Burn And Full Term Pregnancy: A Case Report

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ABSTRACT

Thermal burns during pregnancy are rare, however they require special attention as they affect maternal and fetal prognosis. The Authors report an observation that illustrates the seriousness of this association. The treatment of burns during pregnancy has particularities related to the anatomical and physiological changes of gestation. Maternal and perinatal mortality increases significantly from 50% of the burned body surface area. Multidisciplinary care is therefore essential. The prognosis of burns in pregnant women remains very cautious, hence the interest in multidisciplinary management involving an obstetrician, resuscitator and plastic surgeon.

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INTRODUCTION:
Burns during pregnancy are relatively rare accidents. Fetal and maternal prognosis is at stake, hence the interest of multidisciplinary management.

CASE REPORT:
We report the case of a 32 year old patient, G2P2, with an estimated 39 weeks of pregnancy, victim of a thermal scald burn on an estimated 40% burned body surface with lesions between superficial and intermediate 2nd degree, following a domestic accident in a Moorish bath (Figure 1). The patient was admitted to intensive care at H10 post-burn where she was monitored for maternal-fetal distress. After an 8-hour labour, the patient delivered a 3kg300 newborn baby, APGAR 10/10, by the vaginal route without complications. The patient subsequently presented with acute respiratory distress syndrome, for which the patient was intubated and put on norepinephrine and broad-spectrum antibiotics with good general and local clinical course. The patient was declared discharged at d20 post burn, then followed on an outpatient basis until complete healing (Figure 2).

DISCUSSION:
Although burns during pregnancy are relatively rare, the exact incidence is not known [1]. There is no literature in obstetrics on burns in pregnancy, and the subject is not discussed in the literature on burn treatment [2]. There is no written protocol on how to manage burns during pregnancy, but the most important decision to be made is whether or not to terminate the pregnancy [3]. Data in the literature on the pathophysiology of burn in pregnant women explain the poor prognosis in both mother and fetus. Large amounts of prostaglandin are secreted into the mother's bloodstream. This prostaglandin comes from the thermal effect of the burn on the tissue and from the infection that occurs in severe burns on or after the third day of the burn [4]. The prostaglandin stimulates the parturient's myometrium, which explains why our patient went into labour. Vaginal delivery has always been proven as in our case, even in the presence of perineal burns, but Caesarean section should be considered and may be preferred [5]. Maternal and fetal mortality is directly proportional to the extent of the burned skin surface, with 95% mortality when the burned skin surface is greater than 50% [6]. After 32 weeks of gestational age, the fetal prognosis becomes independent of the maternal prognosis, as the fetus acquires pulmonary maturity favoured by the stress caused by the burn [7]. However, pregnancy does not
appear to affect the mother's prognosis, and maternal survival is often accompanied by fetal survival [8].

CONCLUSION:
The management of burns during pregnancy requires the establishment of a multidisciplinary team involving plastic surgeons and obstetricians. Initial care is almost always provided by a medical team particularly qualified to receive this particular burn case.

REFERENCES: