***Paper 10*: "A case of SVT in a Pregnant woman"**

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Abstract:

A 38 year old pregnant woman with history of Thyrotoxicosis presented to the ED with palpitation. She was diagnosed to have SVT and managed in the ED and followed up and was delivered by CS.

This article discusses the management of SVT in pregnancy and the safety of Antidysrhythmics on the fetus. Also we discuss the effects of thyrotoxicosis on the fetus and management of that in pregnancy.

Serious cardiac arrhythmias are uncommon in pregnancy but may be associated with congenital or acquired cardiac lesions. The incidence and severity of tachyarrhythmias, both SVT and VT may increase during pregnancy.

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Although the reasons for this observation are unclear, some explanations have been proposed.

Pregnancy may predispose to and exacerbate symptoms of paroxysmal SVT.

Clearly, both mother and fetus are at risk when SVT occurs during pregnancy.

However, emergency Caesarean section is often a consequence, increasing maternal risk and if pre-term, increasing fetal risk.

Treatment of SVT in pregnancy may also affect the fetus.

Emergency and elective DC cardioversion is safe at all stages of pregnancy.

There is a risk to both mother and fetus in using antiarrhythmic drugs during pregnancy, and these drugs should be avoided altogether unless the arrhythmias are intolerable.

Thyroid abnormalities affect 5-15% of pregnant women & 4-8% of post partum women. Hyperthyroidism Occurs in 0.2% of pregnancies

The clinical diagnosis of mild to moderate hyperthyroidism in pregnancy can be difficult because pregnant women often exhibit hyperdynamic signs similar to hyperthyroidism.

Diagnosis of fetal thyroid dysfunction is challenging. Although transplacental passage of maternal antibodies (IgG class) to the fetus does occur early in gestation, the fetal concentration is quite low until the end of the second trimester.

Gestational thyrotoxicosis refers to the Hcg mediated increased production of thyroid hormone that occurs in the late first and early second trimesters at the time of peak hCG secretion.

In managing hyperthyroidism during pregnancy, it should be remembered that two patients are being treated: the mother and the fetus. A balance must be made in optimizing treatment for one without impinging on the other.

Owing to obstetric and fetal risks, surgery is not regarded as first-line therapy, but might be considered if necessary for the mother's health.

Administration of radioactive iodine for diagnostic or therapeutic purposes is contraindicated in pregnancy and lactation.