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MOTHER WITH A BIG HEART

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A 25 year old woman came to our emergency department with progressive dyspnea and chest discomfort from one day, two days after her second child's birth. Her pregnancy and labour were without complications. Her medical history was negative for heart and respiratory diseases and haemoglobin levels were normal. She was tachycardiac, tachypnoic, apiretic with central venous pressure (CVP) elevated. First and second tones were normal, with a slight systolic murmur at the apex. There were slight pulmonary bibasal cracks. No edema was observed. The electrocardiogram (EKG) showed sinus tachycardia with non-specific T-wave inversions in the V1-V4 leads and troponin levels were negative.The echocardiogram showed dilated left ventricle (62 mm diastolic diameter) with diffuse hypokinesia, 29% ejection fraction and grade I-II mitral regurgitation. No other structural or valvular abnormalities were noted and the right ventricle and pulmonary arteries appeared normal. Dyspnea in the immediate postpartum may be due to a myriad of conditions. Of these the most important to consider are pulmonary embolism (PE), heart failure (HF), pneumonia and bleeding anaemia. Pneumonia is quite unlikely in the absence of cough and increase in inflammatory indices, while haemoglobin levels excluded anaemia. Although a high CVP and a cantering rhythm may occur in both PE and HF, the presence of cardiomegaly and pulmonary crackles depended for pulmonary congestion, secondary to HF. The absence of actual and gestational hypertension excluded the diagnosis of HF associated with preeclampsia whereas the EKG and the negativity of troponin excluded acute coronary syndrome. Peripartum cardiomyopathy was not only possible, but also probable because the presence of cardiac insufficiency, the timing of emergence of symptoms, the absence of a clear cause and the lack of a positive history of previous cardiac diseases met diagnostic criteria well relevant. Therefore, morphine was administered to the patient to reduce preload, diuretics to relieve fluid overload and anticoagulants to prevent thromboembolic complications. The patient returned to a baseline ventricular function after about six months, with an ejection fraction >50% and with a progressive improvement in symptoms.

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