cardioverter-defibrillator (ICD) treatment. Cardiac transplantation should be reserved for patients where mechanical circulatory support is not possible or not desirable for individual reasons or for patients who do not recover after 6-12 months on mechanical circulatory support. Patients with PPCM have a similar prognosis after transplantation to patients with DCM (8).

Conclusion

PPCM is a serious disease with high mortality and morbidity. Some conditions such as preeclampsia can be the precipitating factor for PPCM, which is not so uncommon. Some novel diagnostic markers like EMPs are effective in early disease diagnosis. Conventional heart failure treatment can be useful but bromocriptine has been proved to be a good, safe, and effective drug in PPCM.

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Conflict of Interest

The authors declare no conflict of interest.

References

1. Yancy CW, Jessup M, Bozkurt B, et al. 2013 ACCF/AHA guideline for the management of heart failure: a report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. J Am Coll Cardiol. 2013;62:e147-239.
2. Reimold SC, Rutherford JD. Peripartum cardiomyopathy. N Engl J Med. 2001;344:1629-1630.
3. Walenta K, Schwarz V, Schirmer SH, et al. Circulating microparticles as indicators of peripartum cardiomyopathy. Eur Heart J. 2012;33:1469-1479.
4. Hilfiker-Kleiner D, Struman I, Hoch M, et al. 16-kDa prolactin and bromocriptine in postpartum cardiomyopathy. Curr Heart Fail Rep. 2012;9:174-182.
5. Melchiorre K, Sutherland GR, Baltabaeva A, et al. Maternal Cardiac Dysfunction in women with Preeclampsia in Term. Hypertension. 2011;57:85-93.
6. Powe CE, Levine RJ, Karumanchi SA. Preeclampsia a disease of Maternal Endothelium. The role of angiogenic Fatctors and Implication of late Cardiovascular disease. Circulation. 2012;123:2856-2869.
7. Leaños-Miranda A, Márquez-Acosta J, Cárdenas-Mondragón GM,et al. Unirary Prolactin as a reliable marker for Preeclampsia, Its severity, and the occurrence of adverse pregnancy outcomes. J Clin Endocrinol Metab. 2008;93:2492-2499.
8. Regitz-Zagrosek V, Blomstrom Lundqvist C, Borghi C,et al. ESC Guidelines on the management of cardiovascular diseases during pregnancy: the Task Force on the Management of Cardiovascular Diseases during Pregnancy of the European Society of Cardiology (ESC). Eur Heart J. 2011;32:3147-3197.
9. Chopra S, Verghese PP, Jacob JJ. Bromocriptine as a new therapeutic agent for peripartum cardiomyopathy. Indian J Endocrinol Metab. 2012;16:S60.
10. Ballo P, Betti I, Mangialavori G, et al. Peripartum Cardiomyopathy Presenting with Predominant Left Ventricular Diastolic Dysfunction: Efficacy of Bromocriptine. Case Rep Med. 2012;2012:476903.
11. Habedank D, Kühnle Y, Elgeti T, et al. Recovery from peripartum cardiomyopathy after treatment with bromocriptine. Eur J Heart Fail. 2008;10:1149-1151.
12. Fett JD. Caution in the use of bromocriptine in peripartum cardiomyopathy. J Am Coll Cardiol. 2008;51: 2083-2084.
13. Sliwa K, Blauwet L, Tibazarwa K, et al. Evaluation of bromocriptine in the treatment of acute severe peripartum cardiomyopathy: a proof-of-concept pilot study. Circulation. 2010;121:1465-1473.