

Case Report: Malaria in Pregnancy – A Diagnostic Challenge

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Objective:

To highlight diagnostic challenges of malaria in pregnancy and the importance of travel history in febrile illness evaluation.

Case report:

A primigravida presented to the emergency department at 31+2 weeks with nonspecific symptoms, including backache, lower abdominal pain, and cough. Initial findings included afebrile, sinus tachycardia (HR 140 bpm) and chest examination revealed congestion. Her elevated inflammatory markers (CRP 119), and a downward trend noted in platelet counts on day2 (92 to 78). Urinalysis suggested a urinary tract infection (UTI), and the patient was initially started on symptomatic treatment and IV fluids. However, a fever spike (37.8°C) later on and persistent tachycardia prompted initiation of the sepsis pathway.

On day 2, she developed shivering, worsening thrombocytopenia, and a recent history of travel to Ghana (had stayed for three months) raised suspicion of malaria. Her blood film also revealed *Plasmodium falciparum* with percentage of parasitaemia 0.9%. The patient was promptly transitioned from oral antimalarials to IV artesunate due to persistent pyrexia and reduced urine output, under the guidance of a tropical disease specialist.

The patient responded well to treatment, with normalization of inflammatory markers, resolution of parasitaemia, and stabilization of platelet counts. Fetal well-being was maintained throughout hospitalization, with a reassuring cardiotocography (CTG) and stable fetal movements.

Discussion:

Malaria during pregnancy is a critical condition, posing risks of maternal anaemia, maternal and fetal mortality, preterm delivery, and low birth weight. In non-endemic regions like the UK, it can be overlooked due to symptom overlap with conditions like UTIs or sepsis. *Plasmodium falciparum*, the most severe species, can lead to underestimated parasite loads due to placental sequestration.

This case emphasizes the importance of considering travel history in pregnant patients with febrile illnesses or thrombocytopenia. Early diagnosis and treatment were pivotal in preventing complications.

Management and Follow-Up:

The patient was counselled on the risk of treatment failure during pregnancy and advised on the need for chemoprophylaxis for future travel. Post-treatment follow-up included repeat malaria blood films, PCR testing, haemoglobin monitoring, and fetal growth assessment. Neonatal malaria testing was scheduled at birth and during the first three months post-delivery, with safety netting advice for fever in both mother and baby.

Conclusion:

This case highlights the critical role of travel history in diagnosing malaria during pregnancy, particularly in non-endemic regions. Multidisciplinary care and vigilance ensured a positive outcome for both mother and foetus. Early recognition and prompt treatment remain key to managing this potentially life-threatening condition.

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