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Pemphigus and Pregnancy: A Case Report

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ABSTRACT

Pemphigus is a rare autoimmune disorder characterized by blister formation on the skin and mucous membranes, with pemphigus vulgaris being the most common and severe form. This case report discusses a 32-year-old pregnant woman diagnosed with pemphigus gestationis at 32 weeks of gestation, managed with moderate-dose corticosteroids. The pregnancy continued without complications, resulting in a healthy baby delivered via cesarean section. Postpartum management included close dermatological follow-up. Gestational pemphigus, triggered by pregnancy-specific hormonal changes, requires careful treatment to balance maternal health and fetal safety, with postpartum monitoring essential to prevent relapses.

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Introduction

Pemphigus is a group of rare autoimmune diseases where blisters form on the skin and mucous membranes. This occurs when the immune system attacks desmosomal proteins, which are essential for cell adhesion in the skin, causing cell separation and blister formation [1]. Pemphigus vulgaris, the most common and severe form, primarily affects the mucous membranes of the mouth and skin. Treatment generally includes corticosteroids and immunosuppressants to control the autoimmune response [2,3].

Case

This is Mrs. A.A., a 32-year-old woman with no significant medical history, G2P2, who had her first vaginal delivery 4 years ago. Her current pregnancy is estimated at 32 weeks of gestation. She presented to the emergency room with painful skin lesions on her right breast and abdomen. A diagnosis of pemphigus gestationis was made after a skin biopsy revealed IgG antibodies against desmoglein. The patient was treated with moderate-dose corticosteroids to control disease progression. Throughout her pregnancy, close monitoring was conducted to assess fetal well-being and adjust medication doses. The pregnancy continued without major complications, and delivery was by cesarean section at term, with a healthy baby born. Postpartum, the pemphigus was managed with dermatological follow-up to address residual symptoms

Discussion

Pemphigus gestationis is a rare form of pemphigus that appears exclusively during pregnancy due to the specific hormonal and immunological changes of this period [4]. It primarily manifests as pruritic skin lesions, often localized on the abdomen and extremities, typically appearing in the second or third trimester [5,6].

The hormonal and immune modifications during pregnancy induce changes in cytokine and antibody regulation, which can exacerbate or initiate pathological autoimmune responses [4]. Specifically, IgG antibodies targeting desmosomes play a central role in the pathogenesis of pemphigus gestationis, disrupting cell adhesion in the skin and promoting blister formation [1,2]. A better understanding of these mechanisms could lead to more targeted treatments.

The management of pemphigus gestationis requires a cautious therapeutic approach, including the use of corticosteroids and, in some cases, immunosuppressants [4]. The goal is to control maternal symptoms while minimizing risks to the fetus. Dosage adjustments are often necessary to meet the specific needs of each patient [7]. In cases of postpartum relapse, immunosuppressants may be reintroduced, necessitating continuous evaluation of benefits and risks, especially concerning breastfeeding [4-10].

In the literature, pemphigus gestationis is often compared to pemphigus vulgaris to highlight differences in presentation, treatment, and prognosis [8]. While pemphigus vulgaris can occur independently of pregnancy and affect the skin and mucous membranes systemically, pemphigus gestationis is specifically triggered by pregnancy [5].

Compared to pemphigus vulgaris, which often requires aggressive treatment, pemphigus gestationis generally benefits from a more conservative approach, with careful use of corticosteroids to minimize fetal risks [1-5]. However, therapeutic decisions should be individualized, taking into account factors such as symptom severity, the stage of pregnancy, and the patient's preferences [10].

Although pemphigus gestationis tends to improve after delivery, late relapses can occur, requiring long-term monitoring [4]. Postpartum relapses, though rare, may necessitate the resumption of immunosuppressive treatments, which has implications for breastfeeding and maternal health [5]. In contrast, pemphigus vulgaris has a chronic course with frequent relapses, often requiring more aggressive therapeutic interventions [9].

Women who have experienced pemphigus gestationis should be informed of the potential risks for future pregnancies. While recurrences are possible, they are not systematic. A preconception consultation is recommended to plan optimal monitoring from the beginning of pregnancy [4-10].

The literature emphasizes the importance of rigorous postnatal monitoring, including the follow-up of antibody levels, the assessment of skin symptoms, and the adjustment of treatments according to individual needs. Coordination with a multidisciplinary team is essential for comprehensive and effective care [4-10]

Conclusion

Pemphigus in pregnant women, although rare, represents a significant clinical challenge due to its implications for both the mother and the fetus. Gestational pemphigus, in particular, requires a carefully balanced therapeutic approach to manage maternal symptoms while minimizing risks to the fetus [1-4]. Corticosteroids, and in some cases immunosuppressants, are the main treatments, but close monitoring is essential to prevent postpartum relapses [10]. Clinicians must be aware of the differences between gestational pemphigus and other forms of pemphigus for optimal and personalized management

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Competing Interests

The authors declare that they have no competing interests.

Consent for Publication

Written informed consent was obtained from the patient for publication of this case report and any accompanying images. A copy of the written consent is available for review by the Editor-in-Chief of this journal.

Ethics Approval and Consent to Participate

Ethics approval has been obtained to proceed with the current study. Written informed consent was obtained from the patient for participation in this publication

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