengue fever or dengue hemorrhagic fever during pregnancy can be very difficult due to various physiological changes occurring in pregnancy and other obstetric complications mimicking a clinical presentation of dengue infection.

Same time diagnosis of dengue can be misled by the presentation of other obstetric complications such as HELLP syndrome and acute fatty liver in pregnancy.

Bleeding manifestation due to very low platelet might progress into retro-placental bleeding even in DHF with the need to expedite delivery for better maternal and fetal outcomes. Rising liver enzymes and acidosis with warning signs direct to the delivery baby with cesarean sections. In some cases, it makes patient conditions and fetal outcomes worse

In the critical phase, she had IV dextran, blood transfusion, N-acetyl cysteine, and medical management for acidosis.

Her baby was not delivered and discharged after extended leaking phase management currently she is in her 38th week with appropriate fetal growth and optimum maternal conditions.

Multi-disciplinary team involvement in managing high-risk conditions in pregnancy always gives the best for the patient.

CONCLUSION

Timely diagnosis, meticulous monitoring, and management based on patient clinical assessment helped to manage the pregnancy up to term.

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