

DOI: <https://dx.doi.org/10.18203/2320-1770.ijrcog20264010>

Case Series

Systemic lupus erythematosus in pregnancy: experience from a tertiary care center in Northeast India

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Received: 14 September 2026

Accepted: 16 October 2026

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ABSTRACT

Systemic lupus erythematosus (SLE) is a chronic autoimmune disorder that most commonly affects women in the reproductive age group. Although pregnancy is allowed with low disease activity, individuals diagnosed with SLE have a higher risk of complications from pregnancy (for both the mother as well as the fetus) than the general population. Such risks may include spontaneous abortions, intrauterine fetal demise, preeclampsia, eclampsia, intrauterine growth restriction (IUGR), and preterm delivery. Pregnant women who have active disease at conception or during early pregnancy, have lupus nephritis in the past, or have antiphospholipid syndrome are at increased risk of obstetrical complications. This retrospective study was carried out at All India Institute of Medical Sciences, Guwahati (Northeast India). This case series includes 3 pregnant patients with SLE as reviewed in the study for maternal and fetal outcomes. In two patients in our case series, caesarean section was provided one for failed induction and another for a non-reassuring non-stress test. Both infants were normal at birth without any cardiovascular anomaly and were sent for neonatal evaluation for neonatal lupus, which was normal. The third patient required medical termination of pregnancy at 25 weeks of gestation in view of worsening maternal condition. Anticoagulants, steroids and immunosuppressants also pose high risks for the mother and the unborn child. The best approach to management will have to be multidisciplinary with medical, obstetric, and neonatal supervision in order to achieve a good prognosis.

Keywords: Antiphospholipid syndrome, Hydroxychloroquine, Lupus nephritis, Pregnancy outcome, Systemic lupus erythematosus

INTRODUCTION

Systemic lupus erythematosus (SLE) is a chronic autoimmune disorder characterized by inflammation and affecting multiple systems, often exhibiting cycles of flare-ups and remission. The affected organs are commonly the kidneys, joints, and skin. A major characteristic of SLE is unusual immune reactions, specifically the production of antinuclear antibodies (ANA).^{1,2} SLE has an overall incidence of five per 100,000 people and is predominantly diagnosed in women of childbearing age.² The reported

prevalence of SLE in India is 3.2 per 100,000 population. However, the prevalence appears much higher among South Asian migrants to developed countries and has been reported to be 2–2.4 times that of the native Western population. Though the prevalence rate of SLE reported from India might be lower than in Western countries, owing to a population of 1.4 billion, there will be at least 50,000 patients with SLE in India.³

While progress has been made in managing pregnancies for women with SLE in recent years, women with SLE are still at increased risk of maternal and fetal complications

compared to the ^{general} population. A combination of risk factors could induce disease exacerbations and complications during pregnancy.⁴

Women with SLE may face several challenges in pregnancy. Besides an increased activity of the disease itself, pregnant women with lupus face a higher risk of mortality and higher risk of eclampsia, preeclampsia, preterm birth, and thromboembolic events. For pregnant SLE patients, the complications of the disease are often hard to distinguish from the physiological changes in the body or complications arising from the pregnancy itself.⁵

Oligohydramnios is observed in less than 1% of preterm pregnancies and in 5% of term pregnancies. The incidence increases to approximately 12% among patients with systemic lupus erythematosus (SLE).⁶

In the general population, stillbirth occurs between 0.3 and 0.6 per cent of pregnancies, but in pregnancies involving systemic lupus erythematosus (SLE) the rate is considerably higher, ranging from 1.2 to 5 per cent.⁷ This higher rate of fetal death is mainly due to placental dysfunction, secondary antiphospholipid syndrome (APS), active lupus nephritis and maternal vascular disease.^{8,9} Since progressive uteroplacental insufficiency can result in silent fetal hypoxia and growth restriction, structured antenatal fetal testing (including non-stress tests, biophysical profiles and Doppler velocimetry) is typically started at 32 weeks' gestation in women with SLE, with earlier initiation as early as between 24 and 28 weeks for those with high-risk features such as active lupus nephritis, antiphospholipid syndrome (APS) or fetal growth restriction, and continued monitoring during labour is more likely to identify early fetal distress and thus reduce the risk of stillbirth.^{10,11}

Advancements in the understanding of systemic lupus erythematosus (SLE) pathogenesis, combined with the judicious application of immunosuppressive therapies, have led to improved disease control. Early identification of risks to maternal and fetal health is essential for achieving optimal outcomes.¹²

Neonatal lupus erythematosus (NLE) is a rare but serious complication of systemic lupus erythematosus (SLE), seen in about 1 in 20,000 live births. NLE usually affects infants whose mothers have SLE, but it can also happen in other situations. Symptoms include skin lesions, congenital heart block (CHB), anaemia, hepatitis, and thrombocytopenia. About half of infants with NLE develop skin lesions.¹³ Postnatal evaluation of a newborn born to a mother with Systemic Lupus Erythematosus (SLE) is primarily concerned with identifying Neonatal Lupus Erythematosus (NLE) caused by the transplacental transfer of maternal autoantibodies (anti-Ro/SSA, anti-La/SSB, or anti-RNP). An electrocardiogram (ECG) at birth is advised for all infants exposed to anti-Ro/SSA or anti-La/SSB antibodies to check for AV block or QT abnormalities, with an immediate echocardiogram if

bradycardia, murmur or conduction delay is present. Physical and cutaneous examination for annular, erythematous scaling plaques or periorbital erythema ("raccoon eyes"), which can occur at birth or appear weeks later after sun exposure. Complete blood count to evaluate for transient cytopenias (thrombocytopenia, neutropenia, anaemia). Liver function test to assess transient hepatitis or cholestasis. Infant Serology to Check baseline anti-Ro/SSA and anti-La/SSB antibody levels. The non-cardiac manifestations (skin, blood, liver) typically resolve spontaneously within 6–8 months as maternal IgG antibodies clear, whereas congenital heart block is permanent and requires long-term pediatric cardiology management.¹⁴

Pre-conceptional counselling and close monitoring throughout the pregnancy period by a multidisciplinary team are an integral part of improving pregnancy outcomes for these patients.⁴

CASE SERIES

A series of 3 cases of SLE in pregnancy are presented here

Case 1

G2A1, a 27-year-old woman married for 2 years, presented to the antenatal outpatient in early pregnancy, with a diagnosed case of SLE 2 years back. She had a history of spontaneous abortion 1 year prior at 6 weeks of gestation. upus anticoagulant and anticardiolipin were positive but the text does not state whether antiphospholipid syndrome was diagnosed. Please clarify the diagnosis antibodies, and Antinuclear antibodies. She was diagnosed with SLE, and treatment began with a rheumatologist on hydroxychloroquine, low-dose aspirin, and oral prednisolone. One year after her abortion, she conceived. She was receiving treatment as advised by the rheumatologist and had scheduled antenatal visits at our Institute. After registration at our centre, her rheumatology referral was obtained, and she was advised to continue taking the medications. Induction of labor was done at 39 weeks gestation in view of oligohydramnios, and in the intrapartum, continuous electronic fetal monitoring was done. She had an emergency LSCS in view of failed induction and delivered a 2450 g male baby with an Apgar score of 8/9. Baby was transferred to the NICU and evaluated for cardiac, haematological, hepatic, and dermatological manifestations, with no abnormalities detected.

Case 2

A primigravida, a 29-year-old woman married for 4 years, presented to the antenatal outpatient department at 21 weeks of gestation, with a diagnosed case of SLE 7 years back. Tests positive: lupus anticoagulant, anti-dsDNA antibodies, anti-β2-glycoprotein I, and aAntinuclear antibodies. She was diagnosed with SLE, and treatment began with a rheumatologist on hydroxychloroquine, low-

dose aspirin, and oral prednisolone. She was receiving this treatment as advised by the rheumatologist and had scheduled antenatal visits to our Institute. She was diagnosed with lupus nephritis in this pregnancy. A fetal 2D echo was done, which was normal. Antepartum fetal surveillance was started from 32 weeks gestation by weekly non-stress tests. She had an emergency LSCS in view of a non-reassuring NST at 39 weeks of gestation and delivered a 2560 g male baby with an Apgar score of 8/9. Baby was transferred to the NICU and evaluated for cardiac, haematological, hepatic, and dermatological manifestations, and no abnormality was detected.

Case 3

A 25-year-old G2A1 at 25 weeks of gestation presented to the emergency with bilateral lower limb swelling and breathing difficulty for the last 1 month. She had a history of high blood pressure record from last 7 days; for that, she was on labetalol and her blood pressure was not controlled, and she was referred from the previous care centre. On presentation, her BP was 155/94 mm Hg, PR 120/min, SpO₂ 90% on room air, with fine crepitations bilaterally. Ultrasonography suggestive of bilateral pleural effusion with ascites. 24-hour urine protein was suggestive of nephrotic-range proteinuria (11578 mg). On workup, her Anti DS(Anti-double-stranded) DNA antibody and Anti-SSA autoantibodies (anti-Sjögren's-syndrome-related antigen A autoantibodies, also called anti-Ro antibody) were positive. She was diagnosed to be a case of SLE for the first time in this pregnancy. The patient was immediately admitted to the obstetrics high dependency unit for close hemodynamic and respiratory monitoring. Initial conservative management over 24 hours consisted of supplemental oxygen via HFNC, intravenous loop diuretics IV Furosemide for pulmonary edema, blood pressure control using IV Labetalol and immunosuppressive treatment IV Methylprednisolone. Due to refractory pulmonary edema, persistent hypoxemia and worsening maternal clinical status despite maximal medical optimization, the multidisciplinary team (Obstetrics, general medicine, Anesthesiology, Critical Care, Neonatology) determined that continuing the pregnancy was an imminent threat to maternal life. Following extensive conversation with the patient and her relatives regarding the maternal risk and possible neonatal outcomes, we made a decision to medical terminate the pregnancy on Day 2 of admission.

The induction of labor started with intravaginal Misoprostol (100 mcg). Intrapartum monitoring was continuous in the HDU setting. In view of high postpartum hemorrhage (PPH) risk due to nephrotic hypoalbuminemia and systemic inflammation blood products (PRBCs/RDP and FFPs) were cross-matched and kept on standby along with prophylactic uterotonic agents and balloon tamponade readiness. Patient delivered an abortus of weight 350 g after 2 doses of misoprostol. The immediate postpartum period was uneventful. On postpartum day 4, the patient developed a seizure for which she was shifted

to the critical care unit. MRI brain was done, which was suggestive of posterior reversible encephalopathy syndrome (PRES). She was shifted to the medicine ward after three days of CCU stay. Blood pressure was controlled after using three antihypertensive medications: cilnidipine, methyldopa and chlorthalidone. Renal biopsy was planned, but due to worsening urea/creatinine, renal biopsy was deferred. She was started on steroid pulse therapy followed by oral steroids. Workup was suggestive of an acute flare-up of SLE. She was discharged on hydroxychloroquine, oral prednisolone, and cyclophosphamide was also started. Currently, she is being followed up in Rheumatology clinic. The patient was advised to wait at least six months of disease remission before attempting another pregnancy. Ongoing follow-up with rheumatology and high-risk obstetrics teams was advised from preconception through any future pregnancy. The patient was also informed of the risk of recurrence and advised to use effective contraception until optimization of the disease.

DISCUSSION

Systemic lupus erythematosus (SLE) is a multisystem autoimmune condition affecting mainly women of reproductive age, which poses an important clinical problem for its management in pregnancy.¹⁵ Although live birth rates in SLE pregnancies have improved to more than 85% in recent decades with the support of multidisciplinary management, adverse outcomes such as lupus flares, pre-eclampsia, preterm delivery, and fetal loss remain significantly greater than in the general population.^{16,17} Data about pregnancy outcomes in women with systemic lupus erythematosus (SLE) in pregnancy from North East India are sparse, mainly due to regional healthcare limitations such as late tertiary referrals and the lack of specialist maternal-fetal and rheumatology services.^{18,19} We present a case series of three SLE pregnancies in a regional tertiary care center with two successful term deliveries and emergency termination of one pregnancy at 25 weeks of gestation due to severe maternal clinical deterioration.

These cases highlight the significance of pre-conception disease control, serological surveillance, and tailored counselling around clinically achievable perinatal outcomes, and they also illustrate successful and challenging attempts in resource-poor settings.

Systemic lupus erythematosus (SLE) prevalence in India is estimated at approximately 3.2 cases per 100,000 population. A large case series involving 1,366 Indian patients with lupus reported a high frequency of renal and neurologic involvement.²⁰ In a recent matched-observational study conducted in southeastern India (2011–2020) of 144 SLE pregnancies, 18.8% of cases were diagnosed for the first time during pregnancy. Mohan P et al identified significant increases in odds of hypertensive disorders of pregnancy (OR 5.10), preterm birth (OR 2.61), and perinatal loss (OR 13.92) from SLE

pregnancies versus controls. Lupus nephritis (OR 4.62) and hypertensive disorders (OR 9.99) independently predicted perinatal loss, while hydroxychloroquine use was associated with reduced flares (OR 0.15).¹⁹

The findings from these studies reflect the increased risk of SLE pregnancies in India as well as the importance of disease control before conception. In North East India, other challenges that add up to these risks include geographical obstacles, delayed referrals and limited availability of specialist maternal-fetal medicine and rheumatology services. Also, there is limited knowledge among general practitioners about the importance of early referral at an early gestation for specialist care. Patients also have no knowledge regarding the need for preconceptional care.

It is time to increase awareness among both medical practitioners as well as the patients regarding the condition. Indeed, the 2 successful term deliveries in our series are consistent with published data, which also suggests well-controlled SLE with quiescent disease at conception strongly improves outcomes. The most recent guidelines recommend disease remission/Lupus Low Disease Activity State (LLDAS) for 6 months before conception, and continuation of hydroxychloroquine during pregnancy. In a 2025 study in India, hydroxychloroquine was significantly associated with reduced lupus flares during pregnancy (OR: 0.15).¹⁹ Cases 1 and 2 were treated with pregnancy-compatible drugs such as hydroxychloroquine, prednisolone (omnacortil) and low-dose aspirin; mycophenolate mofetil, cyclophosphamide and methotrexate were not used. Early detection of any deterioration scheduled fetomaternal surveillance' is feasible by means of the routine fetomaternal surveillance.

The termination of pregnancy in one patient at 25 weeks due to declining maternal health constitutes one of the most challenging but evidence-supported reasons for termination in the context of endangering the lives of mothers. Active lupus nephritis carries increased maternal complications to 57% from 11% in quiescent disease and is associated with an increased incidence of fetal loss.^{16,21} Distinguishing lupus nephritis (LN) from preeclampsia (PE) during pregnancy in systemic lupus erythematosus (SLE) is challenging because their clinical and laboratory features often overlap, complicating both management and prognosis. When SLE with lupus nephritis presents with proteinuria, hypertension and low complement, with proteinuria, hypertension, and low complement, complement levels and anti-dsDNA titers aid in this differential.

In published SLE series, the induced abortion rate is 5.9% and increases in tandem with active nephritis, antiphospholipid antibody positivity, and a high SLEDAI score at conception.¹⁶ An elevated risk of pregnancy loss occurs with active SLE during pregnancy, with a 10.56-fold increase.²² The decision favoured maternal survival,

which goes hand in hand with the principle that maternal health needs to be established before fetal salvage can occur.

Active disease at conception and lupus nephritis are the most powerful predictors of adverse outcomes in SLE pregnancies, and in pregnancy with active lupus, the rate of pregnancy loss is 42%, and pregnancies with active nephritis resulted in 52% of fetal loss.²³ Indeed, this heterogeneity is reflected in our case series two patients had live term births with good neonatal outcomes, probably due to quiescent disease pre-conception and intense monitoring, achieving the reported 81% of pregnancies were uncomplicated in well-controlled SLE.²⁴

Pre-conception management is required to minimize adverse maternal-fetal outcomes in SLE. Pharmacotherapy must be optimized by discontinuing teratogenic drugs and continuing hydroxychloroquine throughout pregnancy to reduce flare and preeclampsia risk.^{25,26} Before conception, patients need to be assessed for baseline renal status and autoantibody profiling (anti-Ro/La, anti-dsDNA, aPL). If antiphospholipid antibodies are detected early, low dose aspirin with or without LMWH is recommended to prevent thrombosis and placental dysfunction.^{10,26}

Hydroxychloroquine remains the mainstay of management for SLE pregnancies. It decreases disease activity as well as use of corticosteroids, and adverse pregnancy outcomes including preterm delivery.²⁷ The management of maternal systemic lupus erythematosus (SLE) disease activity and renal stability before and during pregnancy must be managed in a multidisciplinary manner.²⁶ Rheumatologists, maternal-fetal medicine (MFM) specialists, nephrologists, and neonatologists must collaborate in order to modulate disease-modifying therapies, monitor uteroplacental and renal function, and prevent adverse maternal-fetal outcomes.²⁵

While no data suggest an optimal intervention, weekly antenatal fetal surveillance may be considered by 32 weeks of gestation, with ultrasonography to measure interval growth commonly performed monthly or at least at 28 and 32 to 34 weeks of gestation. In pregnant women with complex SLE (eg, active lupus nephritis, recent lupus flare, aPL antibodies with previous history of fetal loss, anti-SSA or anti-SSB antibodies, or thrombosis) timing of starting of antenatal fetal surveillance and frequency should be individualized and discussed with maternal-fetal medicine and may be considered on diagnosis or at a gestational stage at which delivery may be performed for abnormal testing.¹⁰ In our second case, weekly non-stress testing started at 32 weeks detected a non-reassuring tracing at 39 weeks, which prompted an emergency caesarean section and resulted in a good neonatal outcome, showing that such scheduled surveillance can pick up fetal compromise in time in SLE pregnancies.

Limitations

Limitations of this case series include small sample size (n=3), retrospective observational design, lack of control group, possible incomplete antibody profiling, limited long-term neonatal follow-up, and regional referral bias.

CONCLUSION

SLE in pregnancy is a high-risk condition, and is manageable with early multidisciplinary intervention. The disease control before and during pregnancy is the single most modifiable variable that decides health outcome, as evidenced by the two term deliveries. However, the unique context of North East India underscores the need for regional registry data, preconception counselling, early referral to tertiary centers, universal antibody profiling, and continuation of hydroxychloroquine. Termination of pregnancy may be the life-sustaining option when maternal status worsens, necessitating thorough reporting and empathetic assistance.

Funding: No funding sources

Conflict of interest: None declared

Ethical approval: Not required

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Cite this article as: Bordoloi M, Datta A, Malakar H, Tripathy S, Barman B, Dhakate J. Systemic lupus erythematosus in pregnancy: experience from a tertiary care center in Northeast India. *Int J Reprod Contracept Obstet Gynecol* 2026;15:4573-8.