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Research Letter

Fetal distress and urgent cesarean delivery due to new-onset peripartum Crohn's disease

Misgav Rottenstreich [a, *], Amihai Rottenstreich [b], Moshe Rottenstreich [c]

[a] Department of Obstetrics and Gynecology, Shaare Zedek Medical Center, Hebrew University Medical School of Jerusalem, Jerusalem, Israel
[b] Department of Obstetrics and Gynecology, Hadassah-Hebrew University Medical Center, Jerusalem, Israel
[c] Department of Gastroenterology, Shaare Zedek Medical Center, Hebrew University Medical School of Jerusalem, Jerusalem, Israel

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Dear Editor,

The incidence of inflammatory bowel diseases (IBDs) is increased among reproductive aged women [1]. The presence of active disease at early pregnancy is associated with an elevated risk for maternal and perinatal complications including low-birth weight infants, stillbirth and prematurity [3–5].

A 25 year-old Gravida-4 Para-3 presented at 36th weeks of gestation to the obstetric emergency room following the onset of uterine contractions lasting for few hours. She looked pale and weak with mild tachycardia (115 bpm), abdomen was soft with normal uterine tonus and vaginal examination revealed unfavorable cervix. Fetal heart rate monitoring demonstrated decreased variability with recurrent prolonged decelerations. She was immediately admitted to the operation room and an emergent cesarean section (CS) was performed. A 2674 g male was delivered with normal Apgar scores ($9^1/9^5$). No apparent reason for fetal distress was observed intraoperatively, however, initial maternal laboratory tests on admission showed anemia of 7 g/dL with hematocrit of 22% WBC of 6×10^3/uL blood glucose levels of 51 mg/dL and normal electrolytes. Following delivery, she was treated with two units of packed cells.

During hospitalization, she mentioned having watery-brown diarrhea up to 10 times/day lasting for 3 weeks prior to her admission. She denied abdominal pain, recent travelling, exposure to antibiotics or personal and family history of IBD. Repeat laboratory work-up revealed hypokalemia of 3.1 mEq/L, decreased serum albumin (1.9 g/dL) and markedly elevated C-reactive protein (39 mg/L, upper normal limit-0.5). WBC count increased up to

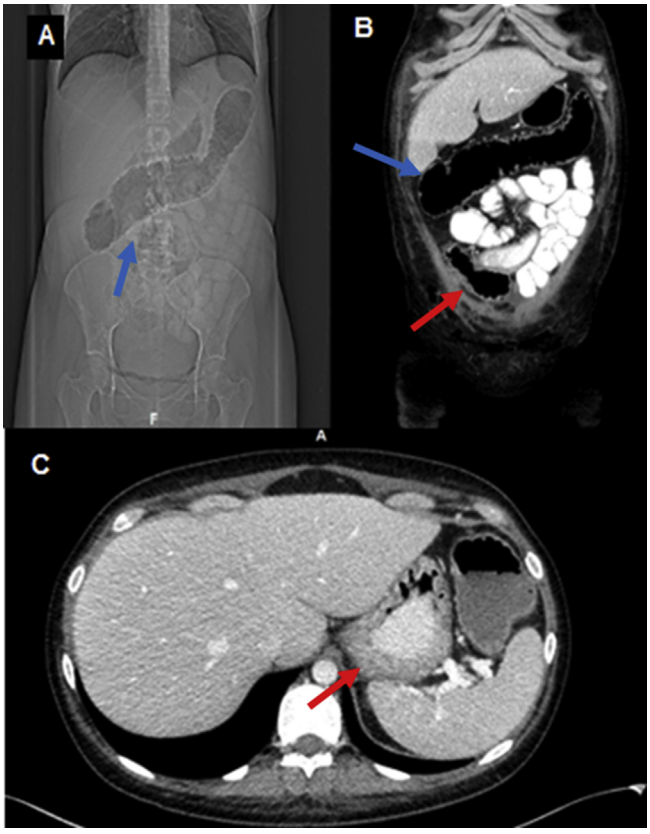

Fig. 1. CT scan showing large bowel distention (blue arrows) (A, B) and significant wall thickening (red arrows) (B, C).

* Corresponding author. Department of Obstetrics and Gynecology, Shaare Zedek Medical Center, 12 Bayit Street, 91031, Jerusalem, Israel. Fax: +972 2 666 6053.
E-mail address: misgavr@gmail.com (M. Rottenstreich).

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21.3×10^3/uL at the fifth postoperative day. Stool cultures for bacteria and parasites, as well as Clostridium Difficile testing were negative. Thyroid function and serology for celiac disease and Rota virus were normal.

A computed tomography scan performed showed dilatation of the right and transverse colon and cecum up to 7.5 cm, with marked colitis from the splenic flexure through the rectum. The small intestine was otherwise normal (Fig. 1).

Sigmoidoscopy performed on the same day showed ulcerated, cobbled-stoned mucosa with scattered ulceration in the descending colon. Biopsy confirmed the diagnosis of CD. She was given intravenous corticosteroids along with total parental nutrition which led to resolution of her symptoms.

She was discharged 24 days postoperatively in good medical condition.

The occurrence of new-onset CD during pregnancy is rare [6–11]. Evaluation and diagnosis of suspected IBD during pregnancy is challenging since typical symptoms may be masked by normal physiologic changes coupled with difficulty in performing adequate radiologic and endoscopic evaluation during pregnancy due to safety considerations [12].

In our case, an emergent CS was performed due to fetal distress. This is in accordance with previous reports which demonstrated higher rates of CS, mostly unplanned, among IBD pregnant patients [5,13]. Fetal distress was reported as the leading indication [14]. As disease course may be fulminant, early diagnosis and prompt treatment is required due to high rate of maternal and perinatal complications.

Conflict of interest

All authors have no conflict of interest or benefit that has arisen from the direct applications this research to disclose.

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Patient consent form has been completed and signed by the patient.

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