PLAQUES IN PREGNANCY: FACTOR V LEIDEN AS A POTENTIAL CAUSE

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INTRODUCTION

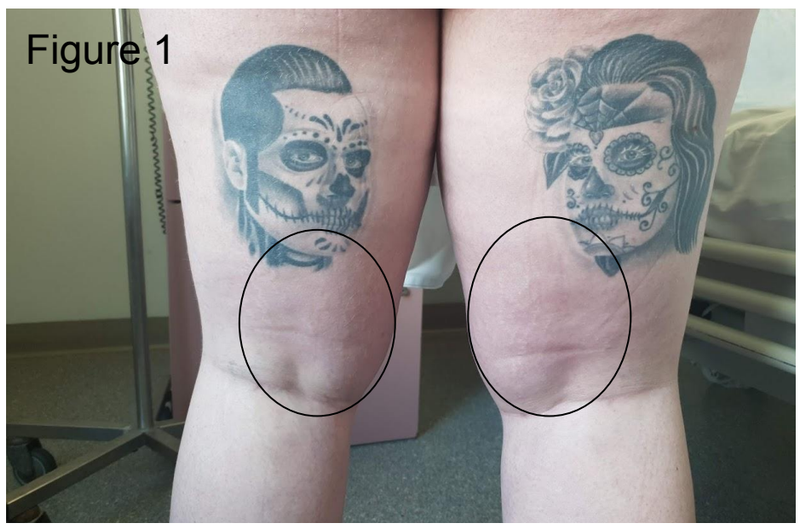
Rashes in pregnancy can present a diagnostic dilemma given the plethora of changes that occur. This report aims to demonstrate a rare presentation of Factor V Lieden (FVL) in an otherwise well patient who had little previous history to suggest such a diagnosis.

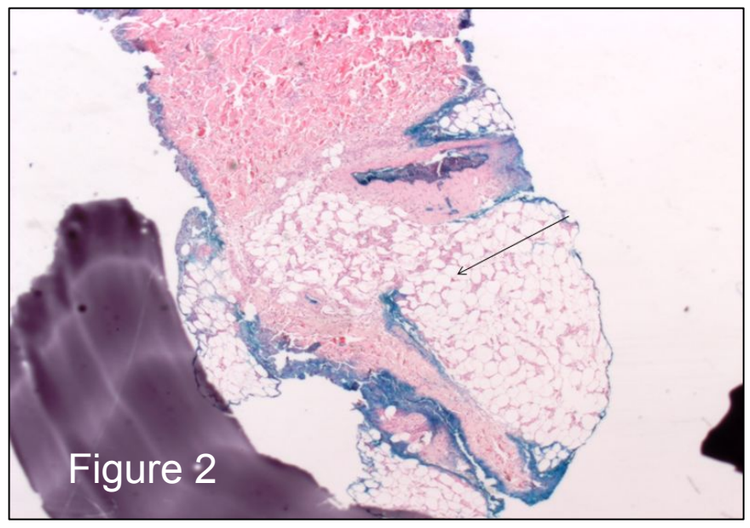
CLINICAL DESCRIPTION

A caucasian 26yo G3P1 who was 33+6 weeks pregnant was transferred from a peripheral hospital febrile to 38 ℃ with tender bilateral posterior thigh swelling (Fig 1), and violaceous rash that appeared spontaneously two weeks prior to presentation. There was no personal or familial history of vasculitidies/ thrombosis/atopy.

This was on a background of recently diagnosed obstetric cholestasis for which ursodeoxycholic acid and phenergan were commenced three weeks prior to presentation, and gestational diabetes that was managed with diet. Her previous pregnancy was uncomplicated.

Blood results demonstrated an elevated WCC to 15.4 x 10^9, CRP of 57, moderate LFT derangement, and bile acids of 9.5 umol/L. Ultrasound revealed no embolus but demonstrated subcutaneous oedema. Consequently a biopsy was performed and suggested small vessel thrombotic occlusive disorder (Fig 2 +3) . Thrombotic screen found her to be homozygous for FVL and was commenced on Aspirin 100mg. Her delivery was expedited at 37 weeks owing to worsening LFT derangement and new diagnosis of FVL, and was commenced on 6 weeks of enoxaparin following delivery.





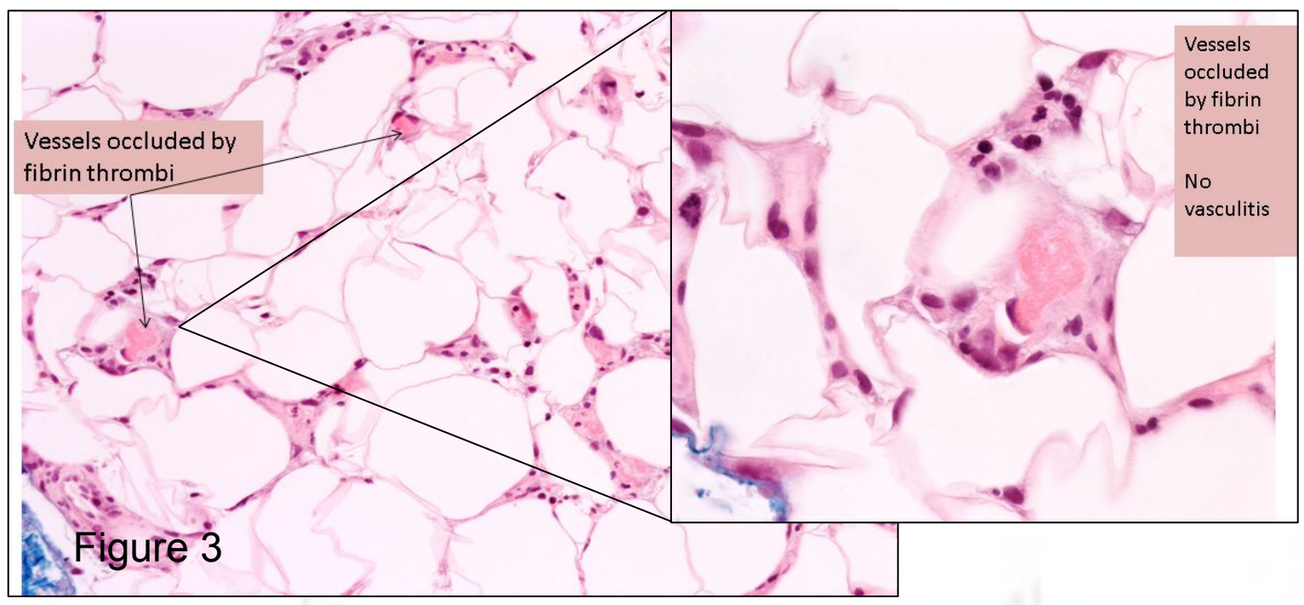


Figure 1: Posteromedial cutaneous rash
Biopsy results: *Figure 2: Increased vascularity in subcut fat, Figure 3: Occluded vessels with no vasculitis*

DISCUSSION:

Common rashes in pregnancy include striae gravidarum, melasma, PUPPS, pruritic rashes secondary to cholestasis, and pemphigoid gestationis.[1]. FVL heterozygous effects 2-5% of the western populous making it the most common cause for inherited thrombophilia.[2] It commonly presents as multiple miscarriages/stillbirths, or venous thromboembolus in pregnancy. [3] Endothelial dysfunction secondary to this poses increased risks for pre-eclampsia, and low birth weight infants. [3]. Whilst cutaneous ulcers have been described in non-pregnant populations, rarely does it cause bilateral symmetrical erythematous plaques. [2].

CONCLUSION:

FVL, whilst common in the caucasian population is not the first diagnosis that comes to mind for bilateral symmetrical plaques. Given the risks of stillbirths, embolus, pre-eclampsia, and low birth weight, it is a diagnosis that should be excluded if such a clinical situation arises.

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