

LPLD in women

LPLD affects women differently to men because of the differences in a woman's biology. Women with LPLD are usually advised against taking oestrogen products or, if they do, they have to be monitored very closely. This is because oestrogen can cause dramatic increases in plasma triglycerides which might lead to pancreatitis. The pill and hormone replacement therapy (HRT) are therefore not advised.

Pregnancy

Before becoming pregnant a woman with LPLD needs to:

- reduce triglyceride levels to as low as possible, as levels rise naturally during pregnancy by about 1000mg/dl (11.3mmol/l). Levels over 2000mg/dl (22.6mmol/l) can result in pancreatitis, so it is sensible to keep starting levels very low. Developing pancreatitis during pregnancy can put both the mum and baby at considerable risk, so sticking closely to a very low fat diet is a must. A daily fat intake as low as 1-2g may be advised
- discuss the benefits, or otherwise, of continuing any prescribed medication and the possible effects it may have on her unborn child

Early in pregnancy a woman with LPLD needs to:

- ask her consultant for a letter explaining her condition and detailing instructions to medical professionals about what they need to look for, and treatments to consider, if there is an emergency and she cannot speak for herself. In particular, emergency and maternity staff will need to know what to do if she presents with stomach pains.

Breastfeeding

Provided LPLD is well managed, it should not interfere with the process of giving birth. However women with LPLD should be cautioned against exclusive breastfeeding as their breast milk is unlikely to be nutritionally complete. Despite this, it is still important that the new mum breastfeeds for the first three days. This is because early breast milk contains colostrum, a source of valuable antibodies, which can protect against early infections. After this time babies born to mothers with LPLD are usually bottle fed.

Gestational Diabetes

The likelihood of gestational diabetes is raised in LPLD mothers. Diabetes and LPLD exacerbate each other, in that raised sugar levels caused by insulin resistance (from diabetes) will be converted into fat and put into the bloodstream as triglycerides, which the mother with LPLD then cannot metabolise, raising the triglycerides further. It is important that expectant mothers with LPLD are monitored regularly for diabetes. Women who develop gestational diabetes may be treated with insulin in order to keep the triglyceride levels as low as possible. Once the baby is born, gestational diabetes usually disappears after a week or two, but it can be a warning that the mother is at increased risk of developing diabetes as she gets older.

Menopause

Little is known about the effects of LPLD on menopause. However, many of the symptoms of the menopause such as tiredness and changes of mood, may make it harder for a woman to maintain a healthy diet and lifestyle. Fatigue is often dealt with by eating more and for some women food is used to manage emotions, both of which can make it harder to choose the right things to eat. It is essential, therefore, that a woman approaching her menopause, understands her symptoms in order to better manage them.

I have a close blood relative with LPLD. Should I be tested before having a family?

Close blood relatives of people with LPLD can be tested prior to pregnancy to see if they are carriers of the altered gene. This is relatively easy if the altered gene defect has been identified. However, not all health care providers will agree to this test and they may prefer to wait to see if any difficulties arise once the baby is born. You will need to talk to your GP or consultant.

Similarly, if both parents are known to be carriers of the altered gene, it is possible to screen the foetus for LPLD, but again this is at the discretion of your health care provider.