PERIPARTUM CARDIOMYOPATHY-A

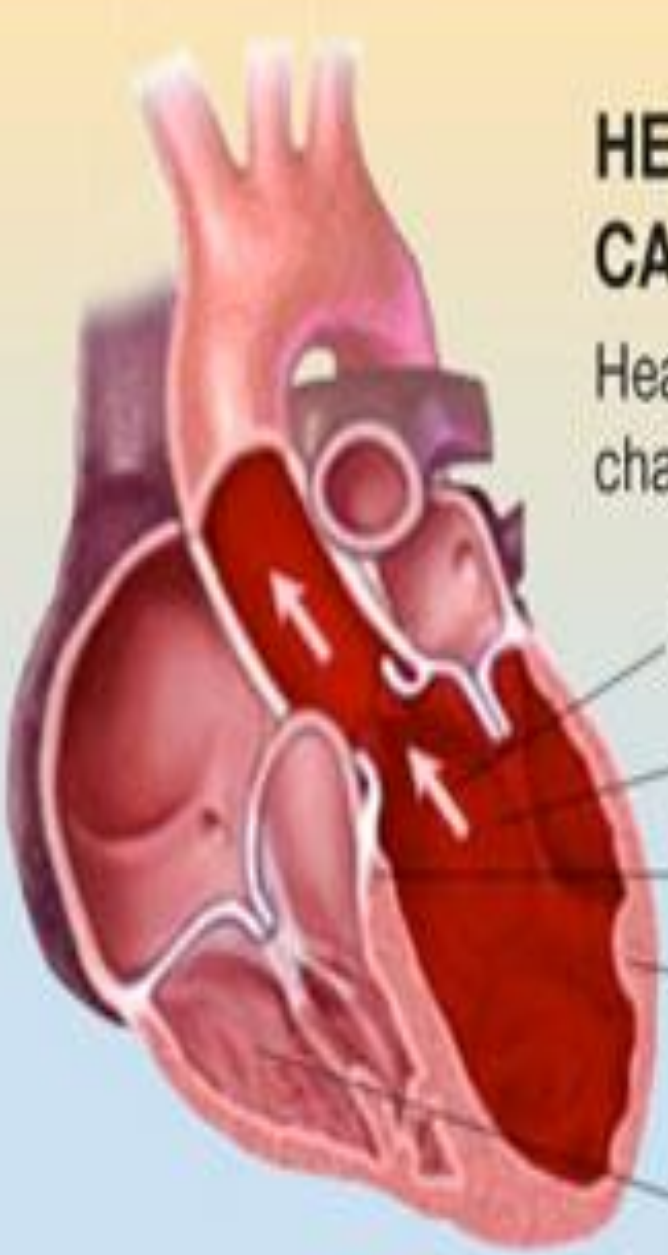
- Clinical presentation
- Defining PPCM
- Etiopathogenesis
- Management
- Prognosis

NORMAL HEART

Chambers relax and fill, then contract and pump.

HEART WITH DILATED CARDIOMYOPATHY

Heart muscle weakens and chambers enlarge.



First described in the 18th century but recognized as a separate clinical entity in 1930 and 1971. Demakis *et al*. described criteria for the diagnosis of PPCM.

Four criteria; 3 clinical and one Echo

Diagnostic criteria for PPCM
Heart failure within the last month of pregnancy or six month postpartum
Absence of prior heart disease
No determinable cause
Echocardiographic evidence of left ventricular dysfunction:
LVEF < 45%
LVFS < 30%
LVEDD < 2.7 cm/m^2 body surface area

In 2010, the European Society of Cardiology Working Group considered modification might be necessary.

Hibbard et al., 1999	**NHLBI definition and a strict ecocardiographic criterion of left ventricular (LV) dysfunction**: 1. ejection fraction < 45% or fractional shortening < 30% 2. end-diastolic dimension > 2.7cm/m^2
American Heart Association [AHA] Scientific Statement on contemporary definitions and classifications of the cardiomyopathies (Maron et al., 2006)	A rare and dilated acquired primary cardiomyopathy associated with LV dysfunction and heart failure
European Society of Cardiology [ESC] on the classification of cardiomyopathies (Dickstein et al., 2008)	A non-familial, non-genetic form of dilated cardiomyopathy associated with pregnancy
Heart Failure Association of the ESC Working Group on PPCM (Sliwa et al., 2010a)	An idiopathic cardiomyopathy presenting with heart failure secondary to LV systolic dysfunction towards the end of pregnancy or in the months following delivery, where no other cause of heart failure is found. It is a diagnosis of exclusion. The LV may not be dilated but the ejection fraction is nearly always reduced below 45%

SUMMARY OF PROPOSED PATHOGENIC MECHANISMS FOR PPCM