Cardiomyopathie du péri-partum

Groupe USIC – Cœur de Femme

Dr Sabrina UHRY
Haguenau

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DÉCLARATION DE LIENS D'INTÉRÊT POTENTIELS

Intervenant : Sabrina UHRY, Haguenau

- [x] Je n'ai pas de lien d'intérêt potentiel à déclarer

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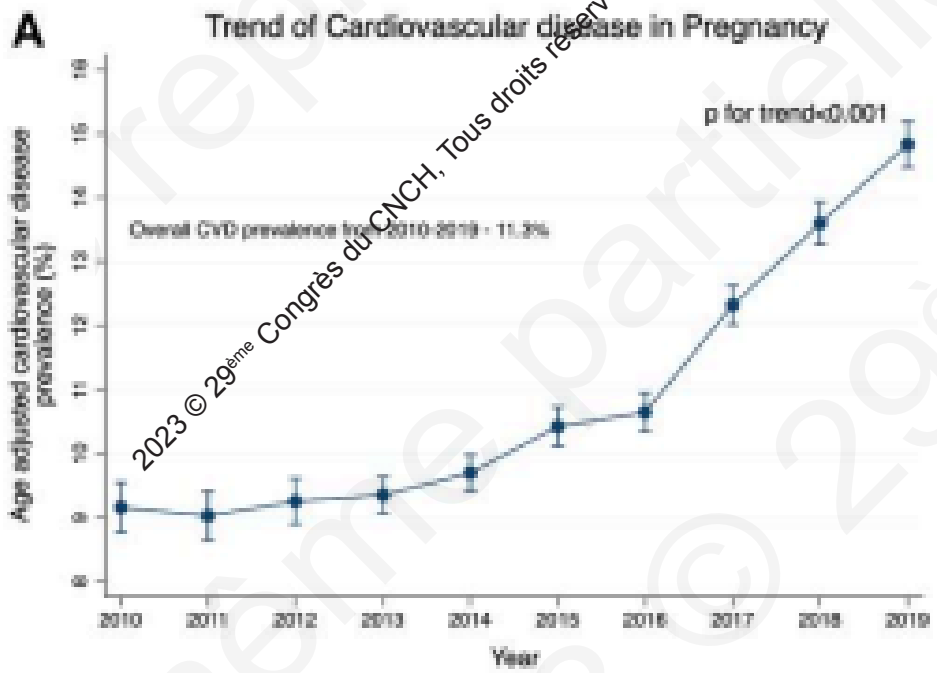
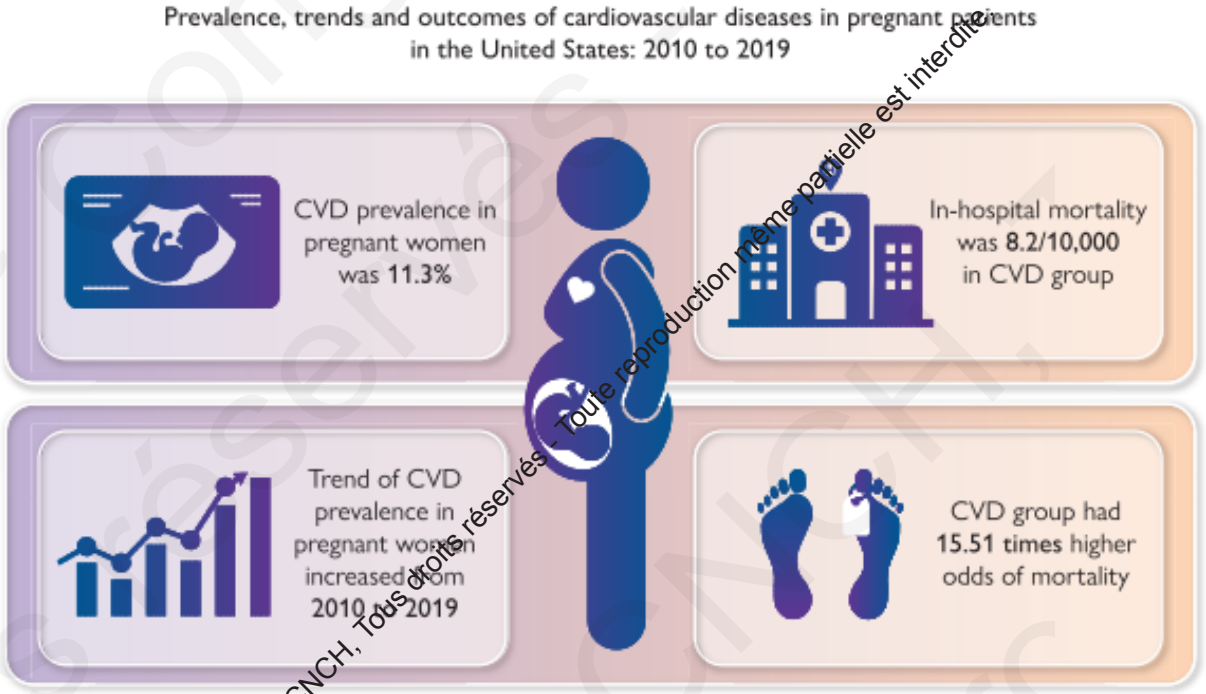
Introduction





Majmundar M et al. Eur Heart J 2023

Maternal, Newborn and Infant Clinical Outcome Review Programme

MBRRACE-UK
Mothers and Babies: Reducing Risk through Audits and Confidential Enquiries across the UK

Généralités

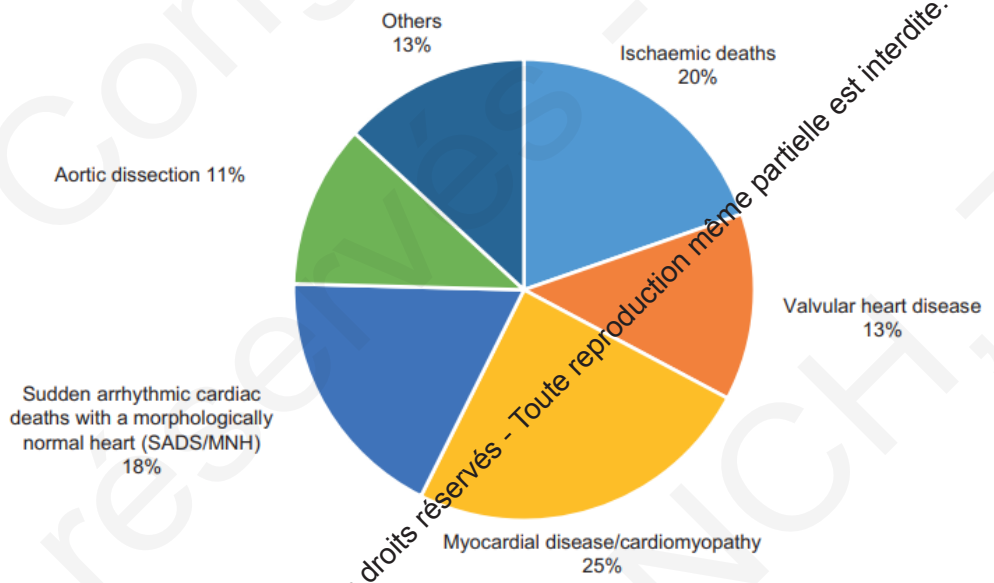
Saving Lives, Improving Mothers' Care

Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20

Compiled report including supplementary material

November 2022

Figure 5.2: Causes of cardiovascular deaths, UK and Ireland 2018-20



Définition

Definition of peripartum cardiomyopathy

1. Heart failure secondary to left ventricular systolic dysfuntion with a LVEF < 45%
2. Occurrence towards the end of pregnancy or in the months following delivery (mostly in the month following delivery)
3. No other identifiable cause of heart failure

ESC European Society of Cardiology

European Journal of Heart Failure (2019) 21, 827–843
doi:10.1002/ejhf.1493

POSITION PAPER

Pathophysiology, diagnosis and management of peripartum cardiomyopathy: a position statement from the Heart Failure Association of the European Society of Cardiology Study Group on peripartum cardiomyopathy

Johann Bauersachs[1]*, Tobias König[1], Peter van der Meer[2], Mark C. Petrie[3], Denise Hilfiker-Kleiner[1], Amanda Mbakwem[4], Righab Hamdan[5], Alice M. Jackson[3], Paul Forsyth[3], Rudolf A. de Boer[2], Christian Mueller[6], Alexander R. Lyon[7], Lars H. Lund[8], Massimo F. Piepoli[9], Stephane Heymans[10,11,12], Ovidiu Chioncel[13], Stefan D. Anker[14], Piotr Ponikowski[15], Petar M. Seferovic[16], Mark R. Johnson[17], Alexandre Mebazaa[18], and Karen Sliwa[19]

Epidémiologie

Table 1 | Worldwide variation in incidence of peripartum cardiomyopathy

Country/ Region	Incidence (per live births)	Reference	Data source
Nigeria	1/102	Isezuo et al[18]	Usmanu Danfodiyo University Teaching Hospital, Sokoto, Nigeria
Haiti	≈1/300	Fett et al[19]	Hospital Albert Schweitzer PPCM Registry
China	1/346	Huang et al[20]	Liaocheng People's Hospital, Shandong Province, China
United States	1/968	Kolte et al[21]	US Nationwide Inpatient Sample
South Africa	1/1000	Desai et al[21]	King Edward VIII Hospital, Durban, South Africa
California, US	1/2066	Gunderson et al[11]	Kaiser Permanente Northern California hospitals
Malaysia	1/2941	Chee et al[22]	University Malaya Medical Centre
Sweden	1/5719*	Barasa et al[23]	National Inpatient, Cause of Death, and Medical Birth Registries
Denmark	1/10 149	Ersbøll et al[24]	Danish National Birth and Patient Registers
Japan	≈1 in 20 000	Kamiya et al[25]	Japanese Nationwide Survey of Peripartum Cardiomyopathy

*Heart failure in late pregnancy and the postpartum period.

Pathologie rare

Honigberg MC et al. BMJ 2019

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Facteurs prédisposants

Clinical Features Associated with Peripartum Cardiomyopathy Compared with Non-Peripartum Cardiomyopathy Delivering Mothers

	Univariate		Multivariate	
	OR (95% CI)	p-value	OR (95% CI)	p-value
Age				
< 18	1.30 (0.74-2.15)	0.31	0.82 (0.37-1.56)	0.58
18-29	Reference	-	Reference	-
30-39	1.63 (1.45-1.97)	< 0.0001	1.82 (1.48-2.24)	< 0.0001
40-49	2.23 (1.49-3.23)	< 0.0001	1.71 (1.09-2.58)	0.01
Race				
Caucasian	Reference	-	Reference	-
African-American	2.67 (2.09-3.40)	< 0.0001	1.79 (1.37-2.31)	< 0.0001
Hispanic	0.86 (0.68-1.08)	0.20	1.00 (0.78-1.28)	0.99
Other	0.72 (0.50-1.01)	0.07	0.77 (0.53-1.11)	0.19
Comorbid conditions				
Diabetes mellitus	3.52 (1.97-5.75)	< 0.0001	1.42 (0.73-2.49)	0.26
Hypertension	13.1 (11.0-15.5)	< 0.0001	6.41 (4.81-8.44)	< 0.0001
Tobacco use	3.01 (2.08-4.21)	< 0.0001	1.43 (0.89-2.22)	0.12
Anemia	7.60 (6.34-9.07)	< 0.0001	4.89 (3.95-6.03)	< 0.0001
Substance abuse	6.56 (4.62-9.03)	< 0.0001	4.12 (2.71-6.04)	< 0.0001
Asthma	3.90 (2.82-5.26)	< 0.0001	2.23 (1.53-3.15)	< 0.0001
Obesity	5.29 (3.56-7.54)	< 0.0001	1.42 (0.84-2.24)	0.16
Autoimmune disease	5.45 (2.16-11.1)	< 0.0001	3.61 (1.42-7.43)	0.002
Pregnancy characteristics				
Multiple gestation	6.74 (5.10-8.74)	< 0.0001	2.88 (2.07-3.8[illegible])	< 0.0001
Preeclampsia	13.60 (11.3-16.4)	< 0.0001	1.99 (1.[illegible]2.69)	< 0.0001
Eclampsia	27.90 (14.4-48.2)	< 0.0001	5.[illegible] (2.88-10.9)	< 0.0001

Kao DP et al. JACC Heart Fail 2013

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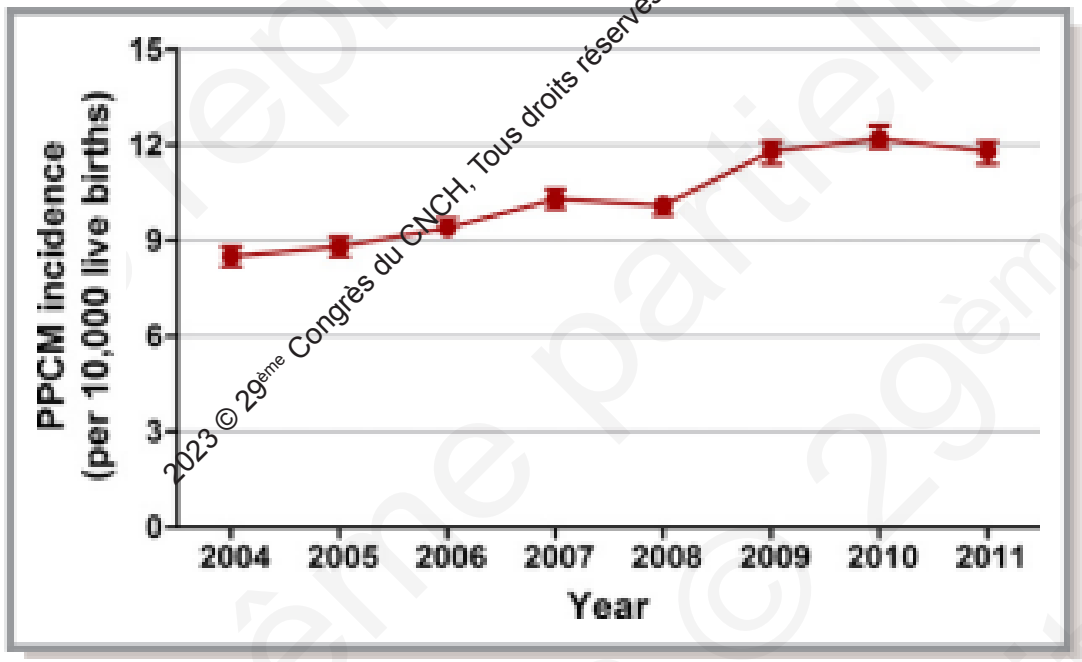
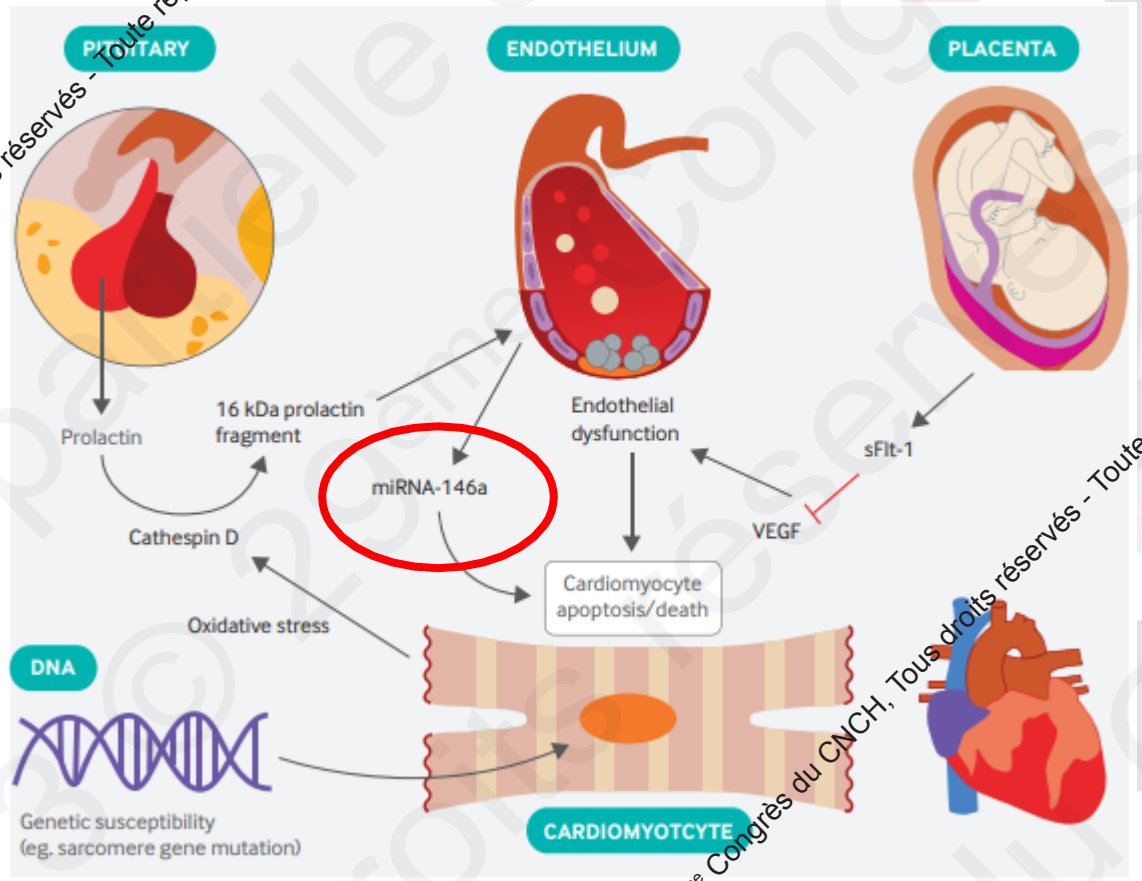
Incidence augmente



- ↗ âge maternel
- ↗ diagnostic
- ↗ grossesses multiples
- ↗ pré-éclampsie
- ↗ comorbidités (HTA, obésité, diabète)

Kolte D et al. JAHA 2014

Physiopathologie



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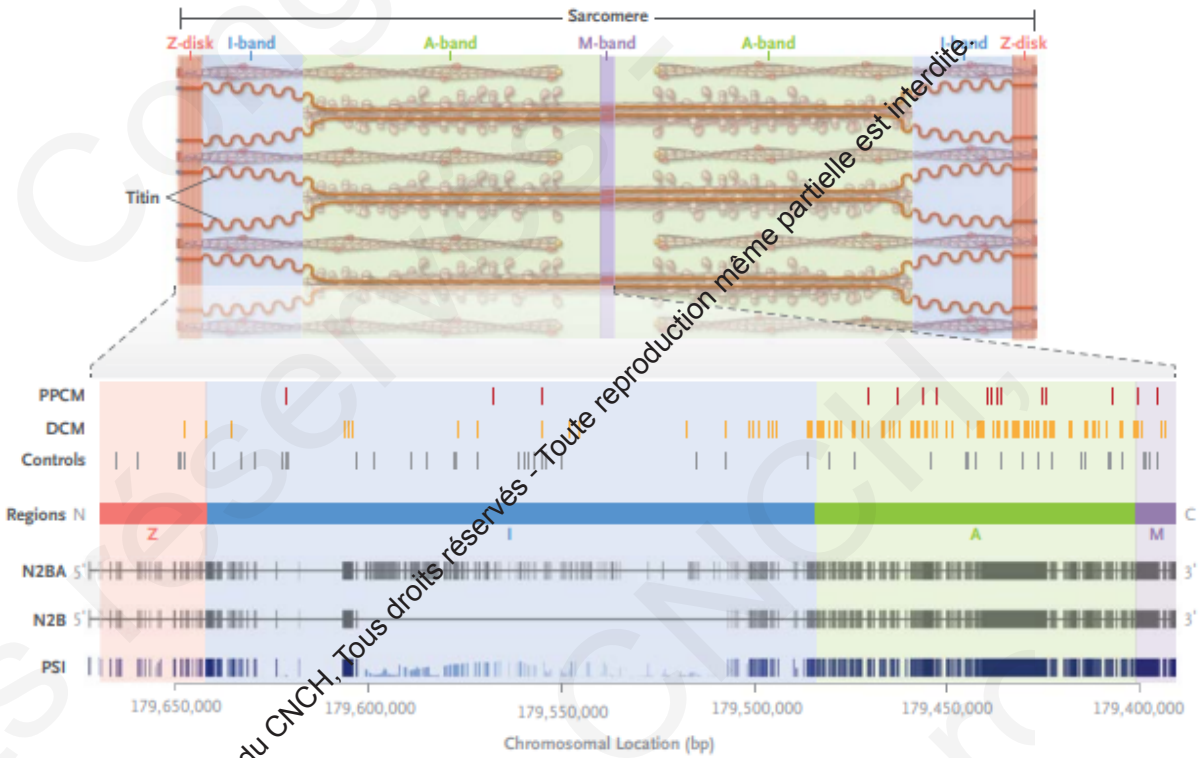
Honigberg MC et al. BMJ 2019

Prédisposition génétique

- Registre CMPP : 15% histoire familiale
- Etudes génétiques : 15% ont variants tronqués dans gènes CMD; 2/3 dans TTN



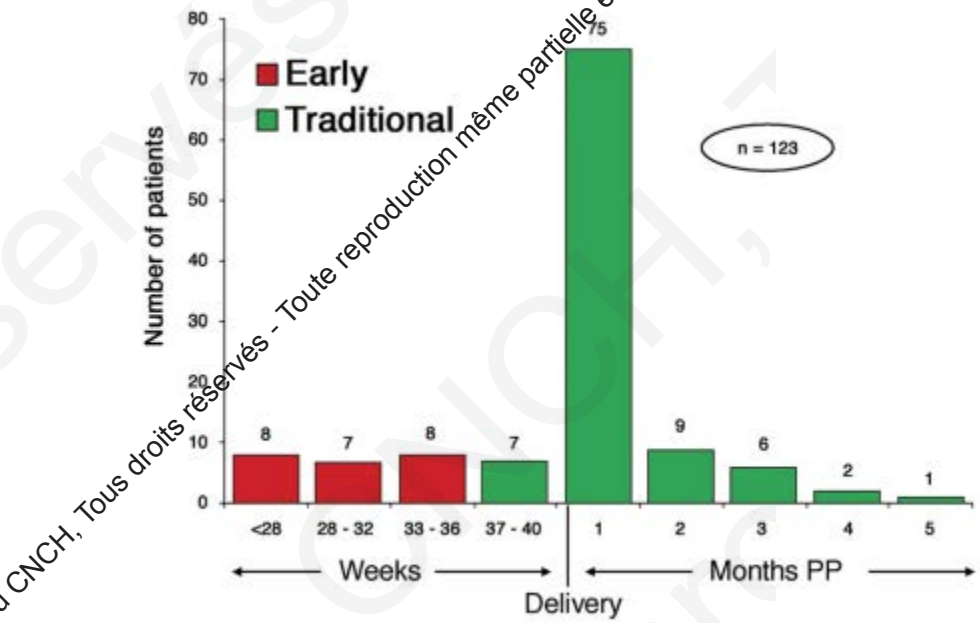
Genetic counselling and testing should be considered in patients with peripartum cardiomyopathy. | IIa | C

ESC European Society of Cardiology
European Heart Journal (2023) 44, 3503–3626
https://doi.org/10.1093/eurheartj/ehad194
ESC GUIDELINES

Ware JS. NEJM 2016

Mode de présentation

- Insuffisance cardiaque gauche → Choc cardiogénique
- Mort subite
- Tachycardie ventriculaire
- Complication thrombo-embolique : AVC, IDM
- 1er mois post-partum typiquement



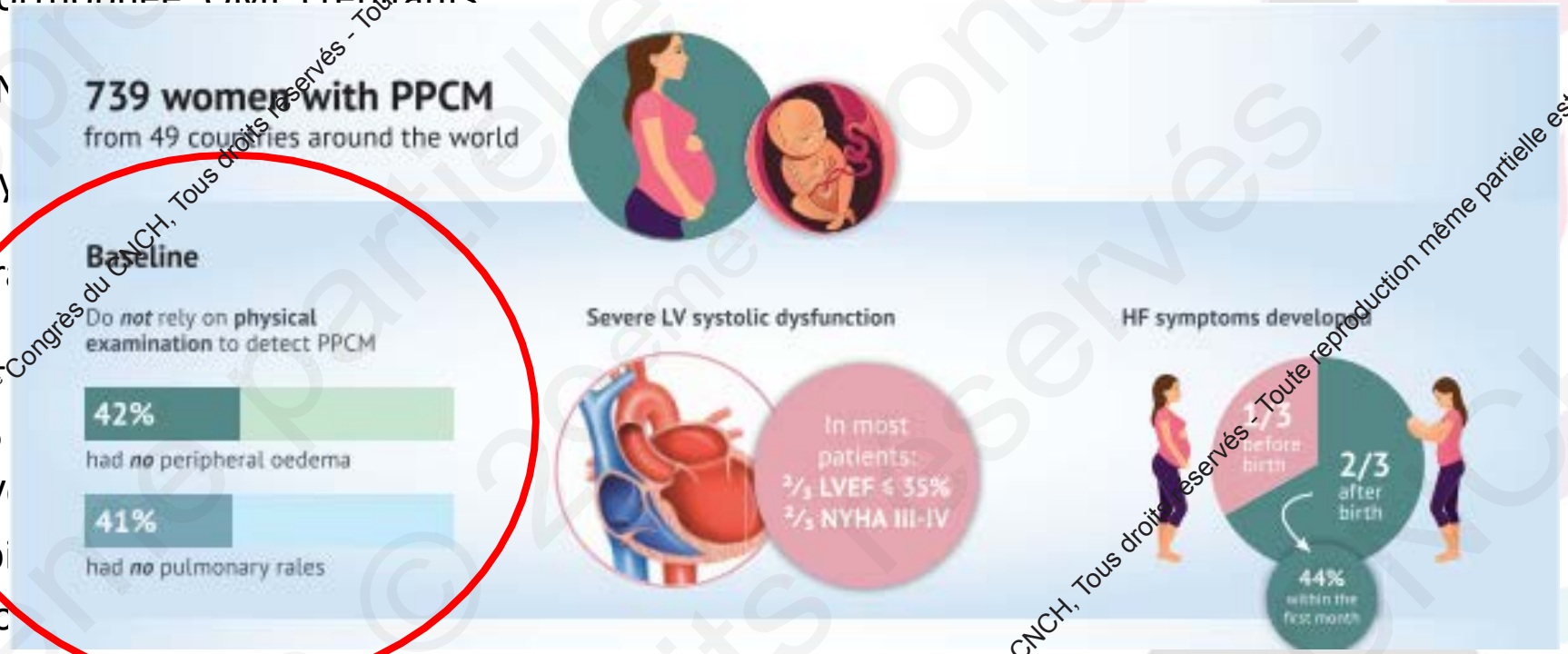
Time of Diagnosis of PPCM in 123 Patients

Elkayam U. JACC 2011

Diagnostic

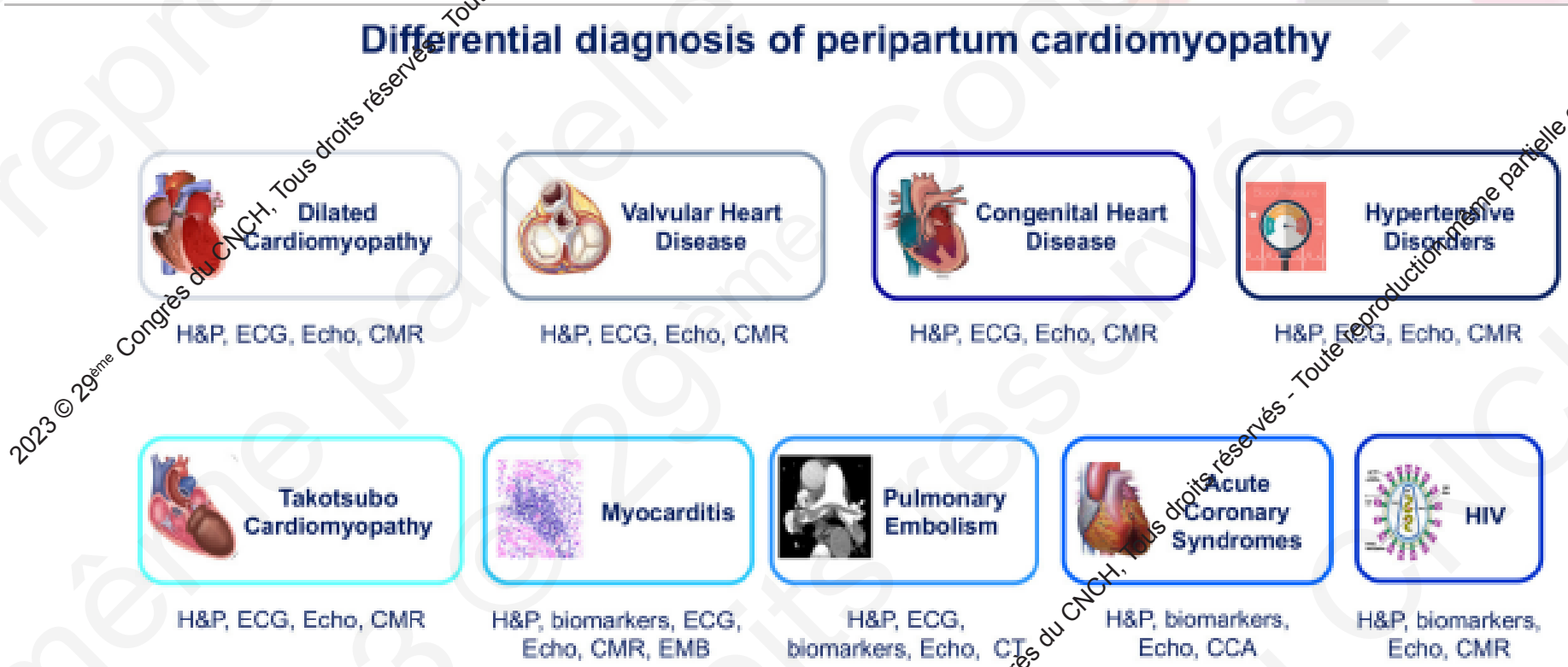
- Clinique : orthopnée, OMI, crépitants
- Biologie : N
- ECG : tachy
- Radio thor
- ETT : Rôle-

- FEVG < 45%
- Dilatation V
- Dilatation bi
- Régurgitatic
- Hypertension pulmonaire
- Thrombus intra-cardiaque



Sliwa K et al. Eur Heart J 2020

Diagnostic d'élimination



Ricci F et al. Frontiers in Cardiovascular Medicine 2020

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Traitement

Figure 1 The BOARD therapies for acute peripartum cardiomyopathy (PPCM). The treatment of PPCM, should consists of Bromocriptine, Oral heart failure therapies, Anticoagulation, vasoRelaxing agents, and Diuretics. Non-invasive ventilation should be added in patients with pulmonary congestion.

Arrigo M et al. Eur Heart J 2017

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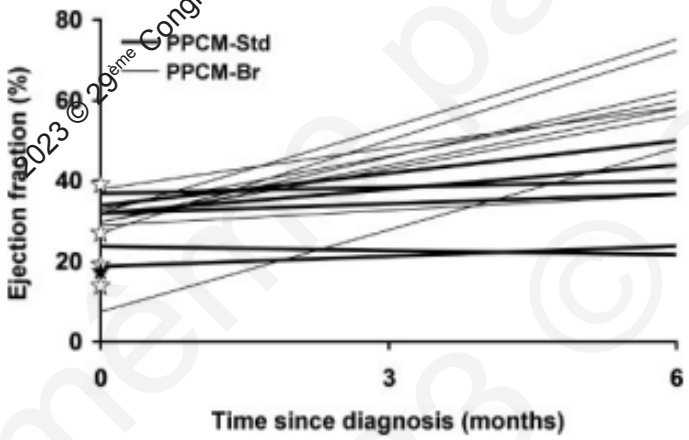
Médicaments , grossesse et allaitement

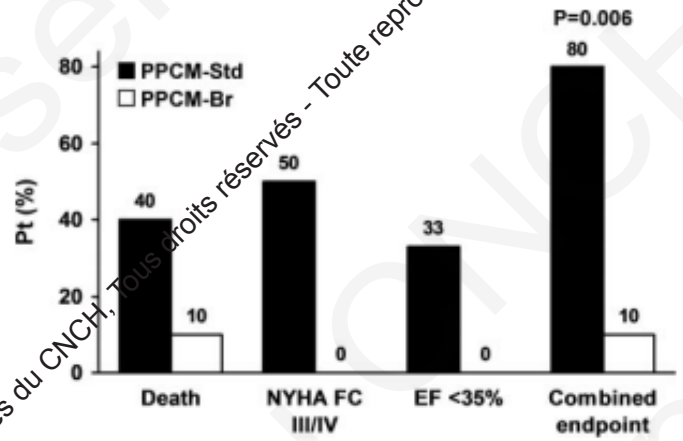
Drug	Use during pregnancy	Potential adverse effects	Use during lactation†
Loop diuretics	Compatible (most experience with furosemide)	Maternal hypovolemia and hypotension, resulting in uterine hypoperfusion	Compatible (overdiuresis may decrease breast milk production)
β blockers	Compatible	Fetal bradycardia, fetal hypoglycemia	Compatible
ACE inhibitors and ARBs	Incompatible	Renal agenesis, oligohydramnios, malformations, fetal demise	Compatible (captopril, enalapril, quinapril, benazepril)
Mineralocorticoid receptor antagonists	Incompatible	Undervirilization of the fetus	Compatible
Sacubitril-valsartan	Incompatible	Same as ACE inhibitors/ARBs	Unknown (lack of data)
Hydralazine/nitrates	Compatible	Maternal hypotension, resulting in uterine hypoperfusion	Compatible
Ivabradine	Not recommended (worrying results in animal studies, no studies in humans)	Unknown	Unknown (lack of data)
Digoxin	Compatible	Low birth weight	Compatible

Honigberg MC, Givertz MM. BMJ 2019

Bromocriptine

	PPCM-Br Baseline (n=10)*	PPCM-Br 6 Months (n=9)*	PPCM-Std Baseline (n=10)*	PPCM-Std 6 Months (n=6)*	P†
Echocardiographic parameters					
LVEDD, mm	55±10	51±9	59±5	56±12	0.50
LVESD, mm	46±9	34±10	52±6	45±11	0.18
LVEF, %	27±8	58±11	27±8	36±10	0.0007





Sliwa K. Circulation 2010

Bromocriptine

In patients with PPCM, bromocriptine treatment may be considered to stop lactation and enhance recovery (LV function).	IIb	B

- 2,5 mg /j pendant minimum 1 semaine si CMPP non compliquée
- 2,5 mg x2 /j pendant 2 semaines puis 2,5 mg/ j pendant 6 semaines si FEVG ≤ 25% et/ou choc cardiogénique (recos ESC 2018)
- + anticoagulation systématique (HNF ou HBPM)

Bromocriptine treatment should be accompanied by prophylactic (or therapeutic) anticoagulation.	IIa	C

Regitz-Zagrosek V al. Eur Heart J 2018

Débat sur la bromocriptine

- <u>Pour :</u>

- modèle murin
- Étude pilote sur 20 femmes
- études, avec limites

→ recommandation IIb ESC 2018

→ Pas en routine, preuve supplémentaire nécessaire (AHA, CCS)

- <u>Contre :</u>

- complications thrombotiques :

AVC, thrombus intra-VG, IDM

- impossibilité d'allaiter :

Accès eau potable nécessaire et coût financier

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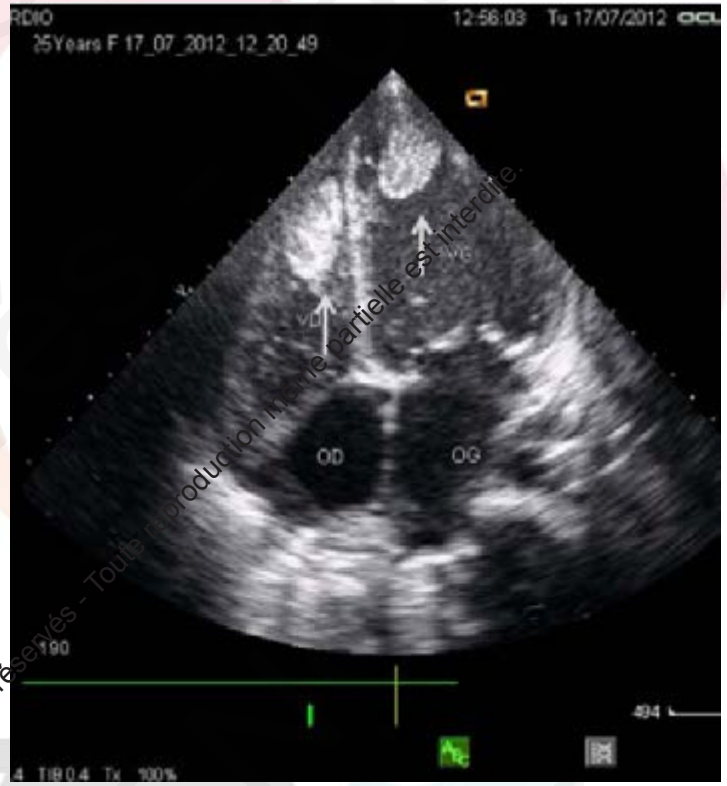
Anticoagulation

- <u>CMPP est associée à des taux plus élevés de thrombo-embolisme que les autres formes d'IC :</u>

- Etat hypercoagulable durant le péripartum
- Dilatation cardiaque, dysfonction endothéliale et immobilité
- Thrombo-embolisme complication la plus fréquente 6-7%

- <u>Recommandations ESC :</u>

- si FEVG très altérée, dose prophylactique
- en association avec bromocriptine
- indications standard : FA, thrombus intra-VG, embolie



Yaméogo NV et al. Journal of Cardiology 2017

Anticoagulants

Drug	Use during pregnancy	Potential adverse effects	Use during lactation†
Heparin (unfractionated and low molecular weight)	Compatible	Does not cross placenta	Compatible
Warfarin	Avoid if possible owing to teratogenicity	Warfarin embryopathy (skeletal deformities), intracranial hemorrhage, spontaneous abortion, stillbirth	Compatible
Direct-acting oral anticoagulants (eg, rivaroxaban, apixaban, edoxaban, dabigatran)	Incompatible	Limited data suggest possible malformations, growth restriction	Currently discouraged owing to lack of data

Honigberg MC, Givertz MM. BMJ 2019

Complications rythmiques

- Cardioversion et défibrillation sont considérées sûres tout au long de la grossesse
- Sans délai en urgence
- Monitorage fœtal peut être considéré dans situations non urgentes
- Recos AHA : considérée port de gilet défibrillateur pour CMPP avec FEVG $\leq$ 35% comme « bridge » jusqu'à la récupération VG ou implantation DAI 3 à 6 mois plus tard (niveau de preuve B)

Assistances cardiaques et transplantation

- Inotropes, BCPIA, assistance VG ou biV, ECMO doivent être utilisés si altération sévère FEVG et choc cardiogénique
- Traitement agressif recommandé car taux récupération sont élevés
- Assistances cardiaques peuvent être utilisées comme bridge à la transplantation

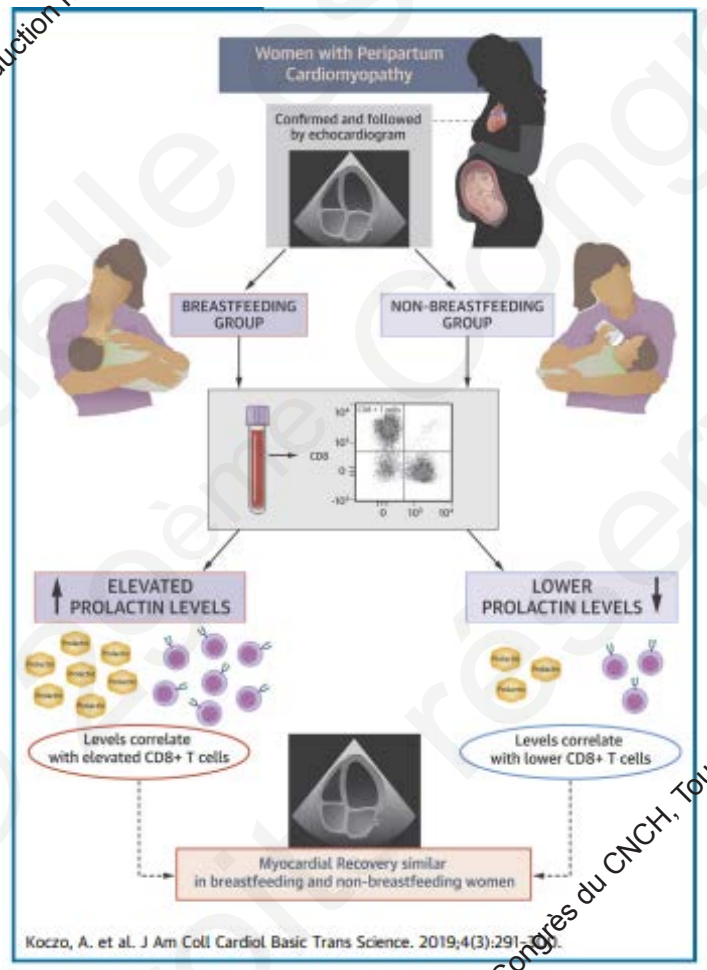
Allaitement ?

- Non :

- rôle de la prolactine dans la physiopathologie

- Travail cardiaque augmenté ?

- médicaments (mais beaucoup peuvent être utilisés)



- OUI :

- Pas de preuve d'un moins bon pronostic

- augmente survie chez enfants dans pays en voie de développement

- bénéfices cardiovasculaires maternels : ↘ diabète, cancers sein et ovaires, dépression post-partum, maladies cardio-vasculaires

Due to the high metabolic demands of lactation and breastfeeding, preventing lactation may be considered in patients with severe HF.[24]	IIb	B

Contraception

- AHA 2016 : si CMPP et pas récup FEVG, CI grossesse (niveau de preuve B)
- Risque thrombo-embolique majoré : éviter oestrogènes
- Implants SC Progestérone ou DIU levonorgestrel Mirena ou DIU cuivre recommandés

Mortalité

Table 3 | Evolution of reported mortality in peripartum cardiomyopathy*

Author	Sample	Mortality	Year of publication
Demakis et al[9]	Single center series of 27 women with PPCM in Illinois, USA	48% at 7.6 years	1971
Burch et al[20]	Single center series of 34 women with PPCM in Louisiana, USA	35% at 5 years	1971
O'Connell et al[21]	Single center series of 14 women with PPCM in Illinois, USA	43% at 6 weeks	1986
Mitlin et al[4]	Single center series of 28 women with PPCM in Tennessee, USA	18% at ~4 years	199[illegible]
Elkayam et al[3]	100 women with PPCM identified by survey of ACC members	9% at 2 years	2005
Harper et al[73]	Women who delivered in North Carolina, USA (85 cases in 235 599 live births)	16.5% at 7 years	2012
Haghikia et al[82]	German PPCM registry (115 women with PPCM)	2% at 6 months	2013
Kolte et al[12]	US Nationwide Inpatient Sample (34 219 women with PPCM identified)	1.3% in-hospital mortality	2014
McNamara et al[76]	Investigations in Pregnancy-Associated Cardiomyopathy cohort (100 women in North America with PPCM)	4% at 12 months	2015

*Abbreviations: ACC=American College of Cardiology; PPCM=peripartum cardiomyopathy.

Honigberg MC, Givertz MM. BMJ 2019

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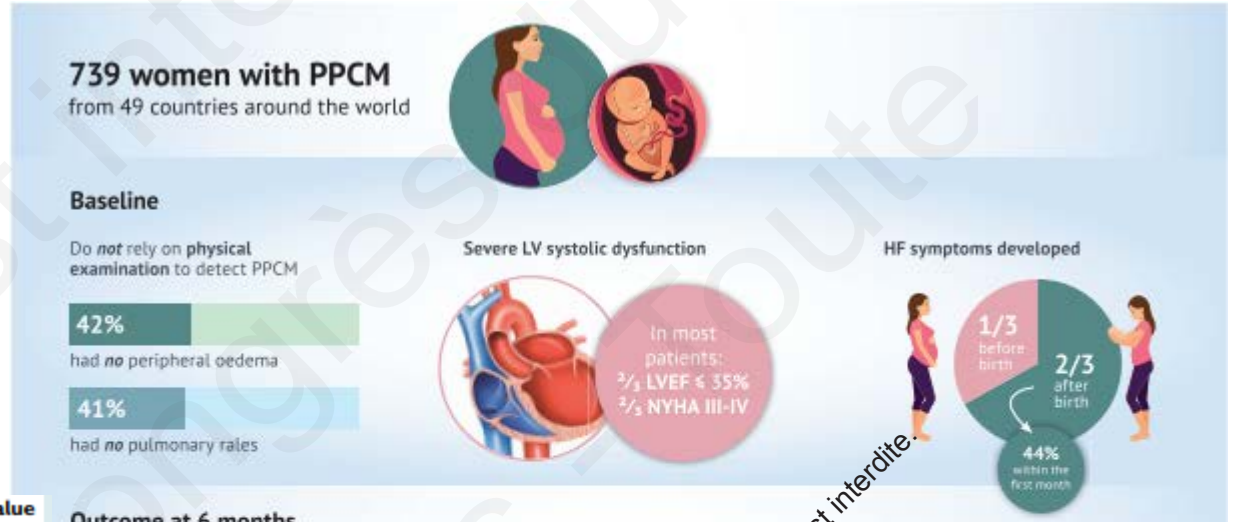
Pronostic

N (%)	All	Europe	Africa	Asia-Pacific	Middle East	P-value
In-hospital devices						
Assist device	17 (3)	12 (7)	0 (0)	5 (6)	0 (0)	<0.001
Implantable cardioverter-defibrillator	5 (0.9)	4 (2)	0 (0)	0 (0)	1 (0.7)	0.101
Cardiac resynchronization therapy	2 (0.4)	1 (0.6)	0 (0)	0 (0)	1 (0.7)	0.833
Death						
In-hospital						
All-cause	16 (2)	7 (3)	1 (0.5)	1 (0.9)	7 (4)	0.046
Heart failure	9 (56)	4 (57)	0 (0)	1 (100)	4 (57)	1.000
Sudden	4 (25)	1 (14)	1 (100)	0 (0)	2 (29)	0.484
Stroke	3 (19)	2 (29)	0 (0)	0 (0)	1 (14)	1.000
6 months						
All-cause	35 (6)	8 (4)	8 (5)	8 (8)	11 (10)	0.082
Heart failure	14 (42)	5 (63)	0 (0)	2 (33)	7 (64)	0.018
Sudden	10 (30)	1 (13)	2 (25)	4 (67)	3 (27)	0.204
Stroke	5 (15)	2 (25)	2 (25)	0 (0)	1 (9)	0.520
Presumed cardiovascular	4 (12)	0 (0)	4 (50)	0 (0)	0 (0)	0.004
Re-hospitalization at 6 months						
All-cause	58 (10)	24 (12)	18 (10)	7 (7)	9 (9)	0.667
Heart failure	30 (53)	9 (39)	11 (61)	3 (43)	7 (78)	0.220
Other cardiac	13 (23)	10 (43)	1 (6)	1 (14)	1 (11)	0.025
Vascular	5 (9)	1 (4)	4 (22)	0 (0)	0 (0)	0.191
Non-cardiovascular	11 (19)	4 (17)	3 (17)	3 (43)	1 (11)	0.441

Sliwa K et al. Eur Heart J 2020



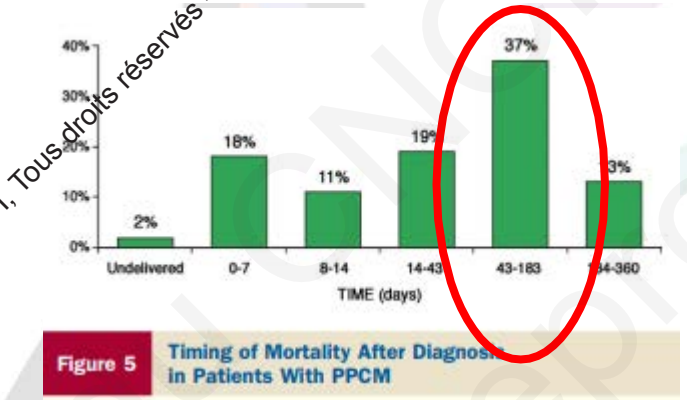
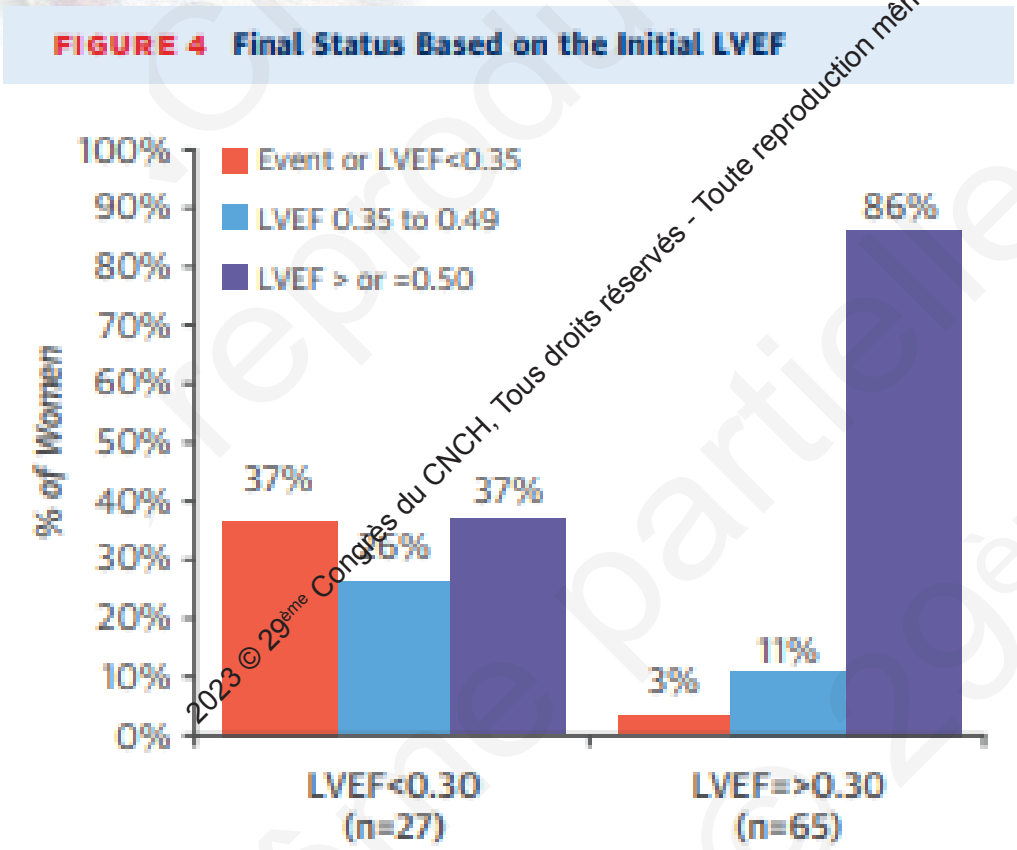
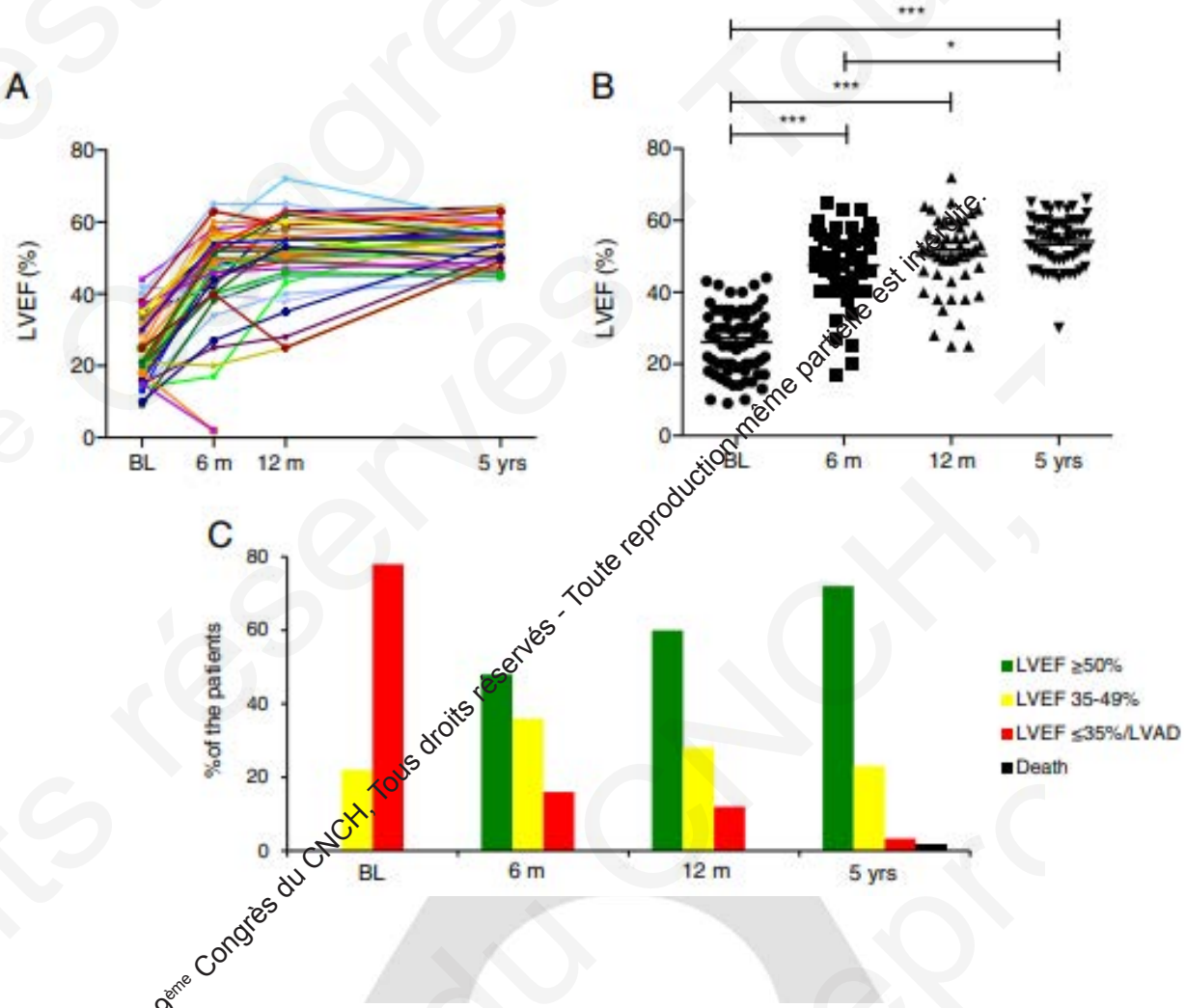


Figure 5 Timing of Mortality After Diagnosis in Patients With PPCM

Elkayam U. JACC 2011

Récupération FEVG





- 72% récupèrent une FEVG ≥ 50% à 1 an
- Récupération dépend de la FEVG initiale

McNamara DM et al. JACC 2015

Moulig V et al. Eur J of Heart Failure 2019

Traitement après récupération FEVG

Long-term Outcomes

- After recovery, optimal duration of medication treatment is unknown
- In the case of stopping medications, wean gradually and observe closely
- Continue surveillance after recovery

Davis, M.B. et al. J Am Coll Cardiol. 2020;75(2):207-21.

Guérison ou rémission ?

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Grossesse ultérieure ?

ESC European Society of Cardiology
European Heart Journal (2018) **39**, 3165–3241
doi:10.1093/eurheartj/ehy340

ESC GUIDELINES

2018 ESC Guidelines for the management of cardiovascular diseases during pregnancy

The Task Force for the Management of Cardiovascular Diseases during Pregnancy of the European Society of Cardiology (ESC)

Consultation pré-conceptionnelle multidisciplinaire

Table 3 Modified World Health Organization classification of maternal cardiovascular risk

	mWHO I	mWHO II	mWHO II–III	mWHO III	mWHO IV
Diagnosis (if otherwise well and uncomplicated)	Small or mild – pulmonary stenosis – patent ductus arteriosus – mitral valve prolapse Successfully repaired simple lesions (atrial or ventricular septal defect, patent ductus arteriosus, anomalous pulmonary venous drainage)	Unoperated atrial or ventricular septal defect Repaired tetralogy of Fallot Most arrhythmias (supraventricular arrhythmias) Turner syndrome without aortic	Mild left ventricular impairment (EF >45%) Hypertrophic cardiomyopathy Native or tissue valve disease not considered WHO I or IV (mild mitral stenosis, moderate aortic stenosis) Marfan or other HTAD syndrome without aortic	Moderate left ventricular impairment (EF 30–45%) Previous peripartum cardiomyopathy without any residual left ventricular impairment Mechanical valve Systemic right ventricle with good to mildly decreased ventricular function Fontan circulation.	Pulmonary arterial hypertension Severe systemic ventricular dysfunction (EF <30% or NYHA class III–IV) Previous peripartum cardiomyopathy with any residual left ventricular impairment Severe mitral stenosis
Risk	No detectable increased risk of maternal mortality and no/mild increased risk in morbidity	Small increased risk of maternal mortality or moderate increase in morbidity	Intermediate increased risk of maternal mortality or moderate to severe increase in morbidity	Significantly increased risk of maternal mortality or severe morbidity	Extremely high risk of maternal mortality or severe morbidity
Maternal cardiac event rate	2.5–5%	5.7–10.5%	10–19%	19–27%	40–100%
Counselling	Yes	Yes	Yes	Yes: expert counselling required	Yes: pregnancy contraindicated: if pregnancy occurs, termination should be discussed
Care during pregnancy	Local hospital	Local hospital	Referral hospital	Expert centre for pregnancy and cardiac disease	Expert centre for pregnancy and cardiac disease
Minimal follow-up visits during pregnancy	Once or twice	Once per trimester	Bimonthly	Monthly or bimonthly	Monthly
Location of delivery	Local hospital	Local hospital	Referral hospital	Expert centre for pregnancy and cardiac disease	Expert centre for pregnancy and cardiac disease

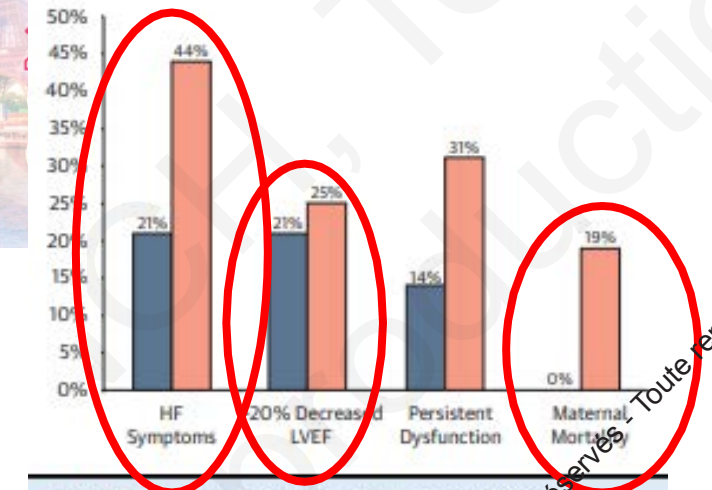


FIGURE 2 Maternal Complications Associated With Subsequent Pregnancy in 44 Patients With a History of Peripartum Cardiomyopathy

Slate bars are group 1, women with left ventricular ejection fraction (LVEF) ≥ 50% before subsequent pregnancy. **Salmon bars** are group 2, women with LVEF <50% before subsequent pregnancy. HF = heart failure. Reprinted with permission from Elkayam et al. (10).

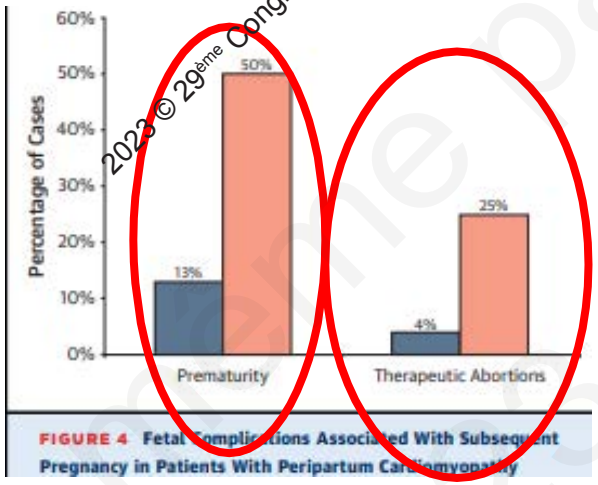


FIGURE 4 Fetal Complications Associated With Subsequent Pregnancy in Patients With Peripartum Cardiomyopathy

Yaméogo et al. BMC Cardiovascular Disorders (2018) 18:119
https://doi.org/10.1186/s12872-018-0856-7

BMC Cardiovascular Disorders

RESEARCH ARTICLE Open Access

Maternal and fetal prognosis of subsequent pregnancy in black African women with peripartum cardiomyopathy

48,3% mortalité !

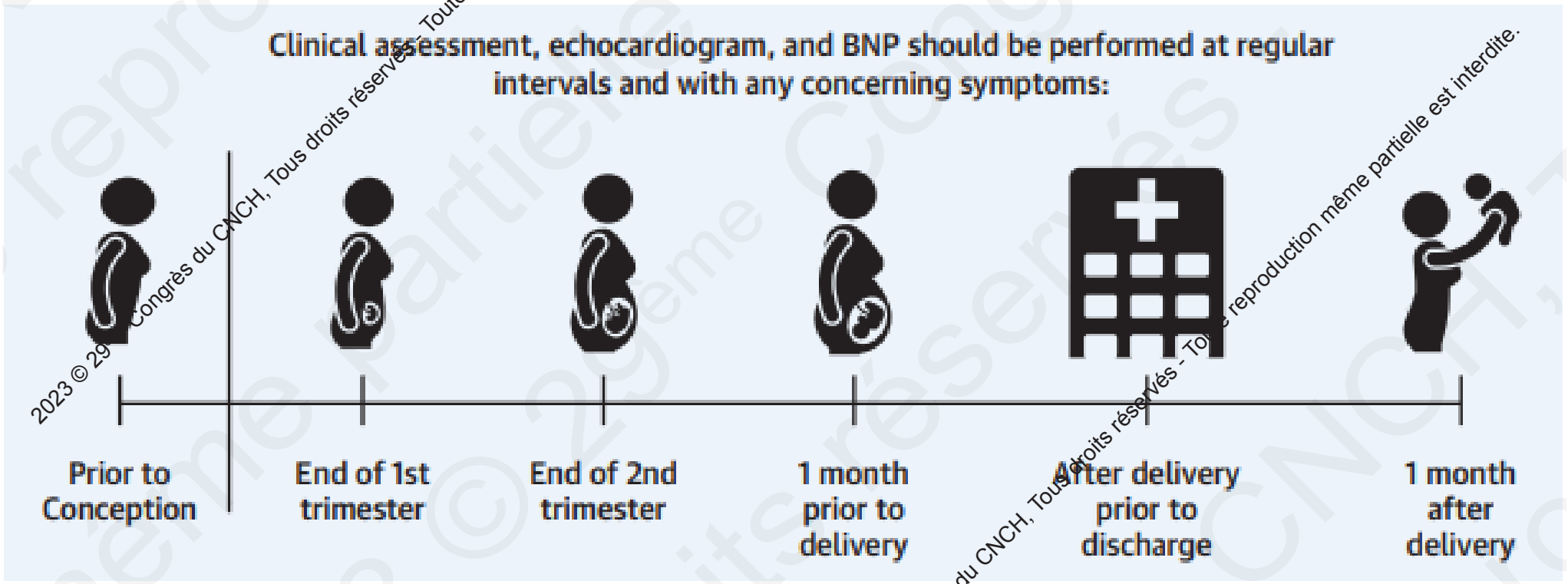
Table 1 Clinical presentation and outcome of subsequent pregnancies (SSPs) in patients entering SSP with persistently reduced (LVEF <50%) or fully recovered left ventricular function (LVEF ≥50%)

	LVEF <50% ($n = 16$)	LVEF ≥50% ($n = 18$)	*P*-value
Age at index PPCM, years (mean ± SD)	27 ± 7 (16/16)	29 ± 5 (18/18)	0.50
Age at SSP, years (mean ± SD)	30 ± 7 (16/16)	31 ± 5 (17/18)	0.59
Gravida SSP, median (range)	3 (2–5) (16/16)	3 (2–5) (17/18)	0.60
Parity SSP, median (range)	3 (2–6) (16/16)	2.5 (1–4) (18/18)	0.04
Twin pregnancy	0% (0/16)	11% (2/18)	0.49
Caesarean section	40% (6/15)	24% (4/17)	0.45
Abortion, miscarriage, still birth	7% (1/15)	17% (3/18)	0.60
Pregnancy-induced hypertensive disorders	6% (1/16)	5.5% (1/18)	1.00
African origin	75% (12/16)	44% (8/18)	0.09
LVEF (%) at diagnosis of index PPCM (mean ± SD)	31 ± 7 (16/16)	32 ± 8 (18/18)	0.68
LVEF (%) before SSP (mean ± SD)	42 ± 6 (16/16)	58 ± 5 (18/18)	<0.0001
LVEF (%) after delivery of SSP (mean ± SD)	43 ± 11 (15/16)	51 ± 13 (17/18)	0.022
LVEF (%) SSP follow-up (mean ± SD)	43 ± 15 (12/16)	50 ± 13 (17/18)	0.24
Full recovery from PPCM after SSP	31% (5/16)	56% (10/17)	0.28
Death	25% (4/16)	0% (0/18)	0.04

Elkayam U. JACC 2014

Hilfiker-Kleiner D. Eur J Heart Failure 2017

Surveillance en cas de nouvelle grossesse



Davis MB et al. JACC 2020

Conclusion 1

- Rare mais y penser devant une dyspnée inhabituelle en péri-partum !
- CMPP définie par FEVG ‹ 45%, diagnostic d'exclusion; NT-proBNP utile
- Traitement médicamenteux :
- IEC/ARA2/ARM contre-indiqués durant grossesse mais utilisables après accouchement
- Considérer anticoagulation si FEVG ≤ 35%
- Bromocriptine est une option thérapeutique prometteuse
- Allaitement souvent possible

Conclusion 2

- Penser à la contraception, santé mentale
- Pronostic s'est amélioré durant dernières décennies
- 60-80% récupération FEVG
- FEVG lors du diagnostic est fort élément pronostique de la récupération
- Information / surveillance cruciale en cas de nouvelle grossesse
- Risque récidive élevé lors des grossesses ultérieures, surtout si pas de récupération FEVG.

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