

Supra Ventricular Tachycardia in Pregnancy

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Abstract

The physiological changes during pregnancy predispose female of new-onset or recurrent arrhythmia. Supraventricular arrhythmia is that the commonest sort of arrhythmia during pregnancy and, although often benign in nature. We describe a complex case of supraventricular arrhythmia during pregnancy and review the currently available literature. In pregnancies complicated by arrhythmia, a follow-up and both maternal and fetal monitoring during pregnancy, delivery and post partum should be made. Diagnostic modalities should be used as in non-pregnant women. All antiarrhythmic drugs cross the placenta, but when necessary, medical treatment should be used.

Electrical cardioversion is safe during pregnancy, and electrophysiological study and catheter ablation sometimes performed in selected patients, preferably with zero-fluoroscopy technique. Sometimes, delivering the fetus (if viable) is that the best therapeutic option.

Keywords: Pregnancy; Supra-Ventricular Tachycardia.

INTRODUCTION

Anatomical, hemodynamic and hormonal changes of maternal physiology make pregnancy a high-risk period for the occurrence of new onset arrhythmia, or the recurrence of pre-existing arrhythmia. The maternal intravascular volume expands up to 45% throughout pregnancy, to compensate in systemic vascular resistance that facilitates the formation of the uteroplacental circulation.¹ The quantity

expansion causes atrial and ventricular stretch, which together with a physiologically increased pulse and contractility, increased sympathetic activity and altered catecholamine sensitivity creates an arrhythmogenic state. Arrhythmia risk peaks within the trimester. Maternal risk factors are previous arrhythmia, advanced maternal age, African ancestry and congenital heart condition, during which surgical scars and aberrant cardiac anatomy compound things.

Data on the prevalence of arrhythmia during pregnancy are scarce and conflicting, and lack clarity because complaints of palpitations are common and predominantly benign. Arrhythmia was observed in 68 per 100 000 pregnancy related hospitalisations, which probably underestimates the entire prevalence considering the extra cases of arrhythmia without hospitalisation. Supraventricular arrhythmias are more common than ventricular arrhythmias and can be the main

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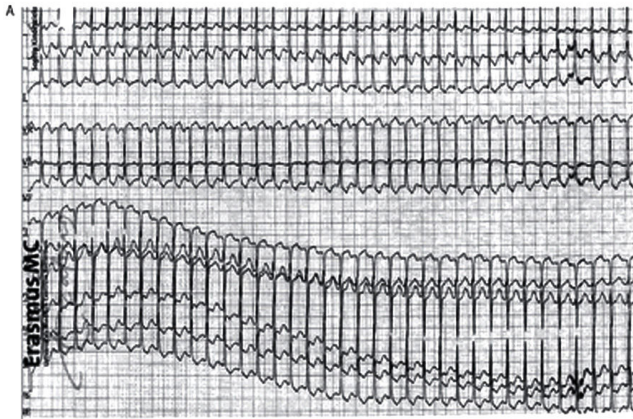
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target of this review.

Atrial fibrillation or flutter (AF, 31–59 per 100 000 pregnancies) is the most frequently reported arrhythmia in pregnancy, with a growing prevalence in the past two decades that may be partly explained by the increasing maternal age.^{7,9} Non-AF supraventricular tachycardia (SVT) is reported in 22–33 per 100 pregnancies,^{5,7,10} including atrioventricular (nodal) re-entry tachycardia (AV(N)RT) and atrial tachycardia.

Although most arrhythmias are benign, they're related to increased maternal mortality (OR 13 for AF and OR 6 for SVT).⁷ Appropriate workup and multidisciplinary management are therefore important, but the literature to guide clinical decisions is scarce.



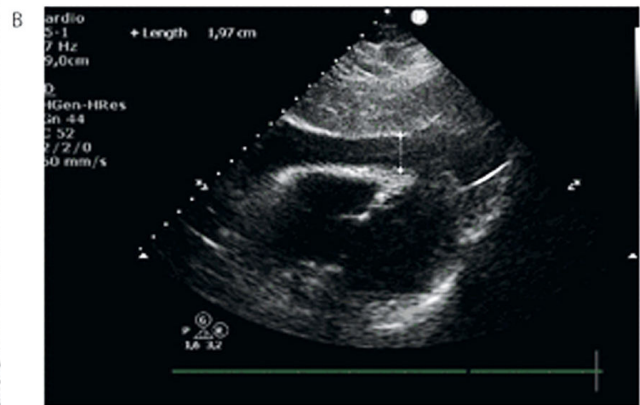
ECG and echocardiogram of a lady aged 38 years at 16 weeks of gestation, presenting with atrioventricular (nodal) re-entry tachycardia (AV(N)RT).

(A) ECG of a daily supraventricular tachycardia of 205 bpm with an intermediate axis and a narrow QRS complex. A retrograde P wave was observed 120 ms behind the QRS complex, implicational an AV(N)RT.

According to the ESC guidelines, our multidisciplinary pregnancy heart team classified her as m WHO II, as all supraventricular arrhythmia without underlying structural heart condition.¹¹ Rhythm-surveillance level 1 was recommended during delivery. An EP study with ablation was discussed, but we decided to first pursue pharmacological treatment and only perform an ablation just in case of refractory complaints. Verapamil 120 mg once daily replaced the metoprolol, and she was advised to avoid excessive exertion. The dosage was gradually increased to 120 mg 3 times daily, with a suitable but incomplete result on the

CASE REPORT

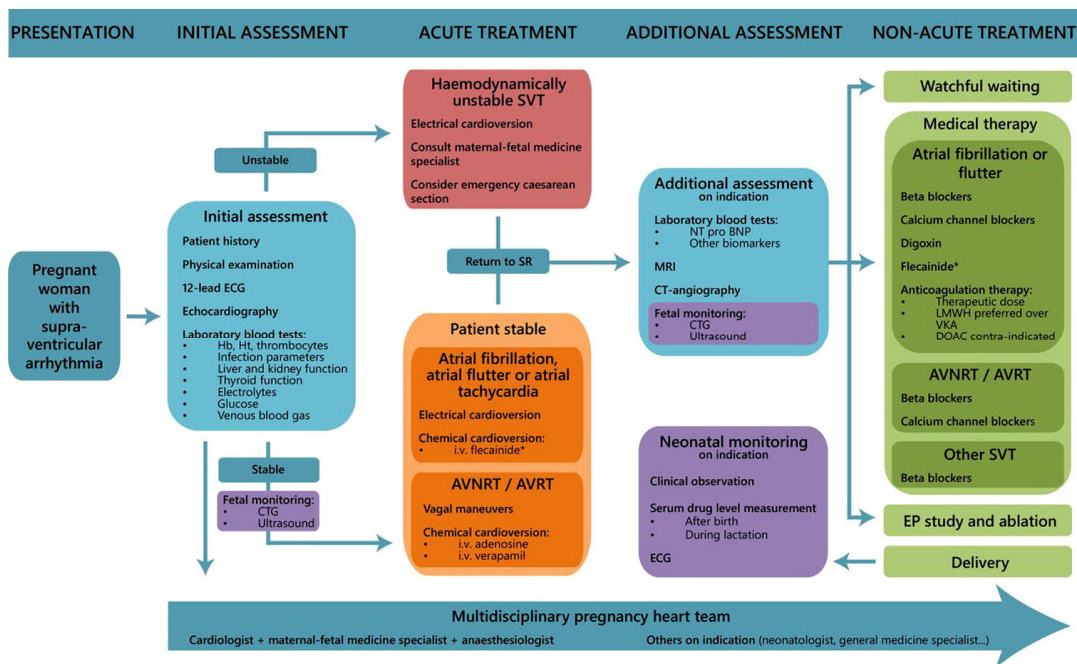
A primigravid woman aged 38 years presented at 16 weeks of gestation at a secondary hospital with palpitations that had increased in intensity during pregnancy. She had no history of cardiac disease. She was diagnosed with an AV(N)RT and treated with metoprolol 12.5 mg twice daily without sufficient effect, after which she was referred to our centre. Here, the ECG showed a regular SVT of 205 bpm with an intermediate axis and a narrow QRS complex (figure 3A). A mid-RP narrow complex tachycardia was observed, consistent with AVNRT, AVRT or less likely atrial tachycardia. The arrhythmia terminated after administration of inj adenosine 6mg iv stat, but afterwards many recurrences were observed, provoked by light physical activity. There were no signs of congestion. An echocardiogram showed that there was no structural heart disease.



frequency and intensity of her complaints. The fetal status and growth were monitored regularly within the obstetric outpatient clinic with CTG and fetal ultrasound, and remained reassuring. Labour was induced at 37 weeks of gestation due to the persisting complaints of arrhythmia. The patient had an uncomplicated delivery of a girl of 3585 g (90th percentile), with Apgar scores of 9/10. Because of the maternal verapamil use during pregnancy and lactation, the neonate was observed for twenty-four hours. The neonatal heart rate and ECG were normal, while the serum verapamil levels were very low and below therapeutic range.

DISCUSSION

We have described case of supraventricular arrhythmia during pregnancy where different forms of intervention were necessary. Below figure presents a step-by-step guide for the diagnosis and management of supraventricular arrhythmia in pregnancy. We discuss the current knowledge on the subject, using the cases and the figure as a framework.



Flow chart of the diagnosis and treatment of supraventricular arrhythmia during pregnancy. *Flecainide is relatively contraindicated in women with structural heart disease, and is also contraindicated in case of atrial flutter due to risk of 1:1 AV conduction. AVNRT, atrioventricular nodal re-entry tachycardia; AVRT, atrioventricular re-entry tachycardia; CTG, cardiocogram; DOAC, direct oral anticoagulants; EP, electrophysiological; Hb, haemoglobin; Ht, haematocrit; LMWH, low molecular weight heparin; NT-proBNP, N-terminal pro b-type natriuretic peptide; SR, sinus rhythm; SVT, supraventricular tachycardia; VKA, vitamin K antagonist.

CONCLUSIONS

Pregnancy creates an arrhythmogenic environment and the pregnant population is increasingly at risk of arrhythmias. Starting at the initial presentation, a multidisciplinary approach is crucial to balance maternal cardiac, obstetric and fetal considerations. In any case, optimal maternal health is a prerequisite for good fetal health, so diagnostic modalities and therapeutic options (such as electrical or chemical cardioversion) should be used where necessary and not be avoided or delayed due to the fetus. Knowledge of the physiology of pregnancy helps to predict the consequences and consequences of interventions and drug therapy. A good secondary assessment for underlying causes of arrhythmia, like structural heart condition or endocrine disorders, shouldn't be forgotten. However, often the pregnancy itself is that the most vital contributor

to the burden of arrhythmia, and therefore the delivery of the child is usually a viable therapeutic option.

Conflict of Interest: None Declared

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