Peripartum cardiomyopathy - therapeutic modality

- Faruk Čustović^{1*}
- ©Edin Begić¹.
- Denis Mačkić¹.
- ©Sanko Pandur²

¹General Hospital "Prim. dr.Abdulah Nakaš", Sarajevo, Bosnia and Herzegovina

²Specialized Hospital "Centar za srce", Sarajevo, Bosnia and Herzegovina KEYWORDS: peripartum period, cardiomyopathies, treatment.

CITATION: Cardiol Croat. 2021;16(1-2):19. | https://doi.org/10.15836/ccar2021.19

*ADDRESS FOR CORRESPONDENCE: Faruk Čustović, Opća bolnica "Prim.dr. Abdulah Nakaš", Kranjčevićeva 12, 71000 Sarajevo, Bosnia and Herzegovina. / Phone: +38761722321 / E-mail: faffek@gmail.com

ORCID: Faruk Čustović, https://orcid.org/0000-0001-7254-8858 • Edin Begić, https://orcid.org/0000-0001-6842-262X Denis Mačkić, https://orcid.org/0000-0001-6540-4944 • Sanko Pandur, https://orcid.org/0000-0001-8595-1451f

Aim: To present a therapeutic modality of peripartum cardiomyopathy (PPCM).

Case report: A 24-year-old female patient, with no prior known diagnosis, was admitted to the Department of Cardiology with signs of acute heart failure. A 45 days prior to admission she delivered a healthy baby (first pregnancy) via cesarean section, while 20 days before hospitalization she developed symptoms like dyspnea, orthopnea, fatique, weakness and extremely low tolerance to effort. Upon admission on X-ray, heart shadow was enlarged and, while on electrocardiogram (ECG) there was a sinus tachycardia with negative T waves from V1-V5. Echocardiography on admission showed initial dilatation of cardiac chambers, reduced ejection fraction of left ventricle (EFLV; estimated about 25%) with global hypokinesia, signs of moderate to severe mitral and tricuspid regurgitation with mild pulmonary hypertension, along with hemodynamically nonsignificant circumferential pericardial effusion (diastolic separation of 8mm). Laboratory findings were as follows: NT-pro BNP 1810.0 pg/mL; signs of anemia, while inflammatory parameters, cardiac necrosis markers, urea, creatinine, D-dimer and thyroid hormones values remained in reference values. Testing for known cardiotropic viruses was not positive and PPCM was diagnosed. The patient was treated with cardio selective beta blocker (metoprolol), angiotensin-converting enzyme (ACE) inhibitor (ramipril), diuretics (furosemide), spironolactone, and digoxin along with supportive therapy. After twelve days of hospital treatment, there was significant improvement of the clinical status of our patient. Her symptoms were notably ameliorated. EFLV before discharge improved to 40%, heart chambers dimensions were in referral values, while mitral and tricuspid regurgitation were significantly reduced into a mild grade, while pericardial effusion was also in regression. Follow-up examination after two and six months showed further improvement of patients' conditions while after six months only beta-blocker and acetylsalicylic acid were prescribed

Conclusion: PPCM can occur during the end of pregnancy or within five months after delivery with no determinable etiology and with absence of cardiac disease in anamnesis.¹

RECEIVED: November 22, 2020 ACCEPTED: December 18, 2020



. Mubarik A, Iqbal AM. Postpartum Cardiomyopathy. In: StatPearls. StatPearls Publishing, Treasure Island (FL); 2019.