

Navigating Pregnancy with Rheumatoid Arthritis: Challenges and Outcomes Explored!

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Introduction

- RA primarily affects women of reproductive age, making pregnancy management a significant concern.
- Pregnancy in RA is complex due to fluctuating disease activity and potential medication-related risks.
- Disease activity often improves during pregnancy, but postpartum flares are common.
- RA can lead to maternal and neonatal complications, requiring close monitoring.
- Effective disease control and multidisciplinary care are crucial for good pregnancy outcomes in RA patients.

Objective

To evaluate maternal and neonatal outcomes in pregnancies complicated by **rheumatoid arthritis (RA)**, focusing on:

- Pregnancy and postnatal flares
- Maternal complications
- Neonatal outcomes
- Effectiveness of multidisciplinary care

Design & Methodology

Study Type: Retrospective clinical analysis
Period: Jan 2015 – Dec 2022
Participants: 92 pregnant women with RA
Data Collected:

- Demographics
- Disease duration and medication
- Flare patterns (pregnancy/postnatal)
- Maternal outcomes: GDM, PE, PTL
- Neonatal outcomes: gestational age, birth weight, NICU, anomalies

Statistical Tools:

- Descriptive statistics; Chi-square test

Parameter	Value / %	Significance
RA duration ≤ 2 years	84.8%	
Pregnancy-related flares	39.1%	
Postnatal flares	46.7%	
GDM	15.2%	$p < 0.05$
Preeclampsia	8.7%	$p = 0.03$
Preterm labor	4.3%	$p = 0.04$
Preterm delivery	18.5%	$p = 0.02$
Low birth weight	18.5%	$p < 0.05$
NICU admissions	13%	$p = 0.01$
Congenital anomalies	0%	
Neonatal deaths	0%	

Discussion

RA flares occurred in 39.1% during pregnancy and 46.7% postpartum, with the postpartum period being particularly high-risk.**Maternal complications** included GDM (15.2%) and preeclampsia (8.7%), while **18.5% had preterm births and low birth weight infants**.**Multidisciplinary care**, including preconception counseling, improved maternal and fetal outcomes.**13% of neonates required NICU admission**, highlighting risks of fetal growth restriction and need for early interventions.**Corticosteroids and azathioprine** were commonly used and considered safe; **biologics may be used with caution**, while some drugs like methotrexate remain contraindicated.

Conclusion

- RA in pregnancy presents **significant risks**: GDM, PE, PTL, postnatal flares.**Active disease management** is vital, especially in the preconception and antenatal phases.**Coordinated care** improves maternal and neonatal outcomes
- Further research is needed on long-term neonatal impacts&medication safety

Recommendation

Preconception Planning

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- Disease control is critical
- Medication review for teratogenicity
- Multidisciplinary planning begins

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1st Trimester (0–12 wks) |

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- Possible RA flare
- Careful medication adjustments
- Risk of miscarriage slightly elevated

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2nd Trimester (13–27 wks) |

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- Disease activity often improves
- Fetal growth monitoring
- Continued joint care and labs

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3rd Trimester (28–40 wks) |

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- Risk of GDM, preeclampsia, PTL
- Plan delivery method
- Neonatal team involvement

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Postpartum Period (0–6 wks) |

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- High risk of RA flares
- Breastfeeding safety with meds
- Adjust postpartum medications
- Monitor maternal recovery

Distribution of Deliveries in the Study Cohort

Category	Percentage
Term Deliveries	77.6%
Preterm Deliveries	22.4%

Neonatal Outcomes

Category	Percentage
Normal Outcomes	68.5%
Low Birth Weight	18.5%
NICU Admissions	13.0%

Maternal and Neonatal Complications in Autoimmune Pregnancies

Complication	Percentage (%)
Pregnancy Flares	39.1
Postnatal Flares	46.7
GDM	15.2
PE	8.7
PTL	4.3
Preterm Deliveries	18.5
LBW	18.5
NICU Admissions	13.0