Birth Control and Pregnancy

All women, beginning at menarche, should talk to their physician about their birth control options and the advisability of becoming pregnant.

Menstruation

Menarche, or the onset of menstrual periods, may occur slightly later than normal in adolescents with congenital heart disease. This is especially true in women who are cyanotic. Women with cyanosis also may be more likely to have irregular periods. Females who have lighter-than-usual periods (fewer than five days per week), or no periods after age 18 should see a specialist (gynecologist) to find the cause.

Birth Control

Use of birth control must be tailored to a woman’s specific heart problem. Women should discuss the best form of birth control to use with their primary care physician, gynecologist and cardiologist. Women with many forms of congenital heart disease can use most methods safely. However, women with complex heart disease, cyanosis or pulmonary hypertension should not use estrogen-containing contraceptive agents like the Pill. The reason is that they increase the risk of blood clots.

Progesterone-only birth control like Depo-provera (the Shot), the Mini Pill or Implanon can be used in most cases although they may cause women to retain fluid. Intrauterine devices (IUDs) are recommended for women in single-partner/stable relationships. They aren’t recommended for women who have multiple sexual partners because of the risk for developing infections such as sexually transmitted diseases (STDs) or endocarditis. Many other birth control options may be appropriate for you. Discuss this in detail with a cardiologist with expertise in adult congenital heart disease and your gynecologist.

Tubal ligation is a permanent sterilization procedure for women. There are two methods. One is a surgical procedure (laparoscope) and the other is a vaginal procedure (Essure).

Pregnancy

The majority of women with repaired congenital heart disease can have a safe pregnancy with little risk. The degree of risk will depend on any complications and/or remaining problems of the heart defect and surgeries. These are important to identify and treat before pregnancy because the normal changes of pregnancy, particularly in the second and third trimesters, can worsen...
symptoms of congestive heart failure and arrhythmias. They also can cause women who’ve had no symptoms to develop problems.

It’s important to talk to a cardiologist with expertise in adult congenital heart disease before becoming pregnant. A “pre-pregnancy” evaluation will give your doctor time to treat any problems that could arise during your pregnancy.

Some types of heart disease are considered extremely high risk so pregnancy isn’t recommended. These include pulmonary hypertension or severe heart failure. Women who remain cyanotic should also avoid pregnancy because it increases the risk of blood clots and stroke. If the woman has Eisenmenger’s syndrome (cyanosis and pulmonary hypertension), the risk is extremely high for both the mother and her fetus.

Anyone with repaired or non-repaired congenital heart disease should consult with their cardiologist to review their risks before they become pregnant.

In many cases, women will be advised to have their pregnancy managed by a high-risk obstetrician along with a cardiologist familiar with their condition. Babies usually can be delivered vaginally. A Caesarean section typically isn’t necessary just for heart reasons.

**Risk to the Baby**

The fetus has a higher risk of heart disease if either parent has a congenital heart defect. In these cases, it’s often smart to have an ultrasound performed to check the fetus’s heart for possible defects. This test, a fetal echocardiogram, must be done by a specially trained physician. It’s usually done about the 18th week of pregnancy.

**Menopause**

No information is available about menopause and whether estrogen replacement is safe for women with congenital heart disease.