

Taking her breath away: Anaphylaxis with breastfeeding

Ali Raza Shaikh MD¹, Jisun Won MD¹, Shruti Rani Kumar MD², Hamza Z. Muhammadzai MD¹, Rahat A. Memon MD¹, Muhammad Shan ul Abedin MD¹, William T. Ford MD¹

1. Department of Internal Medicine, Jefferson Abington Health
2. Department of Ob/Gyn, Jefferson Abington Health

INTRODUCTION

Lactation anaphylaxis, a reaction reported in the mother to her own breast feeding has been reported seldom in literature. Here we discuss a case of this presentation.

CASE PRESENTATION

30-year-old G2P0101 admitted to the hospital in labor on week 38, day 5 of her pregnancy. Past history noted of one preterm birth from a Caesarean section. She had an uncomplicated delivery through low transverse C-section. Post-partum day 3, she started developing diffuse erythematous red pruritic rash starting on her back that eventually spread to her abdomen and chest. She was initially given a dose of diphenhydramine 25 mg intravenous (IV) followed 4 hours later by epinephrine to which she did not respond. Her symptoms progressed to cause tongue swelling and a sensation of throat constriction and dyspnea. She also complained of stabbing abdominal pain that was 10/10 in intensity. Of note, patient reported that she had similar symptoms in her first post-partum period when her breast milk production started requiring her to go to ED several times. She reported improvement in the past with cabergoline and as needed EpiPens. Rapid response was called for concerns of airway compromise and progressing anaphylaxis. Vitals reviewed were BP: 115/81, HR-98, RR-16, 99% SpO2 on room air. She was administered solumedrol 125 mg IV, famotidine 20 mg IV and diphenhydramine 25 mg IV in addition to recently given epinephrine. Her dyspnea and throat constriction improved within a few minutes. She was then moved to intermediate ICU level of care for closer airway monitoring and continued on solumedrol 60 mg q6 hours and as needed epinephrine intramuscular. She started dopamine agonist therapy with bromocriptine 2.5 mg daily to stop milk production and was advised formula feed. She then improved over the next 3 days and was discharged on a steroid taper.

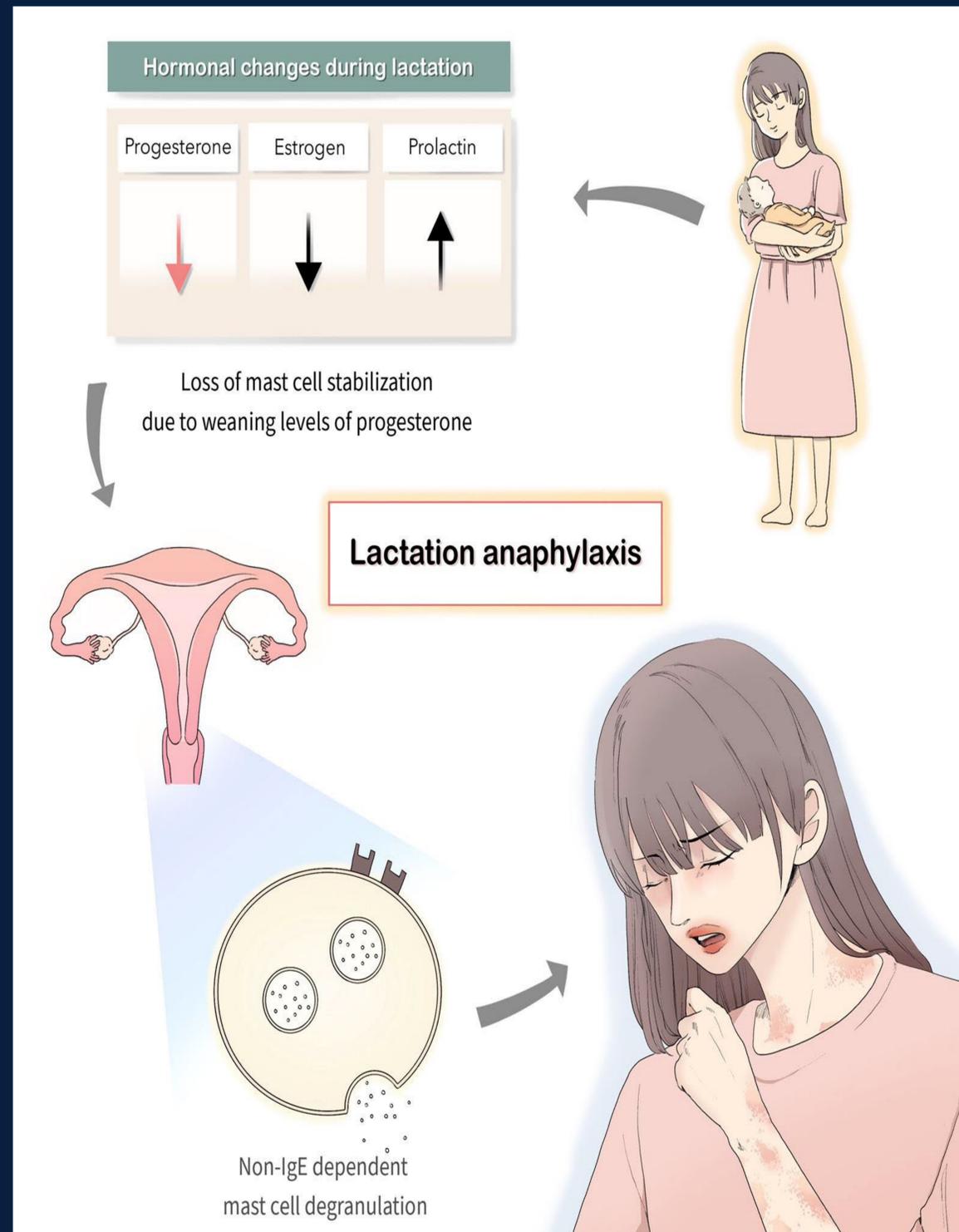


Fig 1: Illustration depicting proposed theory for mechanism of lactational anaphylaxis (by Jisun Won)



DISCUSSION

Very few cases in literature have been reported. This phenomenon has been attributed to destabilization and degranulation of mast cells, notably increased number of mast cells in the uterine walls. Proposed mechanisms include decline in progesterone levels with increase in estrogen along with other necessary hormonal modifications for lactation. Diagnosis remains purely clinical. Serum tryptase levels have been reported to be elevated when measured during the allergic reaction in studies, confirming the reaction mediation by histamine. Treatments in the past have included avoidance of breast feeding and usage of dopaminergic agonism to block prolactin pathway. In cases where mother wished to continue breast feeding, antihistamine therapy was used to control allergic reactions.

CONCLUSION

Lactation anaphylaxis, while rare, is an important trigger to identify in the affected mothers that requires prompt identification and initiation of appropriate measures to prevent life threatening events.

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