AICOG 2025
Mumbai
67th All India Congress of Obstetrics & Gynaecology
FOGSI celebrates 75 years – Diamond Jubliee
11-13 January, 2025 | JIO World Convention Centre

Unveiling maternal and perinatal outcomes in Eisenmenger Syndrome: a case series from an apex institute

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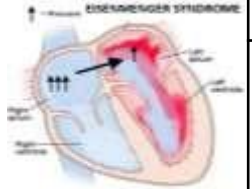
INTRODUCTION



- Eisenmenger syndrome (ES) is characterised by right-to-left shunt secondary to an untreated congenital cardiac defect.
- Poor tolerance of pregnancy-related physiological changes.
- It is considered an absolute contraindication for pregnancy. [1]

METHOD: A **10-year** data was reviewed and **3 women** with ES were studied for feto-maternal outcomes.

DISCUSSION

- Termination of pregnancy is safe only if done early on in pregnancy.
- In case pregnancy is continued, management includes early hospitalisation, multidisciplinary involvement, oxygen supplementation, diuretics, vasodilators and anticoagulation.
- Timing and mode of delivery is controversial. CS although increases morbidity over vaginal delivery, is preferred in severe PAH. [2]
- Sudden demise due to hypovolemia, thromboembolism and pre-eclampsia can occur, more so in the postpartum period.

CONCLUSION

Even though all cases delivered at our centre had satisfactory neonatal outcomes, and no maternal mortality was recorded, pregnancy should ideally be avoided in a woman with ES.

Underlying disease	Presenting features	Obstetric course	Neonatal outcome	Post-partum course
Uncorrected TOF **Diagnosed at 22 weeks gestation**, during evaluation of polycythemia	**NYHA II** Admitted for safe confinement at 29+1 weeks	• Started on Metoprolol • Intermittent oxygen therapy • Otherwise uneventful • Preterm CS at 35+4 weeks under GA i.v.o PPROM	FGR with normal dopplers 1.8kg female baby Apgar at 5 mins- 9 NICU stay for 10 days i.v.o jaundice	• Monitored in ICU for 1 day. • Discharged on POD-18. • NYHA I at discharge.
ASD with PAPVC (uncorrected) **Diagnosed in 2010**	**NYHA III** at 29+3 weeks with cough, dyspnea on exertion. SpO2 on admission- 55% on room air	• Improvement in NYHA status with oxygen therapy and rest • Managed with diuretics, Sildenafil and Digoxin • Preterm CS at 31+4 weeks under epidural analgesia i.v.o REDF	< 1 kg male baby Apgar at 5 mins- 9 NICU admission for 30 days i.v.o prematurity	• Required CPAP and ICU stay for 1 day. • **Syncope and desaturation** (upto 20% on room air) on POD-16. Stabilised on 5 litres of oxygen via face mask. Diuretics and Digoxin stopped. • **DILEMMA: Adequate hydration to avoid hypovolemia versus fluid restriction to prevent heart failure !** • Developed **CHF** on POD-19, ICU admission for 5 days • Discharged on POD-30. • NYHA II at discharge
ASD (uncorrected) **Diagnosed at 30**	**NYHA IV** at 36+4 weeks with cough and chest	?LRTI/ ?CHF - Managed symptomatically Spontaneous precipitate preterm delivery at 36+5	FGR with raised dopplers 1.9kg male baby NICU stay for 10	• ICU admission for 3 days. • Discharged on POD-11. • NYHA II at discharge.

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References: [1] Yuan SM, Braz J Cardiovasc Surg. 2016
[2] 2018 ESC Guidelines for management of arterial hypertension