Postpartum pericarditis

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DESCRIPTION

A 20-year-old woman, who was post partum day 4, presented to the emergency department with acute onset sharp retrosternal chest pain radiating to her back. The pain started at rest, worsened with deep inspiration and lying down, but improved when the patient sat up. Her pregnancy and labour were uneventful. On presentation, vital signs were significant for heart rate of 127/min with no fever and normal blood pressure. She was in mild distress. Cardiac and chest examinations were unremarkable as well with no murmurs, gallops, rubs or crackles. Blood work was remarkable for haemoglobin of 10.5 g/dL and haematocrit of 31.7%. An ECG was performed and showed diffuse upsloping ST segment elevation ECG (figure 1A), which is typical for pericarditis. Serial cardiac troponins were negative. The patient was admitted to the hospital and an echocardiogram was performed, which showed moderate pericardial effusion without tamponade physiology (figure 1B). She was started on colchicine 0.6 mg twice a day and ibuprofen 800 mg thrice a day. Two days later the patient developed hypotension and became haemodynamically unstable. Repeated echocardiogram showed increased amounts of fluid (figure 1C), which prompted pericardiocentesis with 500 mL of purulent fluids drained. Broad-spectrum antibiotics were initiated and the fluids were sent for microbiology and cultures. A day later, the culture came back positive for group G streptococcus, which was sensitive to ceftriaxone. Transoesophageal echo was negative for infective endocarditis and CT of the chest and abdomen was negative for an infectious source. However, vaginal discharges were cultured and came back positive for group G streptococcus as well. The course of her hospitalisation was complicated by septic shock and respiratory failure requiring mechanical ventilation for a few days. She went on to make a remarkable recovery with resolution of her acute illness and was discharged with a 4-week course of intravenous antibiotics.

Learning points

- Bacterial pericarditis is a rare but serious cause of pericarditis with mortality as high as 40% mostly due to cardiac tamponade, systemic toxicity and constriction. However, it is rarely seen in the antibiotic era and accounts for less than 1% of acute pericarditis.[1]
- Group G streptococci are unusual causes of infections in a healthy host; however, these infections can be severe and include infective endocarditis, septicaemia, cellulitis, ascending cholangitis, pneumonia, empyema and peritonitis.[1] Genital tract colonisation has been reported as well.[1 2]

Competing interests None.

Patient consent Obtained.

Provenance and peer review Not commissioned; externally peer reviewed.

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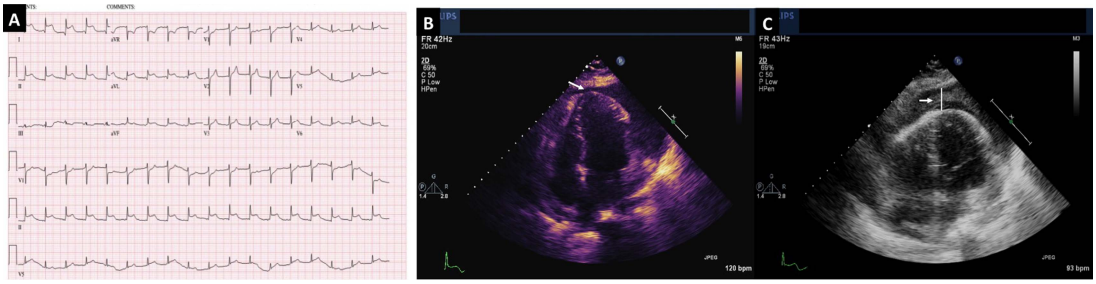

Figure 1 (A) ECG showing diffuse upsloping ST segment elevation especially in the limb leads. (B) Echocardiogram, apical four-chamber view showing normal left venticular function with moderate pericardial effusion (arrow) and no tamponade physiology. (C) Repeated echocardiogram showing increased amount of pericardial effusion with collapsed right atrium in diastole.

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