

An unusual presentation of Peri-partum Cardiomyopathy- A case report

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ABSTRACT

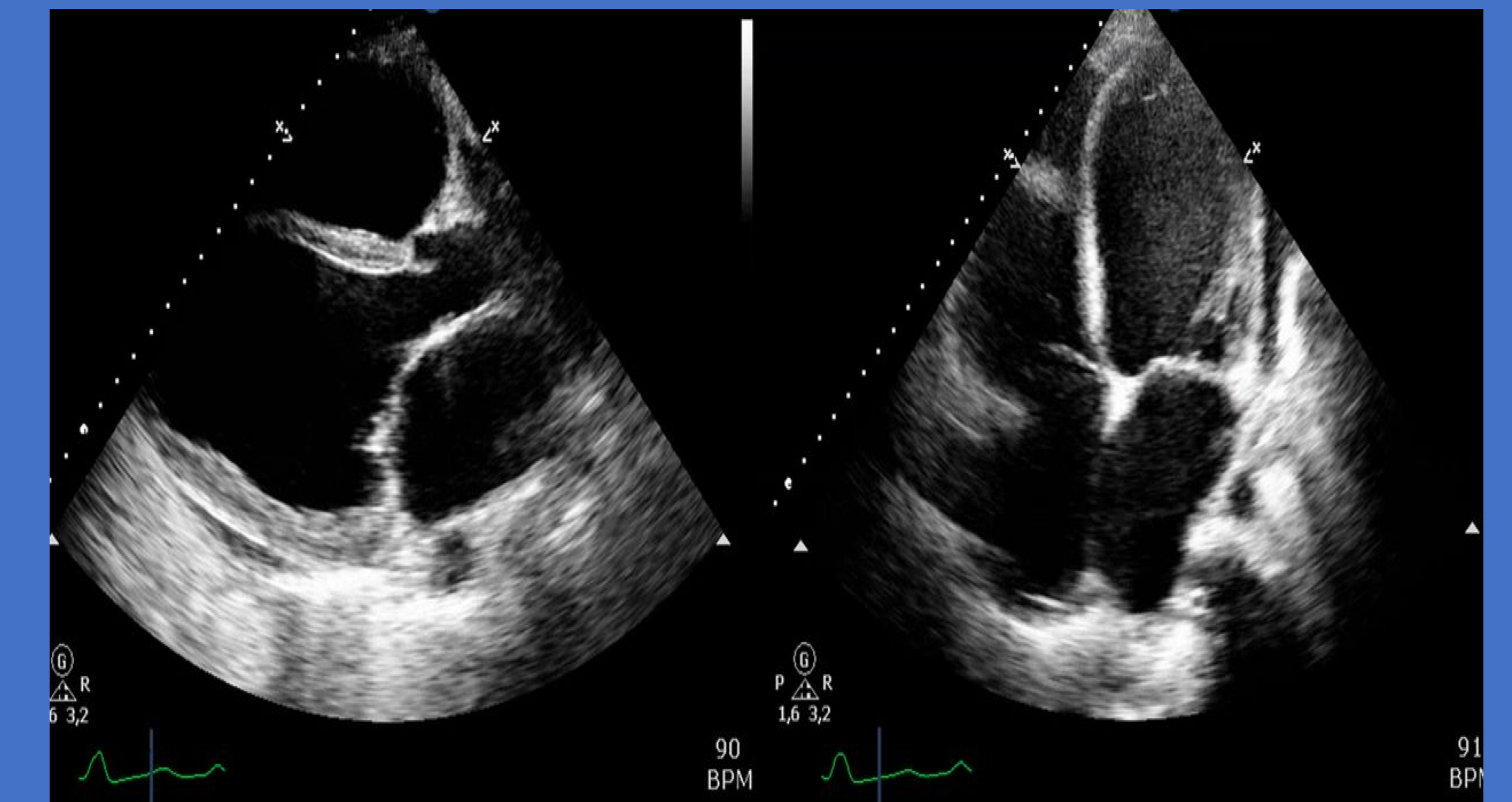
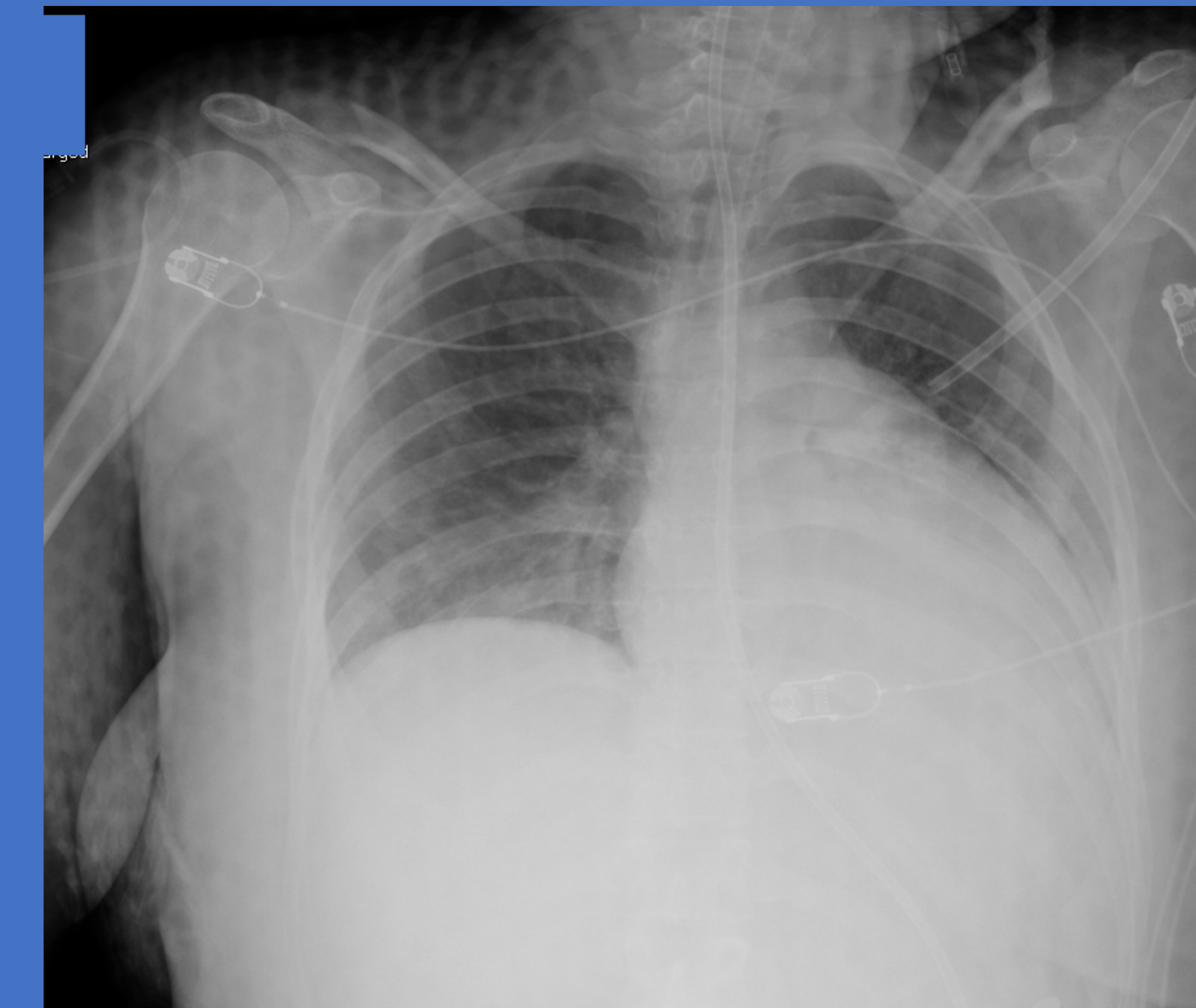
- Peri-partum cardiomyopathy (PPCM) is a rare, but life-threatening disease, which affects women in the last month of pregnancy or in the first 5 months after delivery¹. Its diagnosis is often missed initially and delayed because of its symptoms being non-specific (varying from fatigue, dyspnoea to extreme chest pain, seizures etc). High index of suspicion and prompt diagnosis in a time critical manner is crucial to avoid poor maternal outcome². This case highlights the importance of early recognition, diagnosis by exclusion, escalation and multi-disciplinary team approach for effective management of potentially life -threatening condition of PPCM².

CASE

- Mrs X is a 21- year-old in her first pregnancy, who was low risk and booked under Midwifery led clinic (MLC). All her care was under MLC until 39 weeks, when she had a scan which confirmed Large for gestation age (LGA) baby. Based on scan findings she was counselled regarding risks associated with LGA and offered Induction of labour @ 39 weeks. She went on to have a normal vaginal delivery (NVD)with minimum blood loss and delivered a healthy male baby weighing 3748 grams. Mrs X was discharged 24 hrs post-delivery on Dalteparin and ferrous sulphate. She was followed-up in Community and was discharged from their care 2 days later.
- 9 days post-partum Mrs X presented to emergency department post cardiac-arrest at home. On ambulance arrival @ home, she was diagnosed with Ventricular fibrillation cardiac arrest which required defibrillation (x3 shocks). On examination in Emergency department her Blood pressure was noted to be 192/107, and a differential diagnosis of Eclampsia causing seizures leading to hypoxic arrest was made. She was admitted to DCC after stabilization and continued being treated for eclampsia overnight.
- She did give a history of cough with acute breathlessness with no complains of headaches, visual disturbances and neuro-irritability prior to the event, which was not given attention at the time due to high BP and seizure.
- Following day, on obstetric review diagnosis of eclampsia was questioned in the absence of proteinuria, no symptoms of cerebral oedema and neuro-irritability and need for urgent cardiology input was requested to rule out post-partum cardiomyopathy.
- Following cardiology input, ECG demonstrated sinus rhythm with widespread T wave inversion and significantly prolonged QT interval. Echo reported left ventricular dilatation with significant impaired Ejection fraction to about 46%. Coronary angiogram showed normal coronary arteries. X- ray imaging confirmed cardiomegaly.
- Based on reports and imaging, Mrs X was urgently transferred to a tertiary centre for cardiac MRI via VA pathway.
- Later her symptoms of heart failure were diagnosed to be due to peripartum cardiomyopathy and the treatment was symptomatic with diuretics, inotropes, beta- blockers and ACEIs. Patient was successfully discharged home after a week.

Discussion

PPCM incidence is variable and aetiology is still unclear. For this reason the diagnosis of PPCM is still made by exclusion of other aetiologies. When PPCM is misdiagnosed or its diagnosis is delayed, the consequences for patients can be fatal. Thankfully in this case with MDT approach early cardiology opinion was sought rather than just continuing on management of initial diagnosis of eclamptic seizure.



Learning Points

- This case highlights the importance of early recognition, diagnosis by exclusion, escalation and multi-disciplinary team approach for effective management of potentially life -threatening condition of PPCM².
- PPCM should be anticipated and managed appropriately and promptly.
- There is no evidence in literature to determine the ideal criteria for diagnosing PPCM.

References

- 1.) <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2911830/>
- 2.) <https://medcraveonline.com/OGJ/peripartum-cardiomyopathy-ppcm-dual->