



About 50% of aortic dissections that occur in women younger than 40 years of age are associated with pregnancy. Although the cause of aortic dissection during pregnancy is unknown, it has been postulated that hemodynamic and hormonal changes associated with pregnancy may weaken the aortic wall. The highest incidence of dissection is during the third trimester, although it can occur at any time during the pregnancy or in the early postpartum period. The presenting symptoms and diagnostic work-up are similar to those for the nonpregnant patient (see [Chapter 13](#)). Transesophageal echocardiography is highly sensitive and specific for the detection of aortic dissection and offers the advantage of not exposing the fetus to ionizing radiation. Management includes aggressive blood pressure control and  $\beta$ -blocker therapy to reduce shear forces of the ejected blood. Recommendations for corrective surgery are similar to those for the nonpregnant patient and are discussed in [Chapter 13](#).

### PROSPECTUS FOR THE FUTURE

CABG remains an important but now less commonly used mode for revascularization in symptomatic coronary artery disease. Technical advances in percutaneous coronary angioplasty (PTCA) have emboldened such attempts for revascularization of unprotected left main disease, the established domain for CABG, even in octogenarians. Prospective studies are needed to evaluate the efficacy, health outcomes, and costs and benefits for combined approaches of CABG and PTCA with drug-eluting stents. Percutaneous and minimally invasive surgical options are gaining more widespread application in the management of heart disease. With the limited donor pool for cardiac transplantation, advanced

heart failure will be managed with resynchronization therapy, LVADs, and stem- and cell-based therapies.

### SUGGESTED READINGS

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