Eclampsia in peripartum cardiomyopathy mimicking acute coronary syndrome: a case report

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Aim: Presentation of a patient with diagnosed eclampsia and peripartum cardiomyopathy (PPCM) and delivered in the intensive coronary care unit (ICCU).

Case presentation: 27-year-old patient in the 38th week of pregnancy was admitted to the Intensive Coronary Care due to the suspected acute coronary syndrome and clinical picture of pulmonary edema with headache and severe hypertension (180/110 mmHg). An increase in markers of myocardial necrosis was noted, along with proteinuria (+). Reduced ejection fraction of left ventricle (LVEF 40%) with hypokinesis of the inferoseptal, basal, and mid segments of the inferior and inferolateral, wall and symptomatic severe mitral and tricuspid regurgitation was verified by transthoracic echocardiography (TTE). The patient was treated by non-invasive mechanical ventilation and delivered by a gynecologist during the night. Six hours after hospital admission, the patient had convulsions and, due to respiratory arrest, was intubated and connected to controlled mechanical ventilation with midazolam sedation. The patient received therapy with magnesium sulfate to stop convulsions and continued antihypertensive therapy with diuretics. After 24 hours, the patient was successfully extubated after the T-tube test. The post-extubation period passed neat. After 15 days treatment with bromocriptine and beta blocker, angiotensin-converting enzyme (ACE) inhibitor and mineralcorticosteroid antagonist, TTE showed mild decreased systolic function (LVEF 50) % with mild mitral and tricuspid regurgitation. Three months after discharge, control TTE showed global longitudinal strain (GLS) of -19,7 %, preserved systolic function (LVEF 63%) and proper valvular function (**Figure 1**).

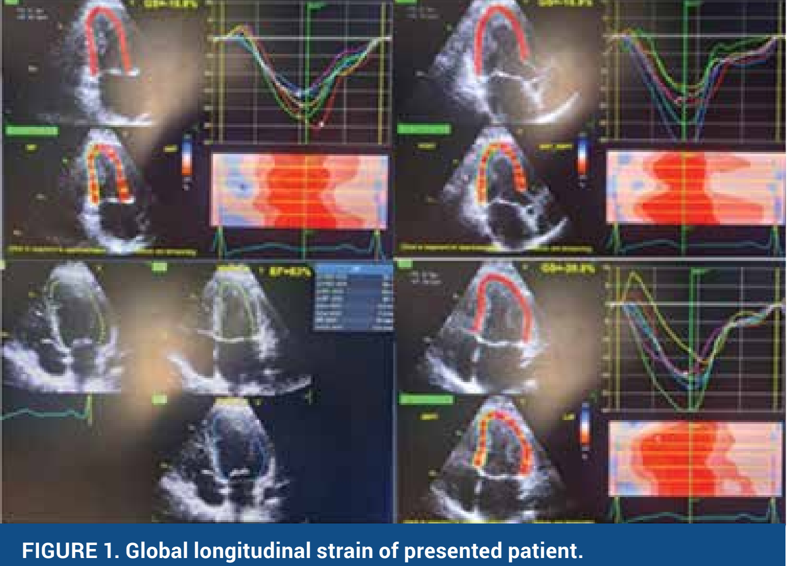

FIGURE 1. Global longitudinal strain of presented patient.

Conclusion: Eclampsia in peripartum cardiomyopathy can mimic acute coronary syndrome.[1,2] GLS can be a tool for diagnosis confirmation.

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LITERATURE

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