Peripartum cardiomyopathy: still unknown
The current state of knowledge

Kardiomiopatia połogowa — wciąż niepoznana. Aktualny stan wiedzy

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Abstract
Peripartum cardiomyopathy (PPCM) is defined as idiopathic cardiomyopathy which occurs at the end of pregnancy or in the first few months after delivery, with symptoms of heart failure (HF) secondary to left ventricular dysfunction, and at the same time there is no other cause for this condition. The pathomechanism of the disease has not yet been fully understood, but it is probably based on the interaction of complex factors. The clinical course of PPCM varies from life-threatening acute heart failure to mild symptoms resembling the symptoms typical of the perinatal period. In Europe, PPCM is a rare disease but there are areas of the world where it occurs in one in every 300 cases. The treatment of PPCM is similar to that of HF with reduced ejection fraction. However, it is important to exclude drugs with teratogenic effects during pregnancy. The inclusion of bromocriptine in PPCM therapy seems to be justified, and in some cases improves the prognosis.

Key words: peripartum cardiomyopathy, PPCM, heart failure, pregnancy, bromocriptine

Introduction
The first reports of peripartum cardiomyopathy (PPCM) were presented in the mid-19\textsuperscript{th} century when Virchow et al. \cite{1} described a number of post-mortem examinations of women who had died during the perinatal period. At that time, the researchers did not know the cause of death, but they noticed that the patients had myocardial degeneration. It took several decades before Gouley et al. \cite{1} associated the perinatal period with cardiomyopathy in 1937. In their study, seven cases of pregnant patients with acute heart failure (HF) were described, of whom four died. Dilated cardiomyopathy at a late stage of pregnancy was characteristic for each case, which persisted also after delivery. Post-mortem examinations of deceased patients showed myocardial hypertrophy with areas of severe necrosis and fibrosis. In 1971, PPCM was named for the first time by Demakis and Rahimtooli \cite{1, 2}. New criteria for PPCM have been developed in subsequent years thanks to the development of diagnostic techniques that include echocardiography and molecular biology, and the discovery of new biomarkers. This article presents the current state of knowledge regarding PPCM.

Definition of PPCM
The current definition of PPCM was created by the Heart Failure Association of the European Society of Cardiology in 2010. It is idiopathic cardiomyopathy, which manifests as HF secondary to left ventricular dysfunction without other
causes. It occurs at the end of pregnancy or in the first few
months after delivery. For a diagnosis of PPCM, the ejection
fraction should be ≤ 45%, although there is no obligation to
document the enlargement of the left ventricle dimension.

PPCM is a diagnosis of exclusion. In contrast to the
previous definition from 2000, it does not take into ac-
count the exact time interval of the disease (previously it
needed to occur between the final month of gestation and
5–6 months after delivery), or specific echocardiographic
criteria (previously: lower ejection fraction < 45%, and
shortening fraction < 30% and enlargement end-diastolic
dimension of the left ventricle cavity > 2.7 cm/m² of the
body surface). The current definition is less restrictive,
thus reducing the chances of missing a patient with this
disease [3, 4].

Pathogenesis

Probably there is a complex mechanism that causes PPCM,
and therefore there is no other theory that can explain
its development. The literature describes many factors
involved in the development of the disease. Some of the
more important ones are presented in Table 1 [3, 5–9].
This paper describes two pathomechanisms that seem to
be the most important in PPCM [6].

Prolactin

Physiologically, prolactin with a mass of 23 kDa protects
the endothelium and promotes angiogenesis. In the period
of oxidative stress caused by pregnancy for example, a short-
ter form of 16 kDa with a strong cardiotoxic effect may be
formed. STAT-3 is a protein responsible for the protection
of the myocardium by the induction of antioxidant enzymes.
The disruption of STAT-3 function leads to an intensifica-
tion of oxidative stress and activation of several enzymes,
including cathepsin D which is responsible for the formation
of a prolactin shorter form (16 kDa). It has been shown that
in women with PPCM, the level of STAT-3 protein expression
is reduced, and the production of 16 kDa prolactin is increa-
sed [9]. One of the new strategies for treating PPCM is based
on this knowledge. It involves the addition to standard HF
therapy of bromocriptine, a prolactin-inhibitor. Currently, the
effects of therapy are satisfactory, and the 2018 guidelines
of the European Society of Cardiology (ESC) assigned the
class of recommendation IIa for bromocriptine treatment,
with the reliability of data at level C [10].

cflt1

At the beginning of pregnancy, the process of angiogenesis
is increased. However, this tendency changes with the pas-
sage of time and especially in the perinatal period when
the placenta begins to secrete anti-angiogenic substances.
These include a soluble fms-like tyrosine kinase-1 (sFLT1)
[11]. In a normal pregnancy, these are physiological pro-
cesses and do not cause any complications. However,
there may be subclinical dysfunction of cardiomyocytes in
abnormal conditions of sFLT1 excess or when the mecha-
nisms protecting the heart against antiangiogenic factors
are compromised. PPCM patients have been shown to have
a significantly elevated level of sFLT1. Moreover, multiple
pregnancy and pre-eclampsia both increase the secretion
of this antiangiogenic. This may explain why multiparous
women with pre-eclampsia are more often diagnosed with
PPCM [10]. An increase of the angiogenesis process by
the administration of vascular endothelial growth factor
(VEGF) has been proposed for PPCM treatment. Previous
attempts were made only on mice, and the use of VEGF
alone did not give the expected results. Only treatment
with a combination of VEGF and bromocriptine turned out
to be satisfactory [12].

Table 1. Major factors involved in the development of peripartum cardiomyopathy (PPCM)

<table>
<thead>
<tr>
<th>Pathogenesis of PPCM</th>
<th>Brief description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Genetic/environmental factors</td>
<td>Epidemiological data on the increased incidence of PPCM in some areas and among selected ethnic groups, especially Africans or African-Americans [3]. Some studies suggest association with familial dilated cardiomyopathy [5, 6]</td>
</tr>
<tr>
<td>Infectious/autoimmune factors</td>
<td>Presence of the viral genome has been evidenced in cardiomyocytes of women with PPCM (31%) [7] Increase in the concentration of inflammatory markers is observed in PPCM: TNF-α, interferon γ, interleukin 6, CRP [8]</td>
</tr>
<tr>
<td>Factors related to angiogenesis</td>
<td>At the end of pregnancy, the placenta begins to secrete anti-angiogenic substances. In the case of impaired cardiac protective mechanisms against anti-angiogenic factors or an excess of these factors, subclinical dysfunction of cardiomyocytes may occur [8]</td>
</tr>
<tr>
<td>Factors related to prolactin</td>
<td>Physiologically, prolactin protects the endothelium and promotes angiogenesis; however, under increased oxidative stress caused by pregnancy, short form of prolactin may be generated that is toxic to cardiomyocytes [9]</td>
</tr>
</tbody>
</table>

TNF-α — tumor necrosis factor α; CRP — C-reactive protein
Epidemiology

The prevalence of PPCM is characterised by significant geographical variations. In many areas, the actual number of cases is unknown and further research is needed. The highest density of recognised PPCMs has been recorded in Nigeria (1:100 cases) and Haiti (1:300 cases). For comparison, the disease affects 1:1,000–1,500 women in Germany, 1:1,000 in South Africa and 1:2,500–4,000 in the USA [3, 10]. From the cited data described in 2010 by Sliwa et al. [3], it is clear that African origins predispose to a more frequent occurrence of peripartum cardiomyopathy. The average age of PPCM incidence rate is 27–33 years, depending on the region. Indeed, compared to older publications, this average age has increased in recent publications [3]. In addition, there has also been an increased incidence of PPCM over recent years — from 1 in 4,350 women in 1990–1993 to 1 in 1,229 in 2000–2002. This increase may be attributable to several factors: the later age at which women are becoming pregnant, an increase in the number of multiple pregnancies, developing access to methods of assisted reproduction, and increased recognition of PPCM [13].

Clinical presentation

Difficulties associated with making the right diagnosis are related to the fact that the clinical picture of PPCM resembles the perceived symptoms typical of the final period of pregnancy or the effort associated with the birth itself. Often the symptoms do not have a high severity, which makes it difficult to make the right diagnosis [3].

The vast majority of patients develop symptoms in the first four months after delivery (78%), and only 9% show disease onset in the last month of pregnancy. The remaining 13% of cases refer to women diagnosed with PPCM earlier than one month before delivery or later than four months after delivery [3].

Typical symptoms include shortness of breath, swelling of the lower limbs, orthopnoea, fatigue, chest pain, reduced exercise tolerance, and heart palpitations. In the study of Patel et al. [14] from 2015, 19 Swedish patients were chosen (according to the ESC criteria from 2010) to determine the most common symptoms of PPCM. All subjects reported more than one symptom. The most common complaints were: dyspnoea (18 out of 19), fluid retention (15 out of 19), excessive fatigue (14 out of 19), and a persistent cough (eight out of 19). The study also looked at mental symptoms: 11 out of 19 women reported at least one of the following symptoms: feelings of unavoidable death (seven), panic attacks (five), anxiety (five) or fear (fear) [14].

Diagnosis of PPCM

A diagnosis of PPCM is based on the exclusion of other HF causes [15]. The disease should be suspected in all peripartum women with symptoms of HF or those who have a delay in returning to their pre-pregnancy baseline [16]. Two key studies that must be performed when PPCM is suspected are echocardiography and N-terminal pro-B-type natriuretic peptide (NT-proBNP) or B-type natriuretic peptide (BNP). Further testing for PPCM is necessary if the left ventricular ejection fraction (LVEF) is ≤ 45% or the level of natriuretic peptides is increased [12]. The useful tests include chest radiograph (this can show enlargement of the heart, low blood circulation and pleural effusion), and ECG (left ventricular overload, non-specific changes in ST segments, prolonged QT interval or large QRS complexes). MRI may be performed as an addition to echocardiography [17] and a myocardial biopsy in suspected HF with infectious aetiology [16].

In addition, newly discovered biomarkers appear to be promising in women suffering from PPCM and could be helpful in the differential diagnosis. Selected ones are presented in Table 2 [8, 18, 19].

Treatment

According to the latest guidelines of the European Cardiac Society (ESC) from 2018, the treatment of PPCM does not

Table 2. Selected biomarkers for peripartum cardiomyopathy (adapted from [8, 18, 19])

<table>
<thead>
<tr>
<th>Biomarker’s name</th>
<th>Level in PPCM</th>
</tr>
</thead>
<tbody>
<tr>
<td>micro-RNA 146</td>
<td>Increased</td>
</tr>
<tr>
<td>Endothelial cells and</td>
<td>Increased circulating levels in the blood</td>
</tr>
<tr>
<td>monocyte microparticles</td>
<td></td>
</tr>
<tr>
<td>sFLT1</td>
<td>Increased in late pregnancy and rapid decrease after delivery (the threshold values are difficult to define)</td>
</tr>
<tr>
<td>Inflammatory proteins:</td>
<td></td>
</tr>
<tr>
<td>CRP, TNF-α, interferon γ,</td>
<td>Increased</td>
</tr>
<tr>
<td>interleukin 6</td>
<td></td>
</tr>
<tr>
<td>Prolactin 16 kDa</td>
<td>Increased</td>
</tr>
<tr>
<td>Catepsin D</td>
<td>Increased</td>
</tr>
<tr>
<td>Relaxin 2</td>
<td>Decreased (the threshold values are difficult to define)</td>
</tr>
<tr>
<td>Oxidized LDL</td>
<td>Increased</td>
</tr>
<tr>
<td>TGF-β1</td>
<td>Decreased</td>
</tr>
</tbody>
</table>

PPCM — peripartum cardiomyopathy; sFLT1 — soluble fms-like tyrosine kinase-1; CRP — C-reactive protein; TNF-α — tumor necrosis factor α; LDL — low-density lipoprotein; TGF-β1 — transforming growth factor β1.
Table 3. Selected drugs used in peripartum cardiomyopathy (adapted from [15, 16])

<table>
<thead>
<tr>
<th>Class of drugs</th>
<th>Non-proprietary name</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACEI</td>
<td>Captopril</td>
<td>Contraindicated during pregnancy (risk of kidney damage, malformations and hypotension in the fetus)</td>
</tr>
<tr>
<td></td>
<td>Enalapril</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Ramipril</td>
<td>There is no data on the risk during pregnancy</td>
</tr>
<tr>
<td>Sartans</td>
<td>Candesartan</td>
<td>Contraindicated during pregnancy and breast-feeding</td>
</tr>
<tr>
<td></td>
<td>Valsartan</td>
<td></td>
</tr>
<tr>
<td>Potassium-sparing diuretics</td>
<td>Spironolactone</td>
<td>Contraindicated during pregnancy and breast-feeding (possible antiandrogenic effects in the fetus)</td>
</tr>
<tr>
<td></td>
<td>Eplerenone</td>
<td>Negative effects have not been fully understood (category B according to the FDA classification)</td>
</tr>
<tr>
<td>Beta-blockers</td>
<td>Extended-release metoprolol</td>
<td>Low risk of bradycardia and respiratory failure in the newborn. Cardioselective drugs preferred during pregnancy</td>
</tr>
<tr>
<td></td>
<td>Carvedilol</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Atenolol</td>
<td>Risk of low birth weight and fetal bradycardia if administered in II or III trimester</td>
</tr>
<tr>
<td>Vasodilators</td>
<td>Hydralazine</td>
<td>In combination with nitrates as a safe alternative to ACEIs/sartans during pregnancy</td>
</tr>
<tr>
<td></td>
<td>Nitroglycerin</td>
<td>Risk of hypotension</td>
</tr>
<tr>
<td>Diuretics</td>
<td>Hydrochlorothiazide</td>
<td>Risk of reduced placental blood flow. Use only in patients with signs of congestion in the pulmonary circulation</td>
</tr>
<tr>
<td></td>
<td>Furosemide</td>
<td>Use only in patients with signs of congestion in the pulmonary circulation</td>
</tr>
<tr>
<td>Inotropes</td>
<td>Digoxin</td>
<td>Consider in patients with low EF. Keep in mind the risk of toxicity when used in high doses</td>
</tr>
<tr>
<td></td>
<td>Dobutamine</td>
<td>Insufficient evidence for safe use during pregnancy</td>
</tr>
<tr>
<td></td>
<td>Milrinone</td>
<td></td>
</tr>
<tr>
<td>Anticoagulants</td>
<td>Warfarin</td>
<td>Risk of abnormal development of the bones of the nose, limbs, joint cartilage, as well as the risk of ear, eye and central nervous system anomalies</td>
</tr>
<tr>
<td></td>
<td>Low-molecular-weight heparin</td>
<td>Use in patients treated with bromocriptine. Implement treatment if EF &lt; 35%</td>
</tr>
<tr>
<td>Prolactin inhibitors</td>
<td>Bromocriptine</td>
<td>Increased thromboembolic risk; recommendation class IIa, level of evidence C</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dosing schedule: 2.5 mg twice daily for 2 weeks, and then 2.5 mg once daily for 6 weeks</td>
</tr>
<tr>
<td>Heart rate lowering agents</td>
<td>Ivabradine</td>
<td>Use in patients with high heart rate</td>
</tr>
<tr>
<td>ARNI</td>
<td>Sacubitri valsartan</td>
<td>Contraindicated during pregnancy and breast-feeding</td>
</tr>
</tbody>
</table>

Red — drugs contraindicated during pregnancy; blue — there are no data indicating fetal toxicity; ACEI — angiotensin-converting enzyme inhibitors; ARNI — angiotensin receptor neprilysin inhibitors; EF — ejection fraction; FDA — Food and Drug Administration

deviate from the recommendations used in acute HF, cardiogenic shock, or chronic HF of a different aetiology. It is important to exclude drugs that may have a harmful effect on the developing foetus or those that are contraindicated during breastfeeding [angiotensin-converting enzyme inhibitors (ACEI), sartans, angiotensin receptor neprilysin inhibitor (ARNI), potassium-sparing diuretics, warfarin, and ivabradine] [15]. Selected contraindicated medications are presented in Table 3 [15, 16]. A pregnant woman with PPCM should be under the combined care of a cardiologist and an obstetrician, and possible complications for the foetus should be observed in ultrasound [3].

Pregnancy in a patient with cardiovascular disease is always at high risk of complications. Therefore, it is necessary to inform the patient that the frequency of ultrasonography of the foetus will be different from the standard procedure.
for an uncomplicated pregnancy. Until the 28th week of pregnancy, the test should be performed once a month for patients in New York Heart Association (NYHA) class I and II and every two weeks or more often for those in NYHA class III and IV. After the 28th week of pregnancy, the examination should take place every week until delivery [20].

In case of acute severe HF, one should bear in mind the need for premature termination of pregnancy with access to a mechanical circulatory support system (MCS) and the implementation of lung maturation accelerating treatment in the foetus beyond the 23rd week of pregnancy + 5 days [15]. Furthermore, the inclusion of intensive acute HF treatment is obligatory.

The principles of PPCM treatment are presented in Figure 1 [15], including the period before and after delivery.

In addition to the standard procedure, it is also worth paying attention to the possibility of bromocriptine inclusion for the treatment of PPCM. According to the 2018 ESC guidelines, the addition of bromocriptine to standard HF therapy favourably affects left ventricular function and improves prognosis in women with a severe PPCM course [15]. For an uncomplicated PPCM, a dose of 2.5 mg per day is recommended for at least a week. Patients with ejection fraction < 25% and/or cardiogenic shock may be considered for a therapy of 2.5 mg twice daily for two weeks, followed by 2.5 mg once daily for six weeks. When treating with bromocriptine, it is important to remember about anticoagulation (prophylactic doses of low molecular weight heparin) [15]. Studies have shown very good treatment effects: in a six-month follow-up, total recovery
Table 4. Summary of the most important data from the papers cited in this article

<table>
<thead>
<tr>
<th>Authors</th>
<th>Follow-up period, country</th>
<th>No. of patients with PPCM</th>
<th>Mean age at diagnosis</th>
<th>EF/NYHA</th>
<th>Recoveries</th>
<th>Recurrences</th>
<th>Deaths (%)</th>
<th>Other</th>
<th>Complications</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sliwa et al. [23]</td>
<td>Start on March 31, 2016, 43 countries</td>
<td>411</td>
<td>30.07</td>
<td>LVEF: 32.2% NYHA I-II: 31.2% NYHA III: 36.6% NYHA IV: 32.2%</td>
<td>n/a</td>
<td>n/a</td>
<td>2.4%</td>
<td>Heart failure: 60% stroke: 10% sudden cardiac death: 30%</td>
<td>PM: 0.7%; ICD: 1.2%; CRT: 0.2%; VAD: 2.0%</td>
</tr>
<tr>
<td>Hilfiker-Kleiner et al. [24]</td>
<td>2005–2015 Germany, Scotland, South Africa</td>
<td>34</td>
<td>27 ± 7% with LVEF &lt; 50%, 29 ± 5% with LVEF &gt; 50%</td>
<td>31 ± 7%</td>
<td>18/34</td>
<td>16/34</td>
<td>2.9%</td>
<td>Heart failure: 25% due to recurrence during the next pregnancy</td>
<td>–</td>
</tr>
<tr>
<td>Ersbøll et al. [25]</td>
<td>2005–2014 Denmark</td>
<td>61</td>
<td>31.7 ± 6.3</td>
<td>26.7 ± 9.0%</td>
<td>32/61</td>
<td>n/a</td>
<td>3.8%</td>
<td>–</td>
<td>Postpartum hemorrhage: 22.9% Chronic HF with LVEF &lt; 35%: 1.8% MCS: 3.28% MCS and heart transplantation: 3.28% MCS and death: 1.64% n/a</td>
</tr>
<tr>
<td>Perveen et al. [26]</td>
<td>2012–2013 Pakistan</td>
<td>22</td>
<td>27.4</td>
<td>44.7 ± 2.3% in recovered patients (LVEF &gt; 50%), 29.7 ± 8.0% in non-recovered patients (LVEF &lt; 50%)</td>
<td>14/22</td>
<td>n/a</td>
<td>9.1%</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Wu et al. [27]</td>
<td>1997–2011 Taiwan</td>
<td>925</td>
<td>30.4 ± 5.7</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>Cardiac deaths: 3.3% overall mortality: 7.8% MACE: 7.0%</td>
<td>Heart catheterization: 8.1%; IABP: 0.8%; ECMO: 4.1%</td>
<td>Heart transplantation: 0.5% Cerebrovascular accident: 0.4% Myocardial infarction: 0.1% Rehospitalization due to HF: 3.6% Dialysis resumption: 0.2% At 12 months, out of 91 women: LVAD: 4 patients, of whom 2 died an 1 required heart transplantation</td>
</tr>
<tr>
<td>McNamara et al. [28]</td>
<td>2009–2013 USA</td>
<td>100</td>
<td>30 ± 6</td>
<td>LVEF: 0.35 ± 0.10% NYHA I: 12% NYHA II: 46% NYHA III: 25% NYHA IV: 17%</td>
<td>72%</td>
<td>n/a</td>
<td>4.4%</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Kothe et al. [29]</td>
<td>2004–2011 USA</td>
<td>34</td>
<td>30.3 ± 7.0</td>
<td>n/a</td>
<td>n/a</td>
<td>n/a</td>
<td>1.3% – inhospital mortality</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>Kamiya et al. [30]</td>
<td>2007–2008 Japan</td>
<td>102</td>
<td>32.7</td>
<td>31.6 ± 12.0%</td>
<td>63%</td>
<td>n/a</td>
<td>4%</td>
<td>LVAS (LVAD?): 2%</td>
<td>–</td>
</tr>
<tr>
<td>Pillarissetti et al. [31]</td>
<td>1999–2012 USA</td>
<td>100</td>
<td>30 ± 6.5</td>
<td>28 ± 9% NYHA I: 30% NYHA II: 17% NYHA III: 45 NYHA IV: 8%</td>
<td>42%</td>
<td>35 became pregnant again and 11 of them died</td>
<td>11%</td>
<td>VAD: 1%; ICD: 13%, including 2 CRT-D</td>
<td>–</td>
</tr>
</tbody>
</table>

PPCM — peripartum cardiomyopathy; LVEF — left ventricular ejection fraction; EF — ejection fraction; NYHA — New York Heart Association; n/a — not available; MACE — major adverse cardiac events; PM — pacemaker; ICD — implantable cardiac defibrillator; CRT — cardiac resynchronisation therapy; VAD — ventricular assist device; MCS — mechanical circulatory support; IABP — intra-aortic balloon pump; ECMO — extra-corporeal membrane oxygenation; ESC — European Society of Cardiology; HF — heart failure; LVAD — left ventricular assist device; ORTO — orthotic resynchronisation therapy with a defibrillator.
with restored left ventricular function, which remain stable after HF medication reduction, an annual follow-up visit is recommended for the next 10 years [22].

Prognosis

Although the clinical course of PPCM may vary considerably, the general prognosis of patients after normal treatment is good. About 50% of women have a full recovery (defined as LVEF > 55% and NYHA class I), while 35–40% improve (defined as an increase of LVEF by more than 10% and improvement of at least one NYHA class) [12]. Based on the literature, mortality varies between 2% in Germany and 12.6% in South Africa 1–6 months after delivery. The mortality rate between six and 12 months after childbirth ranges from 4% to 14%; for women of African descent it is 12–14%. Subsequently, in the range of 1–5 years, mortality in a population of 182 women in the United States was 7% at the time of the follow-up examination in the 19th month. For African-American patients, this rate was higher and in the second year of the study, the mortality rate was 28% in South Africa, 16% in the USA and 15% in Haiti. Between the second and the fifth year, these values varied significantly depending on the region, and ranged from 0–6%, in France and the United States, to 15–30% in China, Brazil, Turkey, South Africa and the Philippines. There is little data available for a prognosis of more than five years. In this period, mortality is 7–16% in India and 8.3% in Malaysia [8].

In addition, there have as yet been no publications on the long-term prognosis for patients after heart transplantation and with an implanted left ventricle assist device (LVAD). Table 4 summarises the most important information from work on PPCM [23–31].

Conclusions

In recent years, the awareness about PPCM has risen, and a growing interest was sparked by recent publications. Although data on the extent of disease prevalence in most parts of the world is lacking, and many issues remains unexplained, in recent years a number of findings have been made that have contributed to improved PPCM diagnosis and treatment. New biomarkers have been proposed, new underlying mechanisms contributing to its onset have been discovered, and bromocriptine treatment has been introduced. It has been documented that bromocriptine in PPCM therapy is beneficial, although more research is needed on the use of this medicine.
Streszczenie

Kardiomiopatię połogową (PPCM) definiuje się jako idiopatyczną kardiomiopatię, która występuje pod koniec ciąży lub w pierwszych kilku miesiącach po porodzie z objawami niewydolności serca (HF) wtórne do zaburzeń czynnościowej lewej komory i jednocześnie nie stwierdza się żadnej innej przyczyny tego stanu. Patomechanizm choroby nie został w pełni poznany, natomiast prawdopodobnie opiera się na działaniu złożonych czynników. Przebieg kliniczny PPCM jest zróżnicowany: od zagrożającej życiu ostrej HF po łagodne objawy naśladujące dolegliwości charakterystyczne dla okresu okołoporodowego. W Europie PPCM jest dość rzadką chorobą, natomiast są rejony, gdzie występuje z częstością 1/300 przypadków (Haiti). Leczenie PPCM jest podobne jak dla HF z obniżoną frakcją wyrzutową, jednak ważne jest wykluczenie leków o działaniu teratogennym w trakcie ciąży. Włączanie bromokryptyny do terapii PPCM wydaje się zasadne i w niektórych przypadkach poprawia rokowanie.

Słowa kluczowe: kardiomiopatia połogowa, PPCM, niewydolność serca, ciąża, bromokryptyna

References


