Pregnancy with Medical Disorders: the Challenge to Meet

Pregnancy with an underlying medical disorder has a large impact on the wellbeing of a mother. The fetus is also vulnerable to the changes in the mother's internal and external milieu.

The welfare of both the mother and the fetus is a major concern in the management of pregnancy with a medical problem. It is evident that pregnancy in women with underlying medical disorders has increased in recent days in the developed world. Similar changes in maternity have been occurring in our country as in the developed world. The reasons for such changes have several explanations.

Firstly, women today are delaying childbearing as a consequence of marriage at a later age and pursuit of professional goals, and success of assisted reproduction treatment in elderly women. Pregnancy after the age of 35 is becoming more common now-a-days.[1] Age-associated medical disorders, such as diabetes mellitus and hypertension are expected to be encountered more frequently in these pregnancies.[2]

Secondly, advances in medicine have enabled some girls who would have died prematurely from their medical or congenital disorders in the past to survive into reproductive age and bear children. This is particularly true for girls with congenital heart diseases, including those who undergo complex heart repair operations.[3]

Thirdly, infertility and early fetal loss were previously associated with many medical disorders, including thyroid disorders, uncontrolled diabetes mellitus, systemic lupus erythematosus (SLE) and chronic kidney diseases. Successful medical treatments, renal dialysis or transplantation have made childbearing a reality for these women.[4-6] Their pregnancies, however, can sometimes bring on changes beyond the limit of their physiological responses and cause decompensations which lead to severe morbidity or mortality of either the parturient or the fetus or both.

A paradigm shift in the concept and practice of pregnancy care is needed to meet the emergence of this cohort of high-risk obstetric population. Conceptually, one has to concede that the paucity of case load in individual obstetrician's practice, complexity of the basis of the disorders, and the very high expectation of the pregnant women and their families from health care providers mean that few obstetricians can garner sufficient experience and expertise to manage such a wide range of complicated medical disorders during pregnancy. Ideally, dedicated trained physicians in obstetric medicine will play an important role in the management of these women.

In practice, these women should be managed through a multidisciplinary approach involving specialists in the relevant fields – for example, internal medicine specialists, obstetricians, neonatologists and anesthetists. Sometimes, individual patients may have to be referred to other institutions, particularly when one hospital is, or individual obstetrician practices in, a stand-alone maternity hospital. While individual specialists can manage the women's conditions satisfactorily, a concerted effort with one coherent management plan is often missing.

Indeed, breaches in communication among these caregivers have been identified as the main reason for suboptimal care, leading to maternal morbidity and mortality in the United Kingdom.[7] Worldwide, the increasing tendency of moving obstetric units from isolated maternity hospitals to the vicinity of general hospitals in the design of modern health care structures has provided a golden opportunity for amalgamated obstetrician-physician clinics for care of pregnant women with medical disorders in different subspecialties. Simultaneous participation of physicians and obstetricians allows a seamless management plan to be drawn up for the individual woman.

Khadija Nazneen
Professor
Department of Gynaecology & Obstetrics
Enam Medical College, Savar, Dhaka
Email: trustibd@yahoo.com

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