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LETTER TO THE EDITOR—BRIEF COMMUNICATION

Managing labour with a history of Exercise Induced Anaphylaxis

Dear Editors,

We describe a case of a 23-year old female with known Exercise Induced Anaphylaxis (EIA) and management of her labour. EIA is a rare condition characterised by an allergy triggered by exertion [1]. Little is known about the condition but symptoms tend to stabilise throughout life and symptoms are controlled by modification of exercise and avoidance of precipitants.

To date there are three [2–4] detailed reported cases of EIA. There was one case-series that briefly mentions seven pregnancies [1]. From this series one lady had mild symptoms during labour (pruritis and urticaria) [1]. No-one had any anaphylactoid type reactions. Unfortunately the information is brief and there was no documentation of mode of delivery or prophylactic treatment.

The most recent cases both took a similar approach to managing the patient [3,4]. From the onset of labour a high dose of hydrocortisone was administered intravenously and repeated at 6-hourly intervals. Both patients were given background IV chlorphenamine and early analgesia via epidural. Both ladies had no exacerbation of symptoms during delivery. One had a VBAC forceps delivery and the other a vaginal delivery.

In this case, EIA was diagnosed at 16 years old. At 10 years of age she experienced throat swelling after 10–15 min of exercise with difficulty in breathing, swelling around her eyes and global urticaria. She previously had asthma and eczema as a child and has hayfever. She experienced some eye watering around cats but no other furry animals. She has no food or drug allergies and no issue with latex. She had never been hospitalized for her symptoms and was initially given daily fexofenadine and chlorphenamine as required.

She was booked at 12 weeks for High Dependency Consultant led care and was referred to Anaesthetics. Her previous immunology team was contacted. At time of booking she was asymptomatic and had no exacerbation of her symptoms for over 3 years. She took no regular medications and carried an Epipen. The pregnancy was otherwise unremarkable.

It was agreed to induce labour at 38 + 5 weeks and an epidural placed prior to commencing oxytocin. 100 mg hydrocortisone intravenously was given initially and then 50 mg 6 hourly. Chlorphenamine 4 mg was prescribed as required. An anaphylaxis kit was available at all times including adrenaline and extra hydrocortisone. During labour she had no evidence of anaphylaxis. Her labour progressed uneventfully and she was delivered by Neville Barnes forceps due to lack of progress and pathological CTG. She suffered an estimated blood loss of 800 ml and was transfused two units of red cells and discharged home.

We have shown that with careful management there is no reason not to have a vaginal delivery. The stress from labour in this case was not enough to trigger anaphylaxis and does not support an elective caesarean section.

This case highlights the importance of a multi-disciplinary approach from the earliest opportunity to ensure effective communication.

This is the third detailed case report of EIA in pregnancy. No guidelines exist for EIA management during labour but this case supports the use of multiple doses of hydrocortisone and chlorphenamine as required.

Contribution to authorship

Dr Hindmarsh – Junior doctor who reviewed the case and drafted the initial report. At the time of labour performed the literature review and acquired full articles.

Dr Mahadasu – Named consultant in the Ante-natal care of this lady. Involved in liaison with other specialties as detailed in the case report. Involved in drafting the final case report.

Dr Meneni – Involved in the management of this lady as was in shared consultant care with Dr Mahadasu. Has seen the lady in follow up Ante-natal clinic appointments. Involved in re-drafting the final case report.

Dr Rao – Consultant on call when the lady in question delivered and was involved in deciding the final management plan based on the evidence presented. Involved in re-drafting the final paper.

Dr Tennant – Consultant anaesthetist on call at the time of delivery. Essential in reviewing the evidence at the time of delivery and providing anaesthetic input, thus ensuring a safe outcome. Involved in the final re-drafting of the paper.

Conflict of interests

None declared.

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Ethical approval

Nil required. Verbal and written consent obtained from the patient for publication and presentation of her case.

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