A Rare Case of Tetralogy of Fallot with Congenital Rubella Syndrome with Pregnancy

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History : Mrs. SRV, 30 years old female, house wife, G_3, P_1, A_1 with no living child came for ANC registration on 14/1/95 with 8 months of amenorrhoea. There was no history suggestive of heart disease in past. She was married since 15 years. Her first pregnancy resulted in spontaneous abortion at 3 months amenorrhoea, 2 years back. Next pregnancy resulted in preterm delivery at 7 months amenorrhoea giving birth to a female child who died after 4 hours of birth. The current pregnancy was uneventful. Her EDD was 27/2/95.

General Examination : - TPR –N, B.P. – 140/90, JVP not raised. No pallor / edema / cyanosis / icterus / lymphadenopathy. Both eyes showed micor-ophthalmus and nystagmus. Immature cataract was present in the left eye.

Systemic Examination : CNS examination revealed moderate mental retardation, cerebellar signs were impaired (FN/KH test; Tandem walking).

CVS examination – Thrill present on left precordium. On auscultation, S1 was loud, S2 soft and systolic murmur grade 4/6 was present, which was best heard in left infraclavicular region.

Obstetric Examination – FH was 28 cm, corresponding to 32 weeks of gestation with longitudinal lie, vertex floating and FHS +reg.

The patient was hospitalized for investigations and further management. The patient was examined by the cardiologist and clinical differential diagnosis was as follows :-

Congenital heart disease without cyanosis with congenital Rubella syndrome with ? PDA;

- Coarctation of aorta;
- Wilsons disease with cerebellar involvement ;
- Craniovertebral anomaly.

Her important investigations showed following results. ECG revealed left atrial enlargement; Rt axis deviation and Rt ventricular hypertrophy.

2 D Echo confirmed the diagnosis of congenital heart disease of Tetralogy of Fallot (Intra-atrial septum, perimembranous VSD, Aortic over – riding more than 50%, pulmonary stenosis infundibular).

USG abdomen and pelvis showed single normal intrauterine gestation of 30 weeks.

Management – The patient was managed on salt restricted diet, bed rest, oral haematinics and inj Penidura 2.4 MUIM ATD with T. Depin 5 mg 1 tds. She went in labour and had full term vaccum delivery on 1/2/95 at 10.20 a.m. The course of labour was uneventful. The female baby cried immediately after birth. The birth weight of the baby was 1.7 kg. The placenta and membranes were completely expelled. Episiotomy was sutured and there was no PPH.

Post delivery at 3 pm :-

Patient developed sudden hypotension and was in altered sensorium. She was transfused with 1 Haemacyl, 1 pint of fresh frozen plasma and 1 pint of packed cells to correct hypovolemia in consultation with the cardiologist. On 2/2/95 i.e. 2nd day of delivery, she developed a cyanotic spell and became drowsy as well as tachypnoeic. Arterial blood gas investigation showed metabolic acidosis with respiratory alkalosis. She was treated with knee-chest position, nasal oxygen, I.V. $NaHCo_3$. But she developed puffiness of face and drowsiness on 3rd day of delivery and was transferred to Medical Acute Care Unit for further management. Investigations showed normal CT Scan and normal CSF picture. She was treated successfully in MACU and was stabilised. She was transferred back to our postnatal ward after 6 days i.e. on the 9th day of the delivery and was managed on high salt diet, bed rest and antibiotics. Meanwhile her female child of 1.6 kg wt. (Full term IUGR) was kept on injectable antibiotics as umbilical discharge came positive for Klebsiella pneumoniae. Weight gain started from D_{15} of delivery. The baby did not have any evidence of congenital heart disease. The mother and her baby were discharged on the 37th day of the delivery in good health.