

Successful management of massive pulmonary embolism in pregnant women with thrombocytopenia

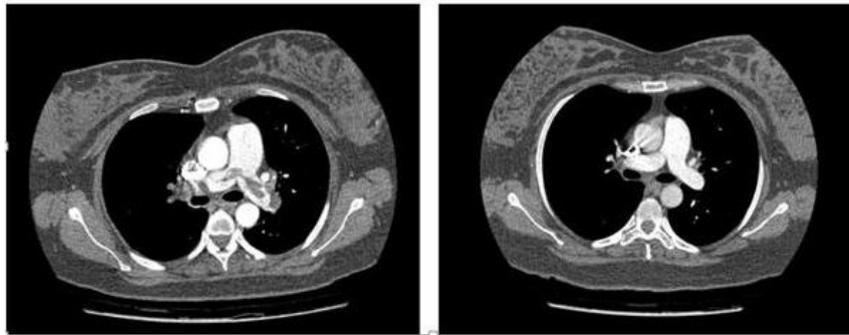
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Thromboembolism (PE) during pregnancy is critically serious, is the most common cause of maternal deaths and its mortality rate is reported to be about 10%. We report a case of massive PE complicated with Idiopathic thrombocytopenic purpura (ITP) at 16 weeks of pregnancy. A 36-year-old woman with at 12-weeks of pregnancy was admitted because of thrombocytopenia (17000/uL). At 40th days of admission, she presented with dyspnea, shock, D-dimer elevated, very high right ventricle systolic pressure (93.46 mmHg) and embolism CT showed Massive PE (Fig 1). The use of thrombolytic agents during pregnancy is contraindicated, we considered embolectomy and abortion, but she was stable during 4 days intravenous heparin administration. Then we switched to Enoxaparin (1 mg/kg every 12 hours). Despite multiple platelet transfusion, serious thrombocytopenia (12000/uL) was not recovered and steroid treatment was started. She was stable and the platelets recovered to 111,000/uL and discharged at the 67th day of hospitalization and maintained self-Enoxaparin injection therapy. At 36th weeks of pregnancy, We stopped enoxaparin for 24 hours prior to labor. After labor, fetus was stable and PE on CT showed almost resolved (Fig 2) and enoxaparin was stopped. This is a case where a woman with ITP at 16-weeks pregnancy with a sudden massive PE and thrombocytopenia was well managed with adequate steroid and self- Enoxaparin injection therapy till delivery. The patient successfully sustained relatively long period of pregnancy (20 more weeks) without further complications.

Fig 1. Diagnosis with PE (16<sup>th</sup> weeks)

Fig 2. Resolved PE (36<sup>th</sup> weeks)\*



The impact of temporal change in metabolic syndrome status over 2 years on incident DM

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**Background & Aims:** Metabolic syndrome (MetS) is a well-known predictor of diabetes mellitus (DM), but whether change in status of MetS over time can modify a risk of incident DM is uncertain. Our study aimed to investigate the association between temporal changes in MetS status over two years and the 10-year risk of DM. **Methods:** A prospective cohort study was conducted of 7,317 adults aged 40-70 years without DM at baseline as well as 2 years later. Subjects were categorized into 4 groups according to the status of MetS at baseline and 2 years follow-up, as defined by the Adult Treatment Panel III guidelines: a non-MetS to non-MetS group, a non-MetS to MetS group, a MetS to non-MetS group and a MetS to MetS group. The relative risk of DM associated with the 2-year change in status of MetS was calculated using Cox models. **Results:** During the 10-year follow-up, DM occurred in 1,099 (15.0%) participants. The fully adjusted hazard ratio (95% confidence interval) for new-onset DM comparing the MetS to non-MetS group, non-MetS to MetS group and MetS to MetS group to non-MetS to non-MetS group were 1.37 (1.09-1.72), 1.87 (1.50-2.33) and 2.08(1.73-2.51) respectively (P for trend = 0.01). In addition, the adjusted hazard ratio for incident DM gradually increased as the number of MetS component at 2 years later increased. **Conclusion:** Change of MetS status is associated with markedly variable 10-year risk of incident DM. Our finding suggest that determining the status of MetS routinely and paying attention to status change in MetS may be important for prevention of DM.