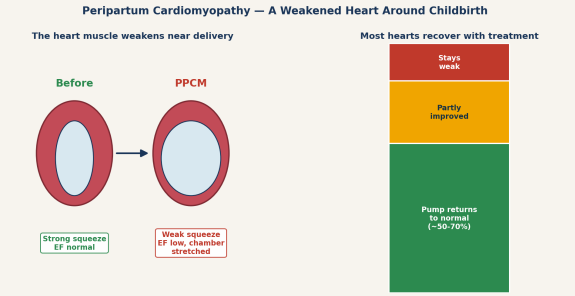
Understanding Peripartum Cardiomyopathy

Heart failure in late pregnancy or the months after birth — and why most hearts recover

A weak heart pump can show up around childbirth. With the right care, many fully recover.



Online: https://go.riasalimd.com/ppcm-guide

Rias KS Ali, MD FACC

Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

Last Updated: August 2026

Names & Terms You Will Hear

Term	Meaning
Peripartum cardiomyopathy (PPCM)	A weak heart pump that starts in the last month of pregnancy or within 5 months after delivery, with no other cause found.
Pregnancy-related heart failure	Heart failure that begins around childbirth. The heart muscle cannot pump enough blood for the body.
Cardiomyopathy of pregnancy	Another name for the same problem. Cardiomyopathy means a disease of the heart muscle.
Low ejection fraction (low EF)	Ejection fraction (EF) is the share of blood the heart pumps out with each beat. In PPCM the EF is under 45 percent. Normal is 55 percent or higher.
Dilated heart	The main pumping chamber stretches and grows larger as it weakens. This is the same pattern seen in other forms of dilated cardiomyopathy.
Recovered EF	When the pump returns to normal (EF 50 percent or higher) after treatment. This happens to about half to two-thirds of patients.

If a new parent suddenly cannot breathe, passes out, or has no pulse, call 911 now. Start Hands-Only CPR: push hard and fast in the center of the chest, about twice per second (the beat of the song "Stayin' Alive"). Keep going until help arrives. If an AED (automated external defibrillator) is nearby, turn it on and follow the voice. An AED will not shock a normal heart, so it is safe to use.

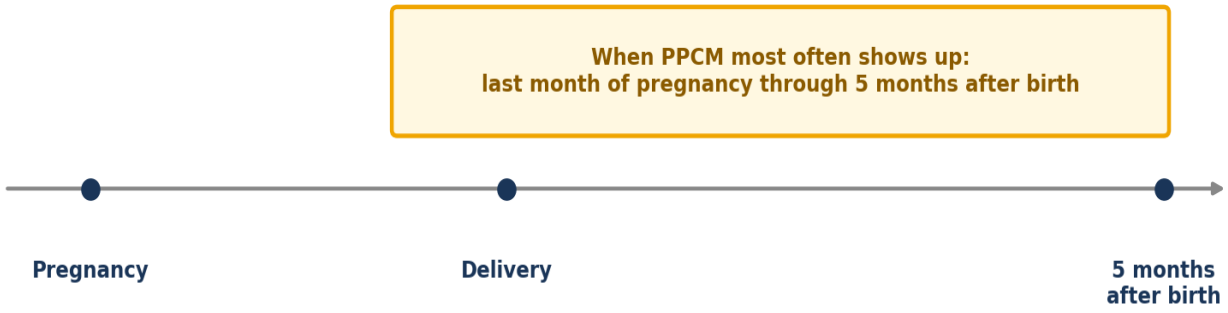
What Is Peripartum Cardiomyopathy?

- Peripartum cardiomyopathy (PPCM) is heart failure that shows up near the end of pregnancy or in the first 5 months after birth. The heart muscle becomes weak and cannot pump well.
- It is a diagnosis of exclusion. Your doctor first rules out other causes, such as a heart attack, a clot in the lungs, or a heart problem you had before pregnancy.
- The main test is an echocardiogram (a heart ultrasound). It measures the ejection fraction (EF). PPCM is diagnosed when the EF is under 45 percent.
- Early signs feel like normal late pregnancy: tiredness, swollen legs, and shortness of breath. That overlap is why PPCM is often caught late.
- PPCM is not common, but it is serious. The good news is that about half to two-thirds of patients recover normal pump function with treatment.
- PPCM belongs to the dilated cardiomyopathy family — the heart stretches and weakens. See our dilated cardiomyopathy guide and our heart failure guide for the broader picture.

Why It Matters

- PPCM can move fast. A heart that looks stable can tip into severe fluid overload within days. Early treatment protects the heart and the new parent.
- The timing is tricky. Swelling and breathlessness look like normal late pregnancy, so the diagnosis is easy to miss. The timeline below shows the window to watch.
- Treatment changes by phase. Some strong heart medicines are not safe during pregnancy or breastfeeding. The care plan shifts after delivery and again after weaning.
- Recovery is common but not guaranteed. A higher starting EF and a smaller heart predict a better chance of full recovery.
- A future pregnancy carries real risk, especially if the pump has not fully recovered. Planning ahead with your heart and pregnancy teams matters.
- PPCM raises the risk of dangerous blood clots and heart rhythm problems. Knowing the warning signs helps you act fast.

When Does Peripartum Cardiomyopathy Happen?



PPCM most often appears from the last month of pregnancy through about 5 months after birth. Most cases start after delivery.

The look-alike trap: swollen ankles and feeling winded are common in late pregnancy. PPCM is different. The warning signs are trouble breathing when lying flat, waking at night gasping, a racing heartbeat, or sudden weight gain. If that is you, ask for a heart check.

Risk Factors

Some patients are more likely to develop this condition. Knowing your risk helps your care team take extra precautions.

Risk Factor	Why It Increases Risk
Older parent age (over 30)	Risk rises with age at delivery, especially over 35.
Twins or higher-order pregnancy	Carrying more than one baby strains the heart more.
High blood pressure or preeclampsia	Pregnancy high blood pressure is one of the strongest risk factors for PPCM.
Black race	Black patients have a higher rate of PPCM, more severe disease, and slower recovery. The reasons are not fully known and include access-to-care gaps.
First pregnancy or many prior pregnancies	Both ends of the range carry somewhat higher risk.
Family history of cardiomyopathy	Some PPCM is linked to inherited heart-muscle genes. A family history raises the odds.

Treatment Options

- Standard heart-failure care is the backbone: lower the heart's workload, remove extra fluid, and help the pump recover. The exact medicines depend on whether you are pregnant, breastfeeding, or done.
- Water pills (loop diuretics like furosemide) ease swelling and breathlessness. They are used in every phase but at the lowest dose that works.
- Beta-blockers (metoprolol or carvedilol) slow and strengthen the heart over time. They are safe in pregnancy and while breastfeeding.
- During pregnancy, hydralazine plus a nitrate stands in for ACE inhibitors and ARBs, which can harm the baby. The medicine-safety chart below shows what is safe in each phase.
- After delivery, ACE inhibitors, ARBs, or an ARNI can be added to help the heart heal. Enalapril and captopril are considered safe while breastfeeding.
- Blood thinners (anticoagulation) are often used when the EF is very low, because a weak, stretched heart can form clots. Heparin is used in pregnancy; warfarin is fine while breastfeeding.
- Bromocriptine, a medicine that stops breast-milk production, is debated. Europe's ESC suggests it for severe cases (always with a blood thinner). The AHA and ACC do not endorse it because it is not approved for PPCM in the United States.
- Most patients keep heart medicines for at least 6 to 12 months after the EF returns to normal. Stopping is a shared decision with your cardiologist.

Heart-Failure Medicines: Safe vs. Avoid by Phase

	During pregnancy	While breastfeeding	After weaning / recovered
Beta-blockers (metoprolol, carvedilol)	Safe	Safe	Safe
Water pills (furosemide)	Safe	Safe	Safe
Hydralazine + nitrate	Safe	Safe	Safe
Digoxin	Safe	Safe	Safe
ACE / ARB / ARNI	Avoid	Safe	Safe
Spironolactone (MRA)	Avoid	Safe	Safe
SGLT2 pill	Avoid	Avoid	Safe
Warfarin	Avoid	Safe	Safe

What is safe changes by phase. Green is safe, amber is limited, red means avoid. Always confirm with your team before taking any medicine.

Heart-Failure Medicines in PPCM — Safe vs. Avoid by Phase

Medicine	During pregnancy	While breastfeeding	After weaning / recovered
Beta-blocker (metoprolol, carvedilol)	Safe	Safe	Safe
Water pill (furosemide)	Safe (low dose)	Safe	Safe
Hydralazine plus nitrate	Safe (first choice)	Safe	May switch to ACE/ARB
ACE / ARB / ARNI	Avoid (harms baby)	Safe (enalapril, captopril)	Safe and helps healing
Spironolactone (MRA)	Avoid	Safe	Safe
SGLT2 pill	Avoid	Avoid (limited data)	Safe
Blood thinner	Heparin only	Warfarin or heparin	Per your team

Planning a Future Pregnancy After PPCM

- **Why it matters:** PPCM can come back in a later pregnancy. The risk is highest when the ejection fraction has not returned to normal.
- **If your EF fully recovered:** another pregnancy is possible but still carries risk. Some patients relapse even with a normal EF. Plan it closely with your heart and pregnancy teams.
- **If your EF did not recover:** another pregnancy is usually advised against. It can be dangerous for the heart and for you.
- **A stress test first:** some teams check how the heart responds to stress before clearing a future pregnancy. This helps reveal hidden weakness.
- **Stop unsafe medicines before trying:** ACE inhibitors, ARBs, ARNIs, MRAs, and SGLT2 pills must be stopped before conception. Your team will switch you to pregnancy-safe options.
- **Reliable birth control matters:** while your heart heals and while you take medicines that can harm a baby, prevent an unplanned pregnancy.

Comfort Measures at Home (No Medication Needed)

These simple steps support healing and ease symptoms. Use them alongside any medication your doctor prescribes.

- Weigh yourself each morning after using the bathroom, before eating. A gain of 3 pounds in 2 days, or 5 pounds in a week, means call us.
- Limit salt to help control fluid. Aim for less than 2,000 to 3,000 mg of sodium a day. Watch canned soups, deli meats, and restaurant food.
- Rest when you need to, but stay gently active as your team allows. Light walking helps once you are stable.
- Ask for help with the baby. Broken sleep and doing too much too soon can set back recovery. You are healing too.
- Talk openly about mood. New-parent depression and anxiety are common and treatable, and a scary diagnosis makes them more likely.
- Discuss safe, reliable birth control. Avoiding an unplanned pregnancy while your heart heals is part of treatment.

Risks, Benefits, and Alternatives

Every choice has trade-offs. Use this table to start the shared decision conversation.

Option	Risks	Benefits	Alternatives
Standard heart-failure medicines (phase-adjusted)	Low blood pressure, dizziness, kidney and potassium changes. Some are not safe in pregnancy.	Lowers the heart's workload and helps the pump recover. This is the proven foundation of care.	No medicine (not advised). Fewer medicines only if blood pressure is too low to tolerate them.
Blood thinner (anticoagulation) when EF is very low	Bleeding risk. Needs monitoring. Warfarin is not used during pregnancy.	Lowers the risk of dangerous clots in the heart, lungs, and legs. Important with a weak, stretched pump.	Aspirin alone (not enough for a very weak heart). No blood thinner if EF is only mildly reduced and risk is low.
Bromocriptine (stops breast milk, for severe cases)	Means no breastfeeding. Raises clot risk, so a blood thinner is required. Not approved for PPCM in the US.	Some European data suggest faster pump recovery in severe cases (ESC suggests it).	Standard medicines without bromocriptine (the AHA and ACC approach). Continue breastfeeding if you and your team prefer.
Wearable defibrillator (LifeVest) when EF is very low	Skin irritation, false alarms, the burden of wearing it. Temporary only.	Protects against sudden cardiac arrest during the early months while the pump may still recover.	Watchful monitoring. A permanent ICD only if the EF stays very low after several months of treatment.
Advanced support (pump device or transplant) in rare severe cases	Major procedure risks. Reserved for the sickest patients.	Life-saving when the heart fails despite full medical care.	Continued medical therapy. Referral to an advanced heart-failure center; see our heart failure guide.

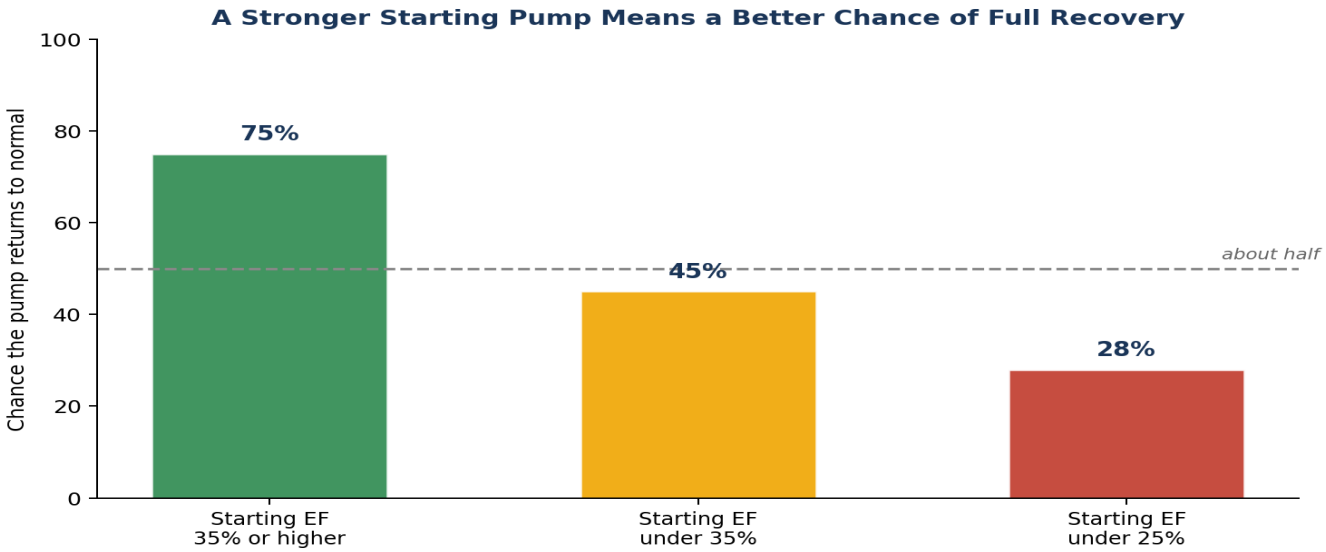
Common Misconceptions

Myth	Reality
Feeling tired and swollen at the end of pregnancy is always normal.	Mild swelling and tiredness are common. But shortness of breath when lying flat, waking up gasping, a fast heartbeat, or sudden weight gain are not normal. These can be signs of PPCM. Get checked.
If my heart recovers, I can stop all my medicines right away.	Even after the EF returns to normal, most patients stay on medicines for at least 6 to 12 months. Stopping too soon can let the heart weaken again. This is a decision to make with your cardiologist, not on your own.
A recovered heart means a future pregnancy is perfectly safe.	Recovery improves the odds, but another pregnancy still carries real risk. Even patients with normal EF can relapse. Patients whose EF did not fully recover face the highest risk and are usually advised against another pregnancy.
I caused this by doing something wrong during pregnancy.	You did not cause PPCM. It is not from exercise, diet, or stress you could have controlled. The exact cause is still being studied and likely involves hormones, inflammation, and genetics.
PPCM only happens during pregnancy, so once I deliver I am safe.	Most cases actually appear in the first weeks to months after delivery, not before. The risk window runs through about 5 months after birth. Keep watching for symptoms after the baby comes.
Heart failure this serious means I will need a transplant.	Most patients do not need a transplant. About half to two-thirds recover normal pump function with medicines alone. Advanced options like pump devices or transplant are reserved for the rare, most severe cases.
I cannot breastfeed if I have PPCM.	Many patients with PPCM can breastfeed. Several heart medicines are safe during breastfeeding. Breastfeeding is usually only stopped if bromocriptine is chosen for a severe case. Discuss it with your team.

Possible Complications

Knowing what can go wrong helps you spot problems early. Most complications are uncommon, especially with treatment.

Where / What	What Can Happen
Sudden fluid overload (acute heart failure)	A weak heart can shift fast from stable to severe fluid buildup in the lungs. This causes breathlessness at rest and is a medical emergency. IV water pills in the hospital are often needed.
Blood clots (thromboembolism)	A weak, stretched heart can form clots inside it. Clots can travel to the lungs (pulmonary embolism), brain (stroke), or legs. This is why blood thinners are used when the EF is very low.
Dangerous heart rhythms (arrhythmia)	A weakened heart can trigger fast, abnormal rhythms. Some can cause fainting or, rarely, sudden cardiac arrest. A wearable defibrillator may be used in the early months when EF is very low.
A pump that does not fully recover	In some patients the EF improves only partly, or stays low. These patients need long-term heart-failure care and carry a higher risk in any future pregnancy.
Risk in a future pregnancy	PPCM can return in a later pregnancy. The risk is highest when the EF has not returned to normal. Careful planning with your heart and pregnancy teams is essential.
Mood and bonding strain	A frightening diagnosis on top of a new baby raises the risk of depression and anxiety. These are common, treatable, and worth raising with your team.



A higher starting ejection fraction means a better chance the pump returns to normal. These are general estimates, not a promise for any one person.

Recovery Outlook — What the EF Can Do Over Time

Full recovery

- EF returns to 50% or higher
- About half to two-thirds of patients
- Best odds if EF started at 35% or higher
- Keep medicines 6 to 12 months

Partial recovery

- EF improves but stays below normal
- Long-term heart-failure care
- Higher risk in a future pregnancy
- Regular echo follow-up

Persistent weakness

- EF stays low despite treatment
- Lowest with very low starting EF
- May need a defibrillator
- Future pregnancy usually advised against

Points to Know

If you remember nothing else, remember these key points.

- PPCM is heart failure that starts in late pregnancy or the first 5 months after birth, with the EF under 45 percent and no other cause found.
- Symptoms overlap with normal late pregnancy. Trouble breathing while lying flat, waking up gasping, or sudden weight gain are red flags. Get checked.
- About half to two-thirds of patients recover normal pump function. A higher starting EF means a better chance of full recovery.
- Some heart medicines are not safe during pregnancy or breastfeeding. The plan shifts by phase, so always confirm before taking anything.
- A blood thinner is often added when the EF is very low, because a weak heart can form clots.
- Keep your heart medicines for at least 6 to 12 months after the EF normalizes. Do not stop on your own.
- A future pregnancy carries real risk, especially if the pump has not fully recovered. Plan it with your heart and pregnancy teams.
- Use reliable birth control while your heart is healing.

When to Call Us - and When to Call 911

If you are not sure, call. We would rather hear from you twice than miss a real problem.

- Severe trouble breathing, gasping for air, or coughing up pink frothy spit — call 911.
- Chest pain or pressure, fainting, or a racing, pounding heartbeat that will not settle — call 911.
- Sudden one-sided weakness, face droop, slurred speech, or trouble seeing — call 911. These can be stroke signs from a clot.
- Shortness of breath when lying flat, or waking up at night needing to sit up to breathe — call us today.
- Weight gain over 3 pounds in 2 days, or 5 pounds in a week — call us today.
- New or worsening swelling in the legs, ankles, or belly — call us this week.
- Pain, redness, or swelling in one calf — call us today (possible clot).
- Feeling very down, hopeless, or unable to care for yourself or the baby — call us; if you feel unsafe, call 988 or 911.

Office: (727) 943-5200

Trusted Resources

The links below are the trusted resources Dr. Ali used to write this guide and that he recommends you visit for more information. Each is a clickable link in the digital version and a Short.io tracked URL on the printed version.

- Cleveland Clinic — Peripartum Cardiomyopathy - Plain-language overview of PPCM symptoms, diagnosis, treatment, and recovery.
- American Heart Association — Peripartum Cardiomyopathy - AHA patient page on PPCM risk factors, warning signs, and monitoring.
- Mayo Clinic — Peripartum Cardiomyopathy - Patient guide covering diagnosis, medicines, breastfeeding, and future-pregnancy planning.
- AHA Hands-Only CPR - How to do Hands-Only CPR if someone collapses — push hard and fast in the center of the chest.

Sources Used to Build This Guide

Every recommendation in this guide is grounded in one or more of the studies, guidelines, or trusted resources below. Short links are tracked so Dr. Ali can see which references patients are reading; nothing personally identifying is captured.

- Cleveland Clinic — Peripartum Cardiomyopathy *[Clinical]*
  Patient overview of pregnancy-related heart-muscle weakening, symptoms, and recovery odds.
- American Heart Association — Peripartum Cardiomyopathy (PPCM) *[Clinical]*
  AHA patient page on PPCM definition, risk factors, and monitoring.
- AHA Scientific Statement — Cardiovascular Considerations in Caring for Pregnant Patients *[Guideline]*
  AHA statement framing peripartum heart failure within pregnancy cardiovascular care.
- Mayo Clinic — Peripartum Cardiomyopathy (Cardiomyopathy in pregnancy) *[Clinical]*
  Patient overview of diagnosis, GDMT, breastfeeding considerations, and future-pregnancy risk.
- American College of Cardiology — Peripartum Cardiomyopathy Review: Key Points (2024) *[Guideline]*
  Current ACC summary: LVEF under 45 percent definition, about half to two-thirds recover, pregnancy-safe vs unsafe medicines, bromocriptine debate, future-pregnancy risk.
- AHA Scientific Statement — Peripartum Cardiomyopathy (Circulation) *[Guideline]*
  Foundational AHA statement on diagnosis, pregnancy and lactation-safe medicines, anticoagulation, and prognosis.
- ACC — Use of Medication for Cardiovascular Disease During Pregnancy *[Guideline]*
  Which heart medicines are safe in pregnancy and breastfeeding, and which to avoid (ACE/ARB, warfarin).
- EORP PPCM Registry — Bromocriptine Treatment and Outcomes (ESC) *[Research]*
  European registry data on bromocriptine plus anticoagulation in PPCM, supporting the ESC-vs-AHA equipoise framing.

About This Guide

Rias KS Ali, MD FACC | Board Certified in Interventional Cardiology & Cardiovascular Disease

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com

Version: 2026-08-15

Reviewer note: Reviewed: Cleveland Clinic, Mayo Clinic, AHA, and ACC patient and guideline pages. This guide adds a when-it-happens timeline, a medicine-safety grid by pregnancy phase, a recovery-outlook chart, and an RBA section that names the bromocriptine debate (ESC vs. AHA/ACC) and future-pregnancy risk.

Disclaimer

This guide is for educational purposes only and does not replace medical advice from your physician. Recommendations may not apply to every patient. Always follow the specific instructions of Dr. Ali and your care team. In an emergency call 911 or go to the nearest emergency department.

Take This Guide With You

Scan or visit: https://go.riasalimd.com/ppcm-guide

Online: https://go.riasalimd.com/ppcm-guide

Office: (727) 943-5200

4740 Mile Stretch Drive, Holiday FL 34690 | Office: (727) 943-5200 | Fax: (727) 943-5201 | RiasAliMD.com