



## Perspective

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## Sjögren's syndrome and reproductive outcomes

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Autoimmune disease is a condition that occurs due to the loss of immunological tolerance to the self-antigens and results in the production of antibodies. The excess production of these antibodies causes specific organ damage and systemic compromise[1]. Sjögren's syndrome is a chronic auto-immune disease characterized by the lymphocytic infiltrations of the exocrine gland and the production of antibodies. It is categorized into primary Sjögren's syndrome and secondary Sjögren's syndrome. The primary Sjögren's syndrome is outlined by xerophthalmia (dry eyes) and xerostomia (dry mouth) without any connective tissue damage, and secondary Sjögren's syndrome is associated with connective tissue disease and other auto-immune diseases like systemic lupus erythematosus, rheumatoid arthritis, systemic sclerosis and less frequently multiple sclerosis.

Primary Sjögren's syndrome is observed to be prevalent in females. It may occur in any age group but it mainly affects the age group of 40 years and above[2]. Currently, the increased risk of Sjögren's syndrome in pregnant women is due to the delay in the first pregnancy, increased disease activity, and antibody-mediated damage. The prominent complication of pregnancy in Sjögren's syndrome is a decrease in the gestation period. A systemic review has reported spontaneous abortions in pregnant women and there was no stillbirth[3]. The fatal outcomes include congenital heart block due to the damage of the atrioventricular node by the antibodies and neonatal lupus[4].

Pregnant women diagnosed with Sjögren's syndrome experience many more complications during the gestation periods than those without Sjögren's syndrome. Studies have reported an increase in the spontaneous abortion rate and premature deliveries. The reason for the increase in the risk can be due to the older age of the patient at the time of conception and immunological factors that are responsible for the miscarriage. The foetal and maternal risk can be decreased by proper counselling[5]. The socioeconomic status of the patients has a key role in the complication to occur in

patients. The spontaneous abortion or preterm deliveries occurrence rate has increased because of the lifestyle changes. The low mean neonatal birth rate is because of the pathological intrauterine growth restrictions. An increase in caesarean deliveries was due to severe foetal complications.

The two important and prominent complications in the foetus of mothers with Sjögren's syndrome are neonatal lupus and congenital heart block. The congenital heart block occurs due to the damage of the atrioventricular node. The general approach for the management of Sjögren's syndrome is only symptomatic care, and there is no complete curative treatment for this disease. Symptomatic therapy and replacement therapy are an available option for the treatment of Sjögren's syndrome to improve the quality of life and prevent the progression of the disease[6]. Patient education plays a key role in compliance and in avoiding the triggering factors for the progress in symptoms. Multiple drug treatments are available for treating Sjögren's syndrome patients.

Sjögren's syndrome is more prevalent among the female population and pregnant women with Sjögren syndrome are more likely to experience a complication during the gestation period. The risk of complication during pregnancy can be decreased by counselling the patients (physicians) about the underlined complications, the risk involved with the medications, and the

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need to properly manage the disease before conception. A high-risk pregnancy is well managed with safer drugs during pregnancy. Medication compliance is very important and the treatment is only symptomatic therapy and replacement therapy.

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The authors declare there is no conflict of interest.

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### Authors' contributions

All authors contributed equally.

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