CONGENITAL CYANOTIC HEART DISEASE DUE TO SINGLE VENTRICLE IN PREGNANCY

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INTRODUCTION
The congenital cardiac defect known as single or primitive ventricle is a relatively rare anomaly. Only six patients are reported to have entered reproductive years and pregnancy. We report here another case.

CASE REPORT
A 22 year old Punjabi Hindu, 3rd gravida with bad obstetric history (P0+1(breech) +1+0) attended antenatal clinic run by Department of Obstetrics & Gynaecology, Nehru Hospital, Postgraduate Institute of Medical Education and Research, Chandigarh, at 18 weeks’ gestation. She was a known case of cyanotic heart disease due to common ventricle. She gave history of cyanosis since 6 years of age; palpitation during exertion since childhood; nonepisodic appearing and disappearing gradually; and also dyspnoea on exertion - presently symptomatic Class IIb to III. Despite this, she had been generally well. There was no delay in developmental milestones.

Physical examination revealed a cyanotic woman with a blood pressure of 120/70mm Hg, pulse 84 per minute and, clubbed fingers and toes. Neck veins were not distended and lungs were clear. There was no oedema. Apex beat was not localised. Left parasternal heave, Grade II/IV was noted. First heart sound was heard normal.

Second sound-only aortic component, and was loud. An ejection systolic murmur at 3rd and 4th intercostal spaces close to sternum and over the sternum of grade II/VI was also noted. Liver and spleen were not palpable. Growth in utero corresponded to the period of amenorrhea. The electrocardiogram suggested right sided ventricular hypertrophy and sinus rhythm. Chest X-ray did not reveal cardiomegaly. Echocardiography showed absence of interventricular septum. The data of cardiac catheterisation performed in the same hospital 10 years earlier is shown in Table I.

Blood gases on room air recorded arterial oxygen saturation of 82 and 84 per cent at two different occasions. Haemoglobin was 14.5 gm/dl; haemtocrit, 44% and serum creatinine 1.3 mg/dl, urinalysis and glucose tolerance curves were normal. VDRL test was nonreactive in both the spouses.

She carried gracefully with satisfactory foetal growth till 36 weeks’ gestation, when she complained of increasing breathlessness and was hospitalised for rest till confinement. Her cardiac status remained stable in the Hospital.

At 38 weeks’ gestation, labour began spontaneously. Ampicillin and gentamycin were administered for bacterial endocarditis prophylaxis. Injection Frusenide was given when she went into second stage. Delivery was assisted by low forceps. Total labour lasted for eight hours. A 2000gm male infant was delivered with Apgar scores of 8 and 10 at 1 and 5 minutes respectively. The patient developed vulval haematoma at the episiotomy site which was drained and episiotomy resutured under local analgesia. Thereafter both the mother and infant did well, and were discharged on eight post-partum day.