Pregnancy May Mask Heart Disease Symptoms

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SAN FRANCISCO — Maternal peripartum cardiomyopathy, seen in 1 in 3,000 live births, generally carries a good prognosis, Dr. Michael Crawford said at a meeting sponsored by the California chapter of the American College of Cardiology.

Diagnosis of peripartum cardiomyopathy—or of other heart diseases during pregnancy—often is delayed because the symptoms of pregnancy can mimic the heart disease symptoms, said Dr. Crawford, professor of medicine at the University of California, San Francisco,

A majority of women with peripartum cardiomyopathy recover after delivery, but 10%-20% require heart transplantation and 1%-2% die, data suggest. The patient's ejection fraction 2 months after diagnosis appears to be the best prognostic factor, he said at the meeting, also sponsored by the university.

Treatment for cardiomyopathy differs for pregnant women compared with nonpregnant patients because some drugs shouldn't be used until after delivery.

ACE inhibitors and warfarin are teratogenic, and β-blockers can lead to fetal bradycardia.

"You get by with diuretics, digoxin, and hydralazine during pregnancy" for peripartum cardiomyopathy, Dr. Crawford said.

In a recent study at a large medical center, ejection fractions improved at least 15% in 62% of women with peripartum cardiomyopathy, remained unchanged in 25%, and declined in 13% (Am. Heart J. 2006;152:509-13).

Ejection fractions returned to normal in 45%. Ten percent of patients required transplantation. No patients died during an average 43-month follow-up. "That's encouraging," he noted.

The initial echocardiogram, obtained between 1 month prepartum and 5 months post partum, did not predict which patients required transplantation, nor which had final ejection fractions below or above 50%. "Don't get discouraged with the first echo," Dr. Crawford said. Echocardiograms 2 months later predicted outcomes in that study.

Patients with ejection fractions below 20% probably are headed for transplant. Those with ejection fractions between 20% and 50% should see some improvement but are unlikely to return to normal. If the 2-month ejection fraction is above 40%, the patient is likely to recover fully (defined as an ejection fraction greater than 50%), he said.

ECGs in normal pregnancies often detect sinus tachycardia, and may show nonspecific ST-T changes. As the pregnancy advances, the heart's axis shifts.

Shortness of breath and decreased exercise capacity, which are symptoms of cardiomyopathy, also are symptoms of a normal pregnancy. Fatigue, orthopnea, and dizziness or syncope, which might be symptoms of other heart disease, also are normal symptoms of pregnancy.

Electrocardiograms in normal pregnancies often detect sinus tachycardia, and may show nonspecific ST-T changes. As the pregnancy advances, the heart's axis shifts more to the left.

Physical findings in normal pregnancies may include jugular venous distension, an enlarged left ventricle apex, right ventricle heave, a palpable pulmonary artery pulse, third heart sounds, systolic ejection murmurs, venous hums, or a mammary souffle noise if you listen over the breast.

"It can be confusing," Dr. Crawford said.

The most common peripartum cardiovascular problem is venous thromboembolism, which is the leading cause of death in pregnancy, he added.

Consider prophylactic medication in women with risk factors (thrombophilia, history of thrombosis, antiphospholipid syndrome, lupus erythematosus, sickle cell anemia, or any kind of heart disease that would lead to thrombus formation).

Coronary artery disease during pregnancy is more common than one might think, perhaps because more women are having children later in life, he added.

Maternal MI occurs in 6 out of 100,000 deliveries, three to four times more common than is expected in age-matched nonpregnant women. ■