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Case Report

Pregnancy in a woman with Henoch-Schönlein purpura: a case report

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ABSTRACT

Henoch-Schonlein purpura (HSP), is an IgA-mediated small-vessel vasculitis that is uncommon in adults and rarely encountered in pregnancy. We report the pregnancy outcome of a 28-year-old woman with biopsy- and direct immunofluorescence-confirmed HSP. An unbooked patient presented at 38+4 weeks with fever, vomiting and decreased fetal movements. She underwent close maternal and fetal surveillance and supportive treatment. After spontaneous onset of labour, emergency lower-segment caesarean section was performed for non-progression of labour, resulting in delivery of a 3.360-kg live male infant. The postoperative course was complicated by lower respiratory tract infection with acute respiratory distress syndrome, requiring 5 days of intensive care and non-invasive ventilation; she subsequently recovered and was discharged on oral antibiotics. This case highlights the importance of multidisciplinary surveillance of renal function, blood pressure, maternal status and fetal wellbeing in pregnancies complicated by a history of HSP.

Keywords: Henoch-Schonlein purpura, Immunoglobulin A vasculitis, Pregnancy, High-risk pregnancy, Caesarean section, Acute respiratory distress syndrome

INTRODUCTION

Henoch-Schonlein purpura (HSP), also called immunoglobulin A vasculitis (IgAV), is an immune-complex small-vessel vasculitis characterised by non-thrombocytopenic palpable purpura with variable musculoskeletal, gastrointestinal and renal involvement. The condition is predominantly a disease of childhood; adult disease is less common and may have more serious renal sequelae.[1,2] Pregnancy complicated by current or previous HSP is uncommon. Reported maternal and fetal risks are driven largely by renal involvement and include hypertension, proteinuria, preterm birth and fetal loss.[3-5] We describe the course and outcome of a late-term pregnancy in a woman with a documented history of HSP and normal renal function at presentation.

CASE REPORT

An unbooked 28-year-old woman, G3P1L0A1, with non-consanguineous marriage of five years, presented on 29 August 2024 in emergency. The pregnancy was dated from a last menstrual period of 3 December 2023, with an expected date of delivery of 10 September 2024. At presentation (38+4 weeks as documented), she had fever, vomiting and decreased fetal movements since the preceding night.

Her first pregnancy ended in a medically managed spontaneous abortion at approximately two months of gestation in 2020. In her second pregnancy, intrauterine fetal demise occurred at 33 weeks in February 2021; she subsequently had a vaginal delivery of a stillborn female infant weighing 1.854 kg on 21 February 2021.

The patient had been diagnosed with HSP in July 2022, following an episode of COVID-19. After the previous pregnancy, she had experienced generalized weakness and arthralgia, followed approximately one year later by palpable purpura over the dorsal arms and anterior lower legs. Biopsy of a skin lesion showed leukocytoclastic vasculitis with intravascular fibrin thrombi. Direct immunofluorescence demonstrated vascular deposits of

IgA and C3 in the upper and mid dermis. Anticardiolipin immunoglobulin M and immunoglobulin G were normal; complete blood count, kidney function tests and contrast-enhanced computed tomography of the abdomen had been normal. In conjunction with the joint symptoms, these findings established the diagnosis of HSP.

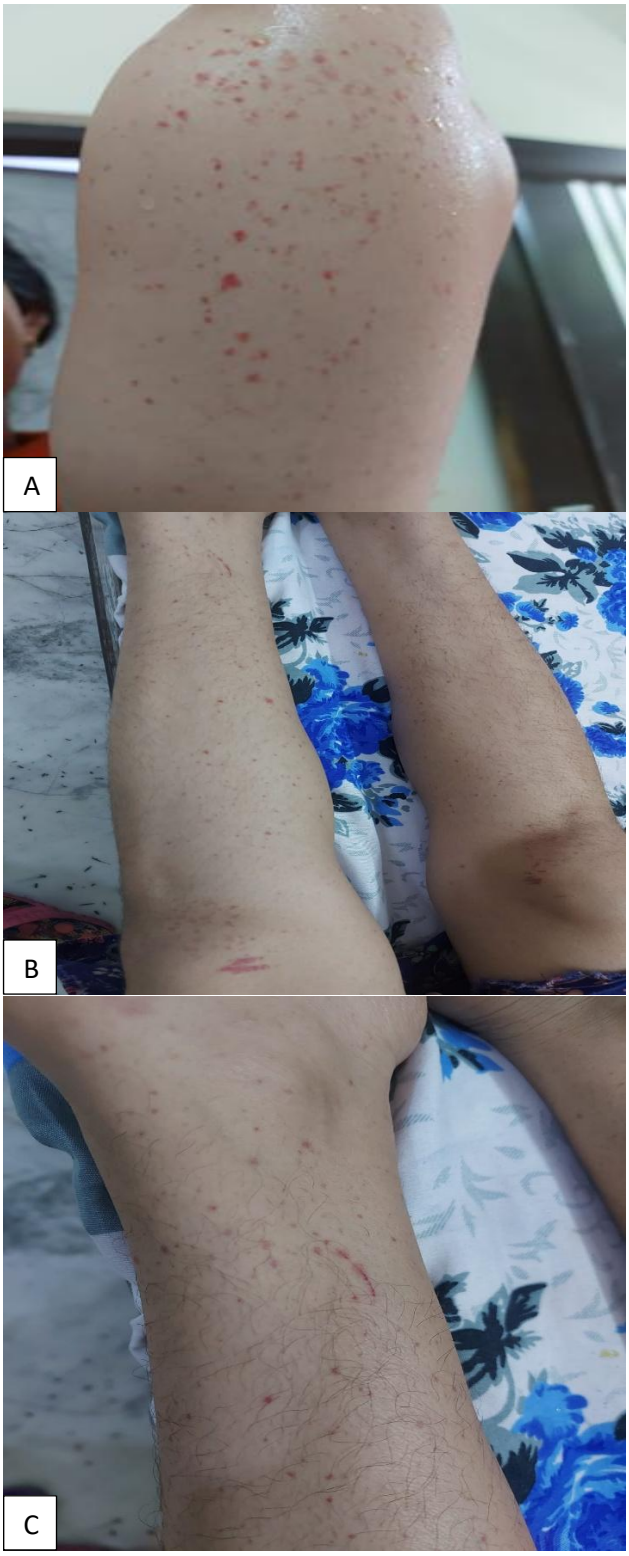

Figure 1 (A-C): Palpable purpurae on dorsal arms and lower legs.

Before conception, she received colchicine 0.5 mg twice daily, hydroxychloroquine 200 mg twice daily and oral corticosteroid therapy. These medications were started in July 2022 and discontinued before conception in December 2023. During the index pregnancy, enoxaparin 40 IU subcutaneously once daily and aspirin 75 mg once daily had been initiated from the first trimester.

Investigations

On admission, she underwent following investigations summarized in table. She had mild anaemia and leukocytosis. Liver and kidney function, urinalysis, coagulation profile, and infectious screening for HIV, hepatitis B surface antigen, anti-hepatitis C antibody and syphilis were unremarkable or non-reactive. Urine culture was sterile. C-reactive protein was elevated.

Table 1: Investigations.

Parameters	Result
Hemoglobin	9.9 g/dl
Total leukocyte count	12,000/ul
Platelet count	2.8 lakh/ul
Liver and kidney function tests	Within normal limits
Urine routine microscopy	Normal
Urine culture	Sterile
PT/INR; APTT	11.5 s/1.029; 29.5 s
C-reactive protein	65 mg/dl
Procalcitonin; LDH	0.546 ng/ml; 199 U/l
Typhi IgM/IgG, malaria antigen, dengue NS1	Non-reactive/negative
HIV, HBsAg, anti-HCV, VDRL	Non-reactive

Management and outcome

The patient was admitted for conservative management and high-risk surveillance. Non-stress testing was performed twice daily, strict fetal movement counting was advised, and obstetric ultrasonography with doppler assessment was undertaken for fetal wellbeing. Temperature was charted four-hourly. Relevant investigations were sent, and physician and pre-anaesthetic assessments were obtained. Intravenous fluids and intravenous antibiotics were administered, and high-risk informed consent was documented.

Her clinical condition gradually improved. Three days after admission, she developed spontaneous labour pains. In view of non-progression of labour, emergency lower-segment caesarean section was performed on 2 September 2024. A live male infant weighing 3.360 kg was delivered at 12:06 pm.

Intraoperatively, the patient developed shortness of breath with oxygen desaturation. She was shifted to the ICU for respiratory distress. A diagnosis of lower respiratory tract

infection with post-caesarean acute respiratory distress syndrome was made. She received non-invasive ventilation, broad-spectrum antibiotics, intravenous fluids, strict input-output monitoring and supportive care. After five days in intensive care, she improved, was transferred to the ward, and was discharged on oral antibiotics. At review seven days later, recovery was reported to be satisfactory.

DISCUSSION

The present case had a well-documented history of HSP, with characteristic palpable purpura, arthralgia, leukocytoclastic vasculitis on skin biopsy, and IgA/C3 deposition on direct immunofluorescence. Palpable purpura plus IgA-predominant deposition fulfils commonly used classification criteria for IgAV.[1] The normal kidney function tests and urinalysis during the index admission were reassuring, because renal disease is the key prognostic determinant in adult IgAV and is particularly important in pregnancy.[2,3]

Published evidence on HSP in pregnancy consists largely of case reports and small observational cohorts. In a review of reported pregnancies, renal involvement appeared to be associated with the more serious maternal and fetal complications.[3] A population-based study of women with a history of IgAV reported increased odds of spontaneous abortion, preterm delivery and gestational hypertension compared with controls, while no disease flares were recorded during the observed pregnancies.[4] These data support preconception counselling and antenatal surveillance for blood pressure, proteinuria, renal function and fetal growth, tailored to disease activity and renal involvement.

The caesarean delivery in this case was undertaken for an obstetric indication, namely non-progression of labour, rather than a documented HSP flare or renal complication. The postoperative respiratory complication required critical care but resolved with supportive treatment. Given the limited evidence base, care for pregnant patients with HSP should be individualized and coordinated among obstetric, physician/rheumatology, nephrology and anaesthesia teams when indicated.[3,5]

CONCLUSION

Pregnancy in women with a history of HSP can have a favourable outcome when renal involvement is absent and maternal-fetal surveillance is maintained. This case underscores the value of confirming prior disease status, monitoring blood pressure, urinalysis and renal function, and providing multidisciplinary care for acute obstetric or medical complications.

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REFERENCES

1. Ozen S, Pistorio A, Iusan SM. EULAR/PRINTO/PRES criteria for Henoch-Schonlein purpura, childhood polyarteritis nodosa, childhood Wegener granulomatosis and childhood Takayasu arteritis: Ankara 2008. Part II: Final classification criteria. Ann Rheum Dis. 2010;69(5):798-806.
2. Pillebout E, Sunderkotter C. IgA vasculitis. Semin Immunopathol. 2021;43(5):729-38.
3. Gouveia L, Campos S, Sousa P. Henoch-Schonlein purpura in pregnancy: a case report. J Med Case Rep. 2018;12:298.
4. Nossent J, Raymond W, Isobel M. Pregnancy outcomes in women with a history of immunoglobulin A vasculitis. Rheumatology (Oxford). 2019;58(5):884-8.
5. Kang Y, Park JS, Ha YJ. Differences in clinical manifestations and outcomes between adult and child patients with Henoch-Schonlein purpura. J Korean Med Sci. 2014;29(2):198-203.

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