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Guest Editorial

TAKING CARE OF MOTHER'S KIDNEY

Rajendra Pandey
Hon'ble Vice-Chancellor, The West Bengal University of Health Sciences
DD-36, Sector 1, Salt Lake City, Kolkata -700064

There can be no denial of the fact that despite of much improvement of Antenatal care and extend of institutional deliveries much still remains to be done to acclaim Sustainable Developmental Goals in term of Maternal Mortality Ratio (MMR). One of the major reasons of mortality in perinatal period is Acute Kidney Injury (AKI) due to various reasons. A pregnant mother's kidney is more vulnerable to ischemic insult and insult to different exotoxins and endotoxins, which may result into different types of cortical necrosis from where renal recovery may not be possible. It has been lately observed that spinal anaesthesia is becoming a popular mode of regional anaesthesia for caesarean section where inability to avoid hypotension and proper fluid management may result in patchy or diffuse cortical necrosis leading to AKI.

Post-partum haemorrhage (PPH) giving rise to prolonged hypotension and ischemic injuries leading to AKI and subsequent correction and blood transfusion at times also causes intravenous haemolysis and renal failure. Puerperal sepsis along with septicaemia and disseminated intravascular coagulation is another cause of AKI. Here it should be pertinent to mention that at a critical care set up in present of ARF adversely affect the mortality rate. Most of the complications are avoidable if timely intervention can be done. We will suggest that NSAIDs should be avoided for purpose of post-operative analgesia which greatly increases the chance of AKI. It is also advisable that fluid administration should be judicial due to massive perfusion of all organs including kidney.

Another important area, to which our obstetrician friends may not sensitive, is an appreciable incidence of thrombotic micro-angiopathic hemolysis, which may range from HELLP (Hemolysis Elevated Liver Enzymes Low Platelet Count) to HUS (Hemolytic-uremic syndrome). To remind that not only the target kidney but also coronary artery involvement may occur which may lead to development of fatal post-partum cardiomyopathy leading to severe disability. So, a general sense of awareness amongst the obstetricians is needed to generate to keep this entity in mind when post-partum recovery is not as expected.

The other important aspect which can never be ignored, taking care of pregnant mothers with lupus. In our socio-economic status many of the patients who premaritally diagnosed of SLE and taking teratogenic medications may conceive after marriage. They are unaware of the fact that the pregnancy may cause a flare of lupus and deterioration of renal functions. I shall ponder whether or not inclusion of questioning for disease and drugs intake should be made at primary interview by the medical and paramedical professionals while they are evaluating and assessing a pregnant mother. Family consensus should be included all patient of lupus is to have normal serum creatinine level prior becoming pregnant.

Our centre having a large population base is not immune to have infection related to glomerulonephritis. While such suspected patient is pregnant, they would require a multidisciplinary approach for safe continuation of pregnancy and

labour. With the incrementing increase DM, HTN in the society and growing number of late marriages, women are becoming pregnant in advanced ages. It is becoming a cause of disease related organ dysfunction and associated with co-morbidities in pregnancy which requires more cautious approach for healthy outcomes of pregnancy.

We would expect obstetricians should take instant measure with people of other disciplines in order to make pregnancy safe and manageable for both the mother and the child.

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