INTERNATIONAL SEVEN JOURNAL
OF MULTIDISCIPLINARY
ISSN: 2764-9547

ANALYSIS OF DERMATOSES IN PREGNANCY: A NARRATIVE REVIEW OF THE LITERATURE

https://doi.org/ 10.56238/isevmjv3n5-017

Receipt of originals: 09/28/2024 **Acceptance for publication:** 10/28/2024

Maria Rita Barcelos Corrêa do Nascimento[1], Catharina Vilalba Lima[2], Gabryella Silva Batista[3], Elder Francisco Latorraca[4], Nadia Aissami[5] , Samuel Sousa Lopes[6], Carolina Chaves Nogueira[7], Lúcio Lima Sanches[8], Mariane Aires Mendes Costa[9] and Ingrid Milena Marques de Andrade[10]

ABSTRACT

Objective: To analyze dermatoses during pregnancy. Bibliographic Review: Pregnancy is a complex physiological state that promotes several changes in the woman's body, such as immunological, metabolic, hormonal and vascular changes. It is possible to observe, during the gestational period, dermatoses that may appear or worsen due to the various transformations resulting from this period. Dermatoses essentially associated with pregnancy (DEG) encompass a group of diseases that appear in the pregnancy or postpartum period. Other dermatoses, on the other hand, can be directly affected by pregnancy, improving, having an unpredictable behavior, but usually end up exacerbating this pre-existing pathology. Final considerations: It should be noted that dermatological diseases typical of pregnancy may be restricted to the skin and mucous membranes, or express a systemic impairment, such as pruritus gravidarum, as a result of cholestasis. Immunological diseases represent a problem during pregnancy, due to the possibility of their worsening or the need for an appropriate choice of drugs used.

Keywords: Dermatoses. Gestation. Cutaneous involvement.

[1]Graduated in Medicine
Universidade Cidade de São Paulo - Unicid
[2]Doctor
Universidad Privada del Este
[3]Medical Student
FAMP
[4]Graduated in Biomedicine
Institution Atenas College Campus Passos
[5]Medical Student
EURO- Unieuro University Centre
[6]Medical Student
EURO- Unieuro University Centre
[7]Medical Student
CESUPA
[8]Medical Student
Catholic University of Pelotas
[9]Medical Student
Atenas College Campus Passos
[10]Physical therapist
Federal University of Pará (UFPA)

INTRODUCTION

Pregnancy is a complex physiological state that promotes several changes in a woman's body, such as immune, metabolic, hormonal and vascular changes. These changes occur mainly due to the appearance of a new endocrine organ, the placenta, in addition to the greater activity of the pituitary, thyroid and adrenal glands that may be responsible for both physiological and pathological skin changes in pregnant women (REZENDE FILHO and MONTENEGRO, 2017).

It is possible to observe, during the gestational period, dermatoses that may appear or worsen due to the various transformations resulting from this period. Dermatoses essentially associated with pregnancy (DEG) encompass a group of diseases that appear in the pregnancy or postpartum period. Other dermatoses, on the other hand, can be directly affected by pregnancy, improving, having an unpredictable behavior, but generally end up exacerbating this pre-existing pathology (TEIXEIRA et al, 2013; BEARD and MILLINGTON, 2012; AMBROSRUDOLPH et al, 2006; REZENDE FILHO and MONTENEGRO, 2017).

Regarding the treatment of these diseases, this should be carried out with caution, since the vast majority of drugs are not indicated for administration during pregnancy. (COUTINHO et al, 2012)

LITERATURE REVIEW

Pregnancy represents a period of intense changes for the woman. Practically all systems of the body are affected, including the skin. Most changes in the female body are due to hormonal and/or mechanical changes. The former are characterized by large elevations of estrogen, progesterone, beta HCG, prolactin, and a variety of hormones and mediators that completely alter the body's functions.

During pregnancy, changes in protein, lipid and glucose metabolism occur; increased cardiac output, blood volume, hemodilution and changes in blood pressure; increased glomerular flow; changes in respiratory dynamics; appetite changes, nausea and vomiting, gastroesophageal reflux, constipation; and various immunological alterations, which allow the woman to withstand the overload of generating a new organism. The intense immunological, endocrine, metabolic and vascular changes make the pregnant woman susceptible to skin changes, both physiological and pathological.

In relation to the skin, gestational changes are divided into: physiological changes of pregnancy, specific dermatoses of pregnancy and altered dermatoses in pregnancy. Each of them will be discussed in detail, in addition to trying to address new realities in relation to the use of specific drugs during pregnancy.

Due to the extent of skin involvement in pregnant women and the stigmas generated for patients, there is no doubt that there is an undervaluation of the skin changes faced by pregnant women. The fact that many of these alterations are described as physiological does not minimize their discomfort for patients.

Pigmentary changes are extremely common, affecting up to 90% of pregnant women. They begin early in pregnancy and are more prominent in black women. Hyperpigmentation is usually generalized, with accentuation of the usually more pigmented regions, such as the mammary areolas, genitalia, perineum, armpits, and inner thighs. The condition tends to regress in the postpartum period, but the skin usually does not return to its initial color.

There is disagreement regarding the number and nomenclature. The most characteristic are: pemphigoid gestationis, polymorphic eruption of pregnancy, pruritic folliculitis and pruritus of pregnancy. Impetigo herpetiformis is considered by some authors to be a form of pustular psoriasis typical of pregnancy. Pruritus gravidarum, due to intrahepatic cholestasis, will also be considered in this group of dermatoses.

Undoubtedly, atopic dermatitis is one of the most frequent dermatoses in dermatological practice. Its symptoms, according to findings in the literature, may vary during pregnancy between improvement and worsening of the condition.

Many dermatoses have pruritus as a clinical manifestation, but it is in atopic dermatitis that it presents as a cardinal manifestation. Its differentiation from diseases such as polymorphic erythema of pregnancy is important, as it allows for more appropriate guidance as well as proper treatment. Indirectly, atopic dermatitis causes harm to pregnant women, since it alters their diet, sleep and emotional well-being. In the treatment, the use of more potent topical corticosteroids should be safeguarded to avoid stretch marks. Other allergic manifestations that are exacerbated in pregnant women are those of the urticaria/angioedema complex, and should be observed.

Systemic lupus erythematosus still has its behavior debated in pregnancy. For some authors, its recrudescence is more severe in pregnant women, with greater

cutaneous (vasculitis) and joint involvement. Systemic treatment with corticosteroids and antimalarials should not be interrupted.8,11

Antiphospholipid antibody syndrome is a severe manifestation linked to lupus erythematosus, and lupus anticoagulant and anticardiolipin antibodies should be evaluated in these patients. It is clinically manifested by thrombosis, fetal losses, and thrombocytopenia.

Pemphigus can manifest or worsen during pregnancy. Exacerbations occur in the first or second trimesters, with an increase in fetal morbidity and mortality. Clinically, the disease does not differ from its usual presentation. The differential diagnosis with pemphigoid gestationis is important and can be made by clinical particularities and direct immunofluorescence. Therapy with corticosteroids is effective during pregnancy, and cytotoxic drugs should be avoided.8

FINAL CONSIDERATIONS

It is noteworthy that dermatological diseases typical of pregnancy may be restricted to the skin and mucous membranes, or express a systemic involvement, such as pruritus gravidarum, as a result of cholestasis. Immunological diseases represent a problem during pregnancy, due to the possibility of their worsening or the need for an appropriate choice of drugs used. The joint and systemic manifestations of these conditions require integrated care between obstetricians, rheumatologists, and dermatologists. Detailed history and physical examination are important for the diagnosis and treatment of pregnancy dermatoses. The doctor must know the gestational age, parity, possibility of twin pregnancy, history of gestational dermatoses, history of diseases prior to pregnancy and use of medications.

REFERENCES

1. Botelho, K. P., & outros. (2017). Penfigoide gestacional: Relato de caso e a importância do diagnóstico precoce (Unpublished manuscript). [Institution not identified].

2. da Rocha Pinto, A. C. C., & outros. (2021). Revisão bibliográfica sobre dermatoses específicas da gravidez. ACTA MSM-Periódico da EMSM, 8(4), 182.

3. de Oliveira, W., & outros. (2024). Gestação e estética: O autocuidado nem sempre disponível a gestantes (biomedicina). Repositório Institucional, 2(2), 45–60.

4. de Souza, A. R., de Paula, M. A., & Sobrinho, H. M. R. (2016). Gestação e predisposição ao aparecimento de estrias cutâneas. Universitas: Ciências da Saúde, 14(1), 41–52.

5. Fagundes, P. P. S. (2023). Caracterização da resposta autoimune humoral e do perfil imunopatológico de pacientes com dermatoses bolhosas autoimunes no período gestacional e extragestacional (Doctoral dissertation). Universidade de São Paulo, São Paulo, Brazil.

6. Fagundes, P. P. S., & outros. (2021). Doenças bolhosas autoimunes na gestação: Características clínicas, epidemiológicas e abordagem terapêutica. Anais Brasileiros de Dermat OOPology, 96(5), 581–590.

7. Marques, A. R., Monteiro, L., & Meneses, M. (2016). Um caso de penfigóide gestacional. Revista Portuguesa de Medicina Geral e Familiar, 32(3), 217–221.

8. Pancote, C. G., & outros. (2017). Fotoproteção na gestação: Um cuidado muitas vezes negligenciado. Enfermagem Brasil, 16(3), 129–130.

9. Pereira, C. M. M. (2019). Eritema nodoso: Um relato de caso. Revista Portuguesa de Medicina Geral e Familiar, 35(5), 417–423.