Balloon Mitral Valvuloplasty in the IInd Trimester Pregnancy With Excellent Result –Case Report

B.R. Brinda, Shakila Shetty, Nagaraj Desai.
Dept of Obst & Gyn, M.S. Ramaiah Medical Teaching Hospital, Bangalore

20 year old primigravida with h/o 6 months amenorrhoea was admitted with severe breathlessness since the past 3-4 weeks. Patient was diagnosed to have rheumatic heart disease with severe mitral restenosis with mild aortic regurgitation with moderate pulmonary hypertension with functional tricuspid regurgitation. She has had closed mitral valvotomy on 26/6/92 and was asymptomatic till recently. Her EDD was on 22/3/97. Her echo revealed dilated left atrium with severe mitral stenosis with a valve area (MVA) of 0.62 cm^2 and moderate PH. There was no mitral regurgitation on echo cardiography. There were no clots or vegetation.

Since she was in IInd trimester & symptomatic the cardiologists opined that she should undergo percutaneous balloon mitral valvuloplasty (PBMV). Otherwise she could experience a complicated course during later part of pregnancy & delivery. Moreover PBMV has minimal risk in present day practice. She underwent elective PBMV through the Rt. femoral vein on 11/12/96 by Inoue technique. Post PBMV echo showed MVA increased to 1.55 cm^2 & PH reduced to 40mmHg. Rheumatic prophylaxis was continued & patient was discharged on 15/12/96. Post operative period was uneventful. She was readmitted on 17/3/97 with labour pains and started on antibiotic prophylaxis. She delivered a live male baby on 17/3/97 by outlet forceps under epidural anaesthesia. Labour was accelerated with syntocinon. Both mother & baby were discharged on 7th PN day in good condition.

We believe that mitral restenosis during pregnancy needs to be tackled & that medical treatment alone is not sufficient to carry the patient through the pregnancy. With the advent of PBMV, a balloon catheter, the palliation of mitral stenosis has proved to be effective. The danger of radiation and its potential to cause foetal anomalies though present, the benefit to risk ratio is immense in appropriately selected patients. Therefore, continuation of medical therapy in a patient who remains very symptomatic in the late II & IIIrd trimester of pregnancy needs a second look as excellent palliation is possible in selected patients with gratifying results both in terms of outcome of pregnancy and maternal health.