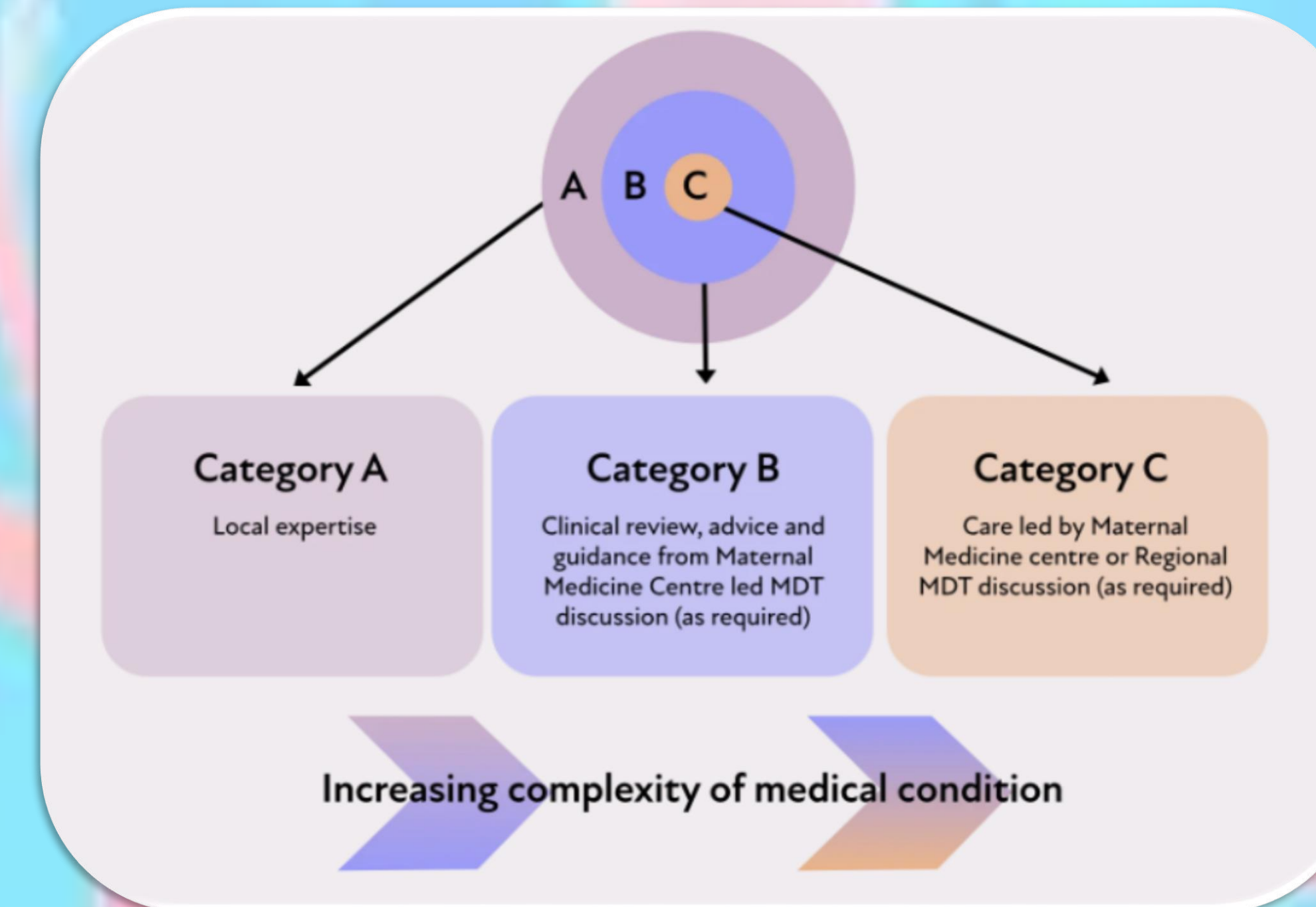


Anaesthetic and Obstetric Multidisciplinary Planning for Preterm Delivery in Severe Interstitial Lung Disease

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Introduction

Pregnancy complicated by significant cardiopulmonary disease poses major challenges for obstetric and anaesthetic management. Pregnancy in Interstitial Lung disease (ILD) is associated with increased risk of adverse events and leads to disease progression in most cases (1). Careful multidisciplinary planning is essential to optimise maternal and fetal outcomes as suggested by NICE guidelines (2). We describe the management of a pregnant woman with worsening ILD requiring preterm elective caesarean delivery.

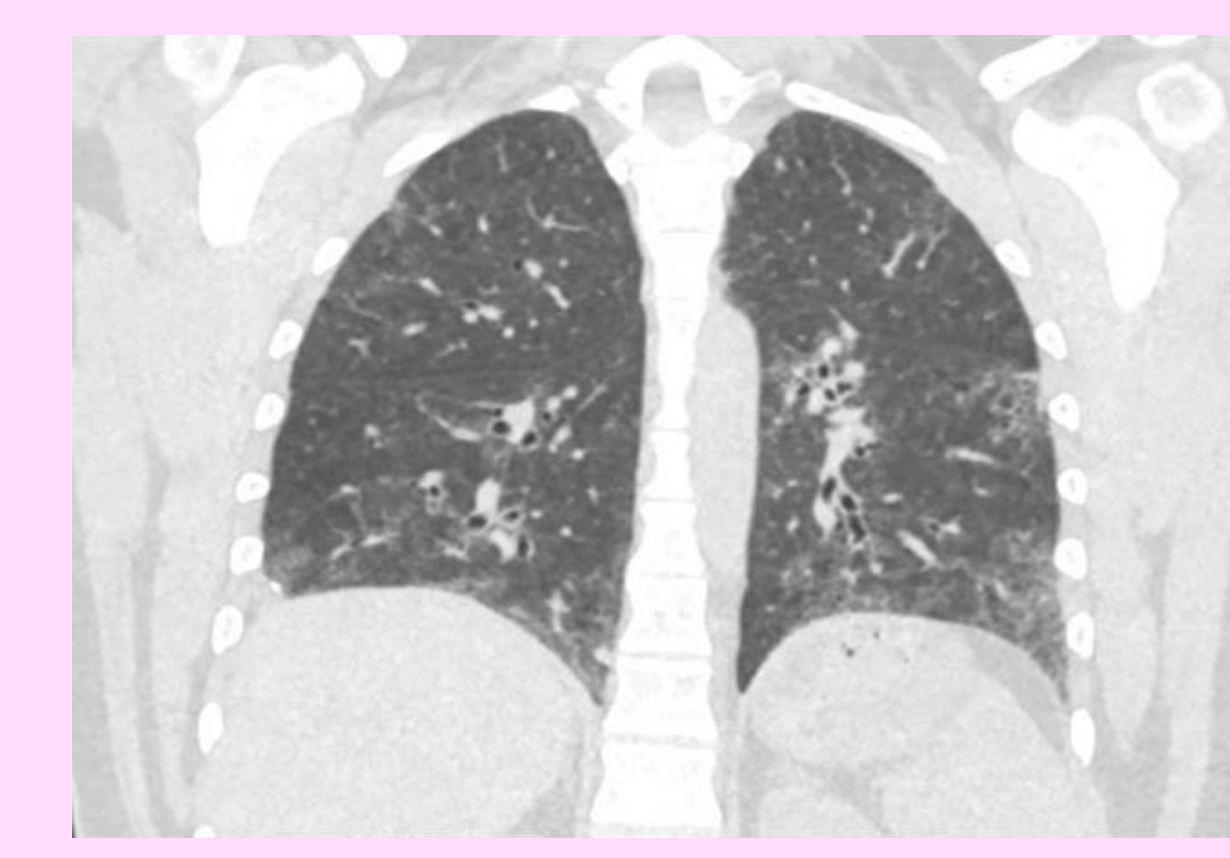
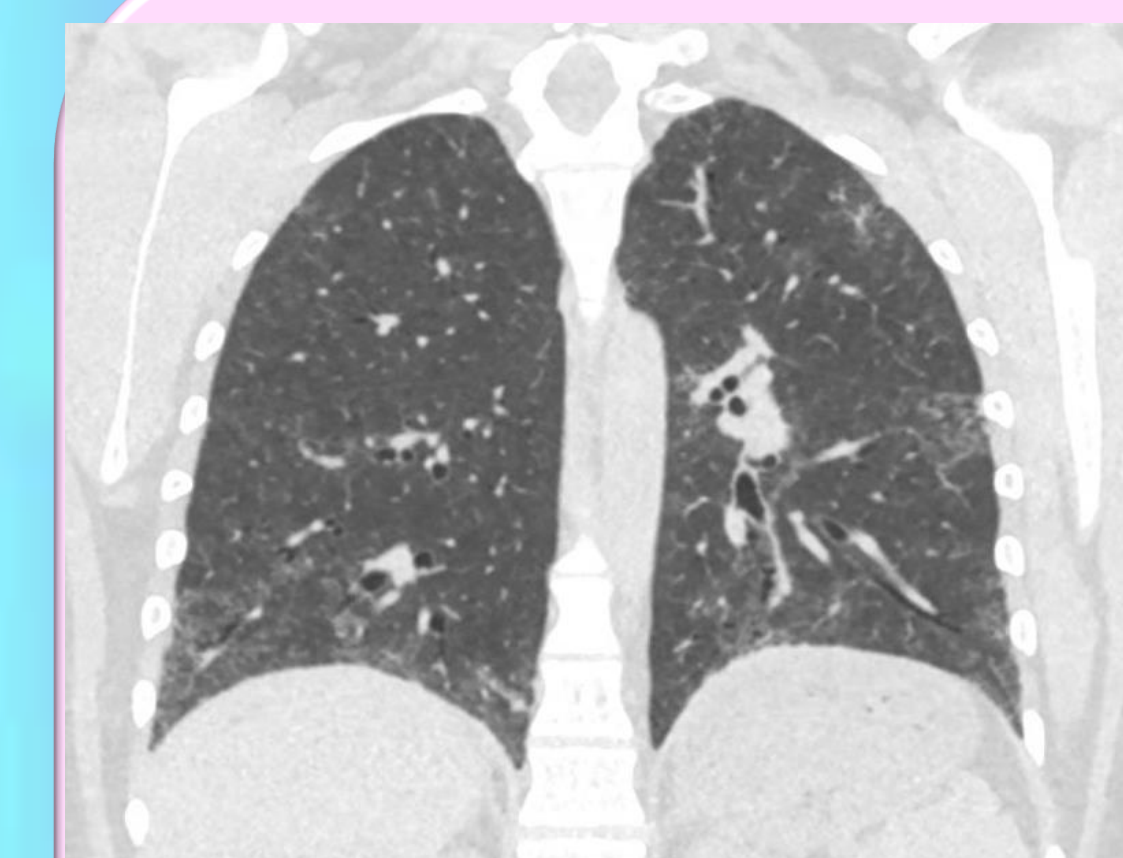


Discussion

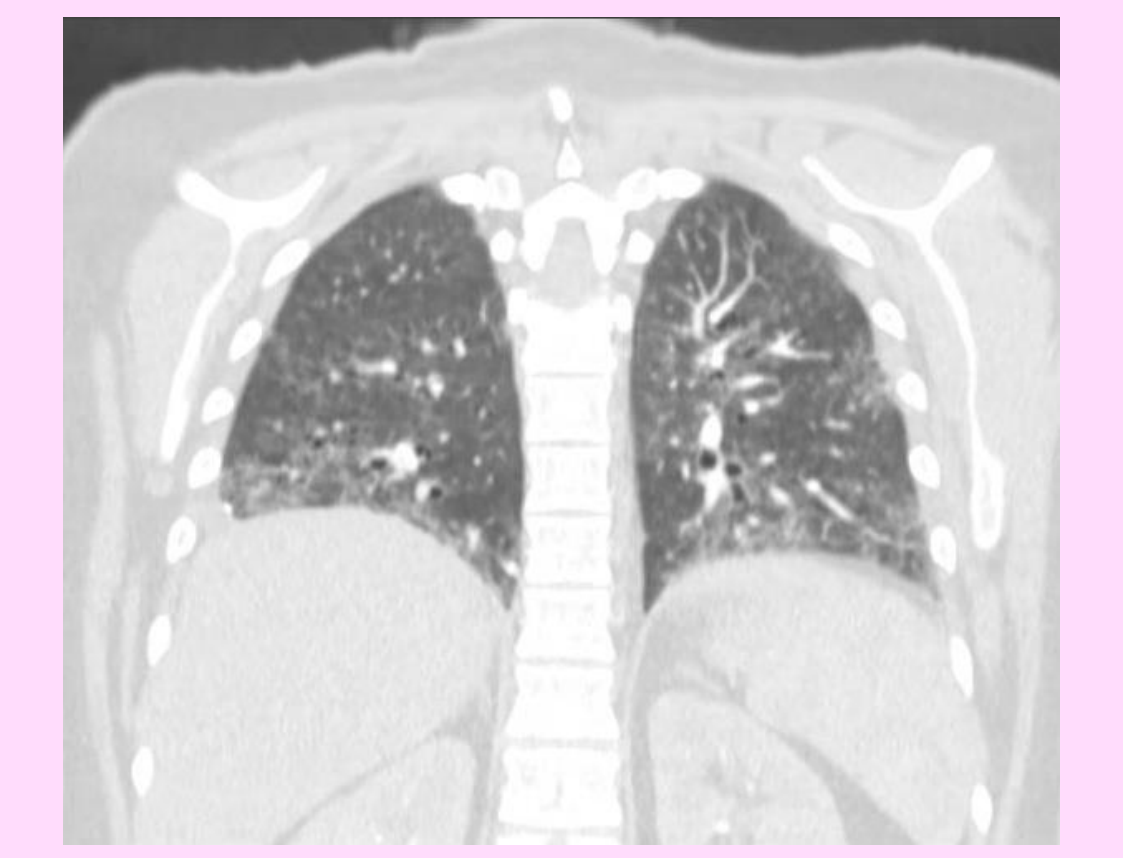
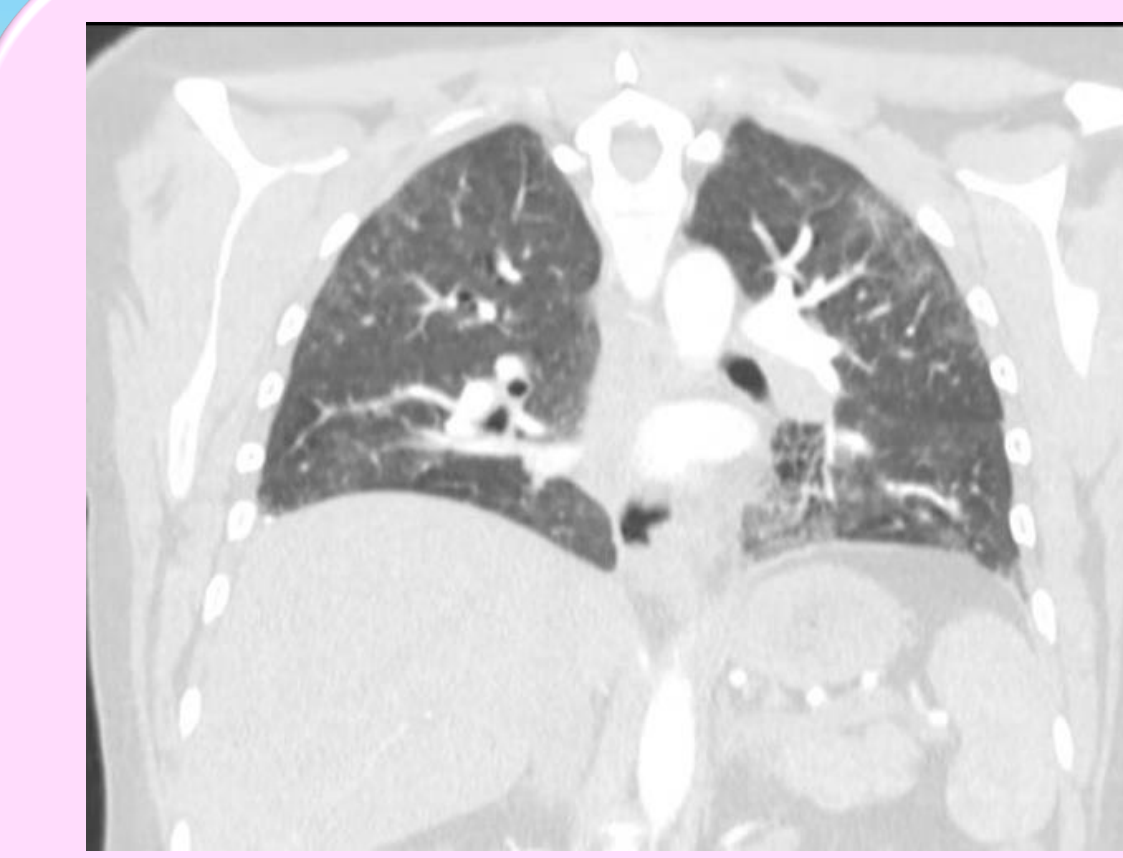
This case highlights the complexity of managing pregnancy in women with advanced respiratory disease. Progressive ILD with hypoxemia and physiological changes of pregnancy, significantly reduced maternal reserve, Early anaesthetic involvement, anticipatory planning and coordinated MDT care allowed timely, controlled delivery and minimised the risk of emergency intervention. Maternal health was appropriately prioritised, demonstrating the importance of individualised, multidisciplinary decision-making in high-risk obstetric care.

Case Report

A 34-year-old gravida 2 para 1 lady with ILD requiring ambulatory oxygen prior to pregnancy presented with worsening dyspnoea. She required admission at 28 weeks for respiratory monitoring following two recent infections. Her dyspnoea escalated to requiring oxygen at rest, and significantly increasing flows during any exertion. Worsening functional capacity and concern regarding her ability to tolerate labour, promoted multidisciplinary (MDT) involvement, including obstetric medicine, anaesthesia, neonatology, respiratory medicine, and critical care. Multiple MDTs were done and delivery options were discussed. Regional anaesthesia for caesarean section with high flow oxygen was recommended to minimise respiratory compromise, with concerns about positioning of patient for neuraxial technique and surgery.. Balancing maternal risk against fetal maturity, the MDT agreed on planned delivery at 32 weeks gestation. A pre-arranged transfer to a tertiary centre with critical care backup linked to our tertiary obstetric centre was undertaken, with admission to critical care prior to delivery, administration of antenatal corticosteroids, and elective caesarean section under regional anaesthesia (combined spinal-epidural) and post-operative ICU care with positive outcome for both mother and baby.



Pre-Pregnancy Scans



Pregnancy Scans

References

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