Eisenmenger Syndrome with Pregnancy

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Mrs X, 33 years old unbooked $G_{3P1+0+1+0}$ reported to antenatal clinic of Guru Teg Bahadur Hospital on 25-08-1998 at 34 weeks 3 days of gestation. She was a known case of congenital cyanotic heart disease and complained of breathlessness on work less than routine activity. She had been having irregular antenatal check up since 20 weeks gestation, took haematinics occasionally, was immunized against tetanus and had an uncomplicated antenatal period. Though symptomatic since birth, she was diagnosed to have cyanotic congenital heart disease at the age of 5 years and the diagnosis was confirmed in 1996 after the last child birth when an echocardiogram showed ventricular septal defect of 17mm with valvular and infundibular stenosis and left to right shunt. She refused surgery as well as contraception. The obstetric history revealed, one term vaginal delivery of low birth weight baby who died of severe birth asphyxia and one spontaneous abortion at 8 weeks which was followed by dilatation and curettage. There was no major deterioration of her cardiac status during these two obstetric events.

The general physical examination revealed stable vital signs, central and peripheral cyanosis and grade 4 clubbing. The cardiovascular examination showed grade 2 pansystolic murmur in parasternal region with loud P_2. Chest was clear. Abdominal examination showed 34 weeks uterus with fetus in longitudinal lye, cephalic presentation, adequate liquor and regular foetal heart rate. Patient was admitted and investigated. She had a haemoglobin of 14gm% and packed cell volume of 48.5%. Other investigations like urine examination, liver and kidney function tests were within normal limits. ECG showed right ventricular hypertrophy. Chest X-ray revealed normal cardiac size, prominent ascending aorta and left hilum. Arterial blood gases showed hypoxemia with respiratory alkalosis. The oxygen saturation of 82%, marginally improved to 86% with oxygen supplementation. Ultrasonography showed 35 weeks pregnancy with normal foetus. With plan of caesarean section at term, she was advised bed rest with foot pedaling exercises and oxygen supplementation at the rate of 5 litres per minute for one hour every 4-6 hours. Both mother and foetus were closely monitored. After 6 days of hospital stay at 35 weeks 3 days, she went into spontaneous labour. She was given prophylaxis against bacterial endocarditis in the form of ampicillin and gentamycin and taken up for lower segment caesarean section (LSCS) with tubal ligation under general anaesthesia. Precautions were taken to avoid hypoxia by administrating a higher oxygen concentration. Intravenous line was guarded against air embolism. A live male baby of 2.7kg with an apgar of 8,9,9 was delivered who had no congenital malformations. During surgery, the vital signs remained stable and oxygen saturation was maintained at 91%. In immediate post operative period, she had an apnoeic spell with fall in SPO_2 to 60%. Patient was shifted to intensive care unit for oxygen supplementation and close monitoring. The post-operative period, was uneventful till 5th post operative day when she developed high grade fever. On 8th, post-operative day, she had a syncopal attack which was followed by left upper motor neuron palsy and left hemiparesis. A diagnosis of thromboembolism of left carotid artery was made which was confirmed by CT scan. Patient was started on low dose of aspirin and physiotherapy. She responded well to treatment and was discharged from hospital in satisfactory condition on 19th postoperative day.