Post-partum hemolytic-uremic syndrome
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Objective
To describe a case of atypical post-partum hemolytic-uremic syndrome (HUS) which presented 6 months post-partum: Presentation, diagnosis, management and therapy.

Methods
Case study of a case of atypical HUS.

Results
36 years-old healthy female (G2P2) who had an uneventful first pregnancy in 2007 and delivered a healthy full-term child. Her current second pregnancy has been complicated by arterial hypertension since early second trimester, medicated with alpha methyl dopa. At 22 weeks, her 24-hour proteinuria was 1866mg/dl. Weekly analysis and fetal surveillance were performed. In June 2010, at 29 weeks, she underwent a caesarean section due to uncontrolled severe hypertension, increased proteinuria and severe thrombocytopenia. During the puerperium, her blood pressure and proteinuria remained elevated and she was medicated with irbesartan. Her blood tests were normal and she was discharged 8 days after delivery. 6 months later, in December 2010, she had flu-like symptoms. 2 weeks later, she was admitted in the hospital with asthenia, polyarthralgias and facial edema. She had no other symptoms. Her blood tests revealed haemolytic anemia, thrombocytopenia and acute renal failure. She was transferred to the nephrology care and had daily plasmapheresis for 6 months, corticosteroids and 4 administrations of rituximab, with no improvement of the renal function. Thus, she started continuous ambulatory peritoneal dialysis (CAPD) with the diagnosis of atypical HUS in July 2011. In January, 2012, she had a relapse after a respiratory infection and had again plasmapheresis for 5 months. In October, 2012, she was readmitted due to a relapse of HUS with cutaneous necrosis in her legs and restarted plasmapheresis for 5 months and CAPD after, which she is undergoing presently.

Conclusion
We describe a case of atypical HUS presented as acute renal failure, associated with anemia and thrombocytopenia 6 months post-partum. Pre-eclampsia is historically associated in 15% of patients. The apparent improvement of patients’ survival in recent years is due to earlier diagnosis, better management of hypertension and early institution of therapy. The gold standard treatment for most patients is plasma exchange, which reverses the microvascular thrombus formation and the resulting symptoms.