Case Report

Obstetric Management of a Patient with Narcolepsy and Cataplexy: A Case Report

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1. Introduction

Narcolepsy is a chronic neurological condition producing disruption to normal sleep pattern resulting into excessive daytime somnolence. Approximately 80% of the patients with narcolepsy suffer from cataplexy (involuntary loss of muscle tone) [1], and cataplexy is pathognomonic for narcolepsy. There is little information on outcome or management of this disorder in pregnancy. We report a case of successful management of pregnancy in a patient with narcolepsy and cataplexy.

2. Case Report

A 44-year-old G3 Para1 (previous normal vaginal delivery at term 24 years ago) with a past history of narcolepsy and cataplexy was referred to the combined medical/obstetrics antenatal clinic at 14 weeks of gestation.

Narcolepsy and cataplexy was diagnosed in January 2005 and since then had been under regular Neurological review. She had developed daytime sleepiness, cataplexy, sleep paralysis, and hallucination on going to sleep. Cataplexy was controlled with clomipramine, and amphetamine (dexamphetamine) was started in November 2010 when her symptoms worsened. Her symptoms were resistant to modafinil.

Antenatally the patient was managed in conjunction with the neurologist, and referral was made to the anaesthetist, and a paediatric alert was made in view of amphetamine use in early pregnancy. The pregnancy proceeded uneventfully, and the dose of dexamphetamine was reduced during the pregnancy and eventually discontinued at 24 weeks of gestation.

She was reviewed by the anaesthetist at 36 weeks of gestation due to concerns regarding option of analgesia and mode of delivery if she presents in labour. She was also reviewed by the consultant obstetrician and after weighing the benefits and risks of elective delivery versus spontaneous labour opted for an elective Caesarean section at nearly 38 weeks of gestation with steroid cover as per unit protocol.

The Caesarean section was performed under spinal analgesia and was uneventful. A female baby weighing 2.84 Kg was delivered with Apgar score 7, 10, and 10 at 1st, 5th, and 10th minutes of life. Cord gases were pH (V) 7.383 BE-2.8, pH (A) 7.361 BE-6.1.

Baby needed only facial oxygen at birth. Neonatal abstinence syndrome (NAS) scoring was not required for baby.

3. Discussion

Narcolepsy is a chronic neurological condition producing disruption to normal sleep pattern, and this causes excessive daytime somnolence. Approximately 80% of patients with narcolepsy suffer from cataplexy (involuntary loss of muscle tone) [1], and cataplexy is pathognomonic for narcolepsy.
The cause of narcolepsy is unknown, but it is thought that both environmental and genetic factors may play apart. It may be caused by the loss of a relatively few neurons that are responsible for producing hypocretin-1 in the CNS. It is also associated with specific HLA allele, DQB1*0602. Possible triggers include head trauma, infection, and change in sleeping habits [2]. Diagnostic criteria including excessive daytime sleepiness, almost daily for greater than 3 months, and cataplexy triggered by emotion, confirmed by diagnosis with nocturnal polysomnography followed by a multiple sleep latency test (MSLT) and alternatively confirmed by CSF hypocretin-1 levels <110 pg/mL or one-third of mean control values [3].

In summary, we have presented a successful management of a patient with narcolepsy and cataplexy in pregnancy. This was achieved with good multidisciplinary care involving the obstetrician, neurologist, anaesthetist, paediatrician, and midwife with each professional contributing to patient’s care.

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References


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