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LETTER TO THE EDITOR

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Key Words: Addison's disease, pregnancy

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To the Editor,

We herein report a 37-year-old woman with Addison's disease (AD) in whom successful maternal and fetal outcome resulted after 5 uncompleted pregnancies.

She had experienced 5 pregnancies and all of them had resulted in stillbirths. AD was diagnosed during her 3rd pregnancy. Before her 5th pregnancy, the patient has taken 10 mg hydrocortisone in the morning and 5 mg in the afternoon. After the diagnosis of the 6th gestation, the morning hydrocortisone dose was increased to 15 mg because of increased nausea, vomiting, and fatigue. The biochemical parameters were normal and she did not have any symptoms during her pregnancy.

Laboratory analysis had shown subclinical hypothyroidism [fT3: 2.4 pg/ml (1.71-3.71), fT4: 1.02 ng/dl (0.7-1.48), TSH: 10.6 uIU/ml (0.35-4.94), antiTPO: 53.3 IU/ml (0-34), antiTg: 32.5 IU/ml (0-115)]. We achieved euthyroidism with 50 µg levothyroxine daily. The first and third trimester ultrasonography examinations did not reveal any fetal or placental abnormalities. The patient was strictly followed up because of the high-risk pregnancy and she had no addisonian crisis attacks during her follow up. She underwent caesarean section and a healthy girl baby weighing 2850 g was delivered at the 38th week of gestation. During the 15-month follow-up period after the delivery baby was healthy and had no problems.

Adrenal insufficiency during pregnancy is associated with a high incidence of serious fetal and maternal complications, such as fetal death in utero and post-partum adrenal crises, if the disorder is not recognized and adequately treated (1). Fertility of women in AD is very difficult. If AD is treated very carefully during pregnancy, patients can complete the pregnancy. Maternal AD poses a high risk of maternal mortality if the disease is not recognized and treated (2).

In the literature, there are few presentations related to AD during pregnancy. Schelling et al. reported a patient with AD who was diagnosed during pregnancy and showed a variety of complications [serum electrolytes (Na, K, Cl, Ca, P), severe hypotension] after caesarean section. After corticosteroid treatment, rapid normalization of the abnormal parameters was achieved (3).

A 29-year-old woman with AD was hospitalized in the 8th week of pregnancy because of an addisonian crisis. The crisis was successfully treated with

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physiological saline infusions, as well as hydrocortisone (25 mg/day) and fludrocortisone (0.05 mg/day). A mature infant was delivered spontaneously on the 282nd day of pregnancy (4).

Xia et al. reviewed 6 cases of pregnancy with AD. Five of them were treated with hormone replacement therapy and the remaining one received no hormone treatment due to lack of symptoms during pregnancy. However, she had an addisonian crisis and died soon after delivery. The other 5 patients had smooth course delivery during the postpartum period (5).

Ozdemir et al. reported a pregnant woman with AD diagnosed before conception. Throughout her pregnancy, she received prednisone and the disease did not worsen during pregnancy. She gave birth by caesarean section due to breech presentation (6).

We can briefly conclude that pregnancy is a very rare condition in AD and even if conception takes place the rates of fetal and maternal complications, fetal growth retardation, adrenal crisis during pregnancy, and in the postpartum period fetal and maternal mortality are high. Adequate steroid treatment together with regular follow up during and before pregnancy allows normal fetal growth and uncomplicated pregnancy.

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