

CORRESPONDENCE

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Exercise-induced anaphylaxis and pregnancy

A 20-year-old primigravida presented at 37 weeks' gestation for a routine antenatal appointment giving a history of exercise-induced anaphylaxis (EIA). She described the development of a widespread urticarial rash and weals, followed by "chest tightness" and oedema of the tongue and face on exertion (e.g. walking fast, aerobics, cold weather) and during periods of stress. She had had six hospital admissions since the age of 18 for these episodes, but had never been ventilated or required admission to the intensive therapy unit. She had been seen in the accident and emergency unit with facial swelling and urticaria on these occasions, and was treated with i.v. hydrocortisone and chlorpheniramine. She had not been able to identify any ingestible triggers for these symptoms. She had previously failed to attend a specialist appointment for further investigation and was awaiting another appointment. She had modified her life-style to avoid the precipitating factors. She had no other past medical history and had no known allergies, nor did she suffer with asthma. Chlorpheniramine was taken as required, when she felt any of the above symptoms. This pregnancy had been unremarkable.

The patient requested a normal vaginal delivery, if possible. A delivery plan was therefore agreed with the obstetricians in which hydrocortisone was to be started at the onset of labour, initially 100 mg i.v., followed by 50 mg four times daily i.v. She was encouraged to have an early epidural with the aim of reducing the chance of EIA symptoms triggered by the stress of labour.

She presented to the delivery suite in early labour the next day and, at 4 cm cervical dilatation, an epidural catheter was inserted; this provided good analgesia throughout her labour. Intravenous hydrocortisone 100 mg was given as planned, followed by a single 50-mg dose 6 h later. She had an uneventful normal vaginal delivery 12.5 h after admission and was discharged home 48 h later.

EIA is an uncommon condition. In 1980 Sheffer and Austen¹ provided the first report of patients with EIA. In

EIA exercise lowers the mast cell degranulation threshold, causing release of histamine and other mediators, which leads to progression from pruritus and urticaria to the symptoms of anaphylaxis.² It is an episodic condition in which the frequency of attacks tends to stabilise or decrease over time. A review of the available literature revealed a single case report of EIA in pregnancy.³ In this case a woman developed swelling, urticaria and bronchospasm after her first delivery, which was presumed to be caused by ergometrine administration. However, a similar episode in her second delivery without any oxytocic led to a diagnosis of EIA. In both episodes the symptoms were successfully treated with oxygen, steroids and chlorpheniramine.

An important question in the peripartum management of EIA is whether the stress of labour will induce symptoms, and whether the patient should therefore be advised to have an elective caesarean section. We believed that the single case report of a positive outcome after normal vaginal delivery justified our management plan, as the stresses associated with caesarean section might trigger symptoms in any case. The patient was referred for formal investigation in the postpartum period, and was advised that similar precautions might be required in future pregnancies.

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