Gravidas With CHD Need Careful Management

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TORONTO — There is much to be done to assist women with congenital heart disease in having healthy pregnancies and healthy babies, but this area is fraught with unknowns and requires expertise on the part of a multidisciplinary health care team.

At a session dedicated to the issue of pregnancy during the 18th International Symposium on Adult Congenital Heart Disease, several experts addressed the sticky issues of risk stratification and management before, during, and after pregnancy in women with congenital heart defects.

All speakers stressed the importance of extensive prepregnancy counseling. "Females with congenital heart disease (CHD) should have age-appropriate preconception counseling beginning in adolescence," said Dr. Samuel Siu, the Gunton Professor of Medicine and chair of cardiology at the University of Western Ontario, London. This counseling should include careful discussion of the risk of pregnancy to both the mother and the fetus, the recurrent risk of CHD in offspring, and antepartum and peripartum management, he noted.

Several congenital conditions carry an excessively high mortality risk during pregnancy, and affected women should avoid pregnancy, said Dr. Siu. Marfan syndrome and aortopathy, Eisenmenger's syndrome (an advanced form of pulmonary artery hypertension), peripartum cardiomyopathy with residual left ventricular dysfunction, severe aortic stenosis, and mechanical valves are all associated with high maternal and fetal death rates, and pregnancy in women with these conditions should be avoided and possibly electively terminated when it does occur, urged the experts.

One particularly sensitive issue is the life expectancy of women with repaired heart defects, taking into account that motherhood is generally at least an 18-year job.

"What is difficult to discuss, and difficult to predict, is the likely longevity of the mother," said Dr. Carole Warnes, director of adult congenital heart disease at the Mayo Clinic in Rochester, Minn. "Is she going to live another 10 years or 18 years to see this baby going off to college? This is a painful discussion for all of us but I think it's one we have to have as we gaze into our crystal balls."

Dr. Matthew Sermer, an ob.gyn. from Mount Sinai Hospital in Toronto, stressed the importance of proactive rather than reactive management of this patient group. "Any institution opting to look after this often complex patient population must establish policies and practices that ensure optimal perinatal outcomes," he said. This should include establishing a multidisciplinary team composed of not only cardiologists and perinatologists, but also a neonatologist, a hematologist, an anesthetist, and nursing staff.

"Nurses must be kept in the loop," he added. "They are on the front lines and are often the ones seeing a patient crashing. They have to know what to look for and who to tell."

Patient education is also important, Dr. Sermer noted. "There's no point in having your patient sitting at home in heart failure and waiting for it to go away," he said. ■

Fontan Palliation Has Myriad Risks

Pregnant women who have undergone Fontan repair face myriad risks, to themselves and to their fetuses. Cardiac and obstetric complications are common, including New York Heart Association functional class deterioration, atrial fibrillation, gestational hypertension, premature rupture of the membranes, and fetal growth retardation.

Although data are scarce, fetal loss in patients with a Fontan is high, likely approaching 30%, Dr. Warnes said in a discussion of risk stratification and management of pregnant women post–Fontan palliation.

Prepregnancy counseling should include a discussion of the genetic risks to the fetus and a discussion of the patient's drug regimen. "Many of these patients, of course, are on ACE inhibitors and angiotensin receptor blockers that are contraindicated in pregnancy," Dr. Warnes said.