Abstract:
Pulmonary Embolism is a common potentially lethal condition. Every woman is at risk of it as pregnancy is a hypercoagulable state. Studies state that pulmonary embolism is more common in postpartum period than in pregnancy. Despite diagnostic advances delay in diagnosis are common, as patient presents with non specific symptoms. Therefore a high index of suspicion is always required in patient at risk of pulmonary embolism for prompt diagnosis treatment. This is a case report of woman with peripartum pulmonary embolism who survived due to early diagnosis treatment.

Keyword: Postpartum pulmonary embolism, anticoagulation

HISTORY:
Mrs. G, 26 yrs P_2L_2 with History of prev 2 LSCS with Sterilisation with Last child birth – 14 daysbackadmitted in the Dept of Obs & gyn, KMCH on 9-4-2012 with complaints of breathlessness for past 3 days. Breathlessness was initially grade II gradually progressed to Grade IV. No Complaints of Chest pain, Palpitation, syncope or leg swelling with pain. No H/O any cardiac illness or similar illness in the past. Both LSCS was For Obstetric indications with uneventful intra – OP & Post – OP period. ON EXAMINATION: Patient was moderately built & nourished, not anemic, not icteric, no cyanosis, dyspnoc, tachypnoic with bilateral grade I pedal edema. CVS-Normal, RS-clear with Bilateral air entry equal, with no added sounds. Abdomen: uterus involuting, with a healthy Tranverse scar, no organomegaly. Lochia healthy. Vitals: PR-128/min, BP-110/70 mm Hg, RR-22/min, SPO_2-98%, Temp-100.4’. Investigations: Hb – 9.8g%, CBC, RFT, LFT – within normal limits. ECG – Sinus Tachycardia with Rate-126/min, with no other abnormalities. Chest X Ray- No Cardiomegaly & Lungs clear. Provisionally Diagnosed as 1) Peripartum Cardiomyopathy 2) Pulmonary Embolism
Cardiologist opinion stated ECG – Sinus tachycardia. ECHO revealed a normal heart with no-hypokinesia with normal ejection fraction with no evidence of pulmonary thrombus. In view of Persistent Tachycardia & to rule out Pulmonary embolism d-dimer levels was done and ddimer levels came as 650ng/ml !!. CT – angi Chest was taken and it was reported as “Thrombus involving Right & Left Pulmonary arteries with subpleural infarts”.

Patient was started on Inj.Heparin 5000IU iv QID with aPTT follow up. Patient was symptomatically better after 3 days of treatment with PR-100/min & RR-16/min. After 3 Days of Heparin treatment, patient was started on T.Acitrom 3mg HS with gradual tapering of heparin dosage. Heparin was stopped on day 8 & T.Acitrom continued at 3mg Hs with PT – INR of 2-3. Patient was discharged with normal vitals after seven days of observation and advised to continue T.Acitrom 3mg HS and to review in Cardiologist & OG dept.

FOLLOW UP:

Patient was on T.Acitrom 3mg Hs For 3 months & review CT–Angio showed a normal study of Pulmonary Vasculature with No evidence of thrombus at present. Patient at present advised to continue T.Acitrom 3mg Hs for 3 more months.

DISCUSSION:

Post partum women are at risk of Pulmonary embolism and a high index of suspicion required as the classical picture of abrupt onset of pleuritic chest pain with shortness of breath & hypoxia is rarely seen. This patient presented with unexplained breathlessness & undue tachycardia with good oxygen saturation. The varied non-specific presentation of pulmonary embolism includes fever > 37.8°C (40% of cases) and lower extremity edema (21% of cases). This patient had both of these. D-dimer levels is an useful test as it has a 95% negative predictive value for Pulmonary Embolism & can rule out Pulmonary Embolism if negative.