

The therapeutic dilemma of peripartum cardiomyopathy

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We have greatly enjoyed reading the recently published article by Aksu et al. [1] In this article, the authors described the management of a 25-year-old female patient with peripartum cardiomyopathy and the left ventricular thrombus. We want to congratulate the authors for the successful management of the patient; however, we have some concerns about the article and the therapy of the patient.

In the current article, the patient treated successfully in the acute phase of the disease and the left ventricular function was recovered. Although the patient had complete resolution of the ventricular thrombus in the 1st month, with normalized cardiac function, the authors decided to provide lifelong anticoagulation. The authors stated that nearly 50% of cases, peripartum cardiomyopathy coexists with ventricular thrombus.

Patients with peripartum cardiomyopathy are at high risk for thrombus formation and thromboembolism due to both the hypercoagulable state of pregnancy and stasis of blood due to severe left ventricular dysfunction. However, the incidence of ventricular thrombus is not as high as 50%.

In a prospective study of 42 peripartum cardiomyopathy patients, we have detected the left ventricular thrombus in 4 patients (9.5%) [2]. To the best of our knowledge, in women with peripartum cardiomyopathy, the left ventricular thrombus is detected in up to 17% of patients, in whom the risk of systemic embolization is high [3].

Peripartum cardiomyopathy patients with persistent left ventricular dysfunction should be continued on standard heart failure treatment indefinitely. In those patients who demonstrate persistent normal left ventricular function for a period of at least 6 months, we suggest stepwise weaning of the heart failure regimen with close clinical follow-up and with echocardiographic monitoring to ensure stability of the left ventricular function during and for at least 2 years after weaning of heart failure medications to ensure stability. There is no consensus as to how long to continue anticoagulation after delivery in patients with peripartum cardiomyopathy. Some argue that, as the procoagulant effects of pregnancy are low after 6 weeks, anticoagulation should be stopped. Others continue until 6 months or until substantial recovery in cardiac function is seen.



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We suggest that anticoagulation therapy should be continued until the left ventricular function has improved [4]. While the current guidelines do not prescribe a defined duration of anticoagulation therapy, we think that anticoagulation therapy should be stopped after resolution of thrombus and full recovery of the left ventricular function. However, it is imperative that if heart failure therapies are withdrawn, the patient should be followed clinically and by echocardiography to ensure stability.

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