Pityriasis Rosea in a Pregnancy

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A pregnant woman with Pitriasis rosea whose lesion onset is in first trimester is presented. No interventions were undertaken and her eruption remitted completely 6-7 weeks. We found no evidence of active infection for HHV-6 and HHV-7. A girl with a birth weight 2000 kg was born at 34 weeks and 6 days. She had to stay in the neonatal intensive care unit for 5 days. The baby is now 6 months of age and is healthy. In order to evaluate whether PR especially when it develops within the first weeks' gestation, is associated with adverse pregnancy outcome, further investigations are required.

Key Words: Human herpesvirus-6, Human herpesvirus-7, Pitriasis rosea, Pregnancy

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Introduction

Pityriasis rosea (PR) is an acute, self-limiting skin disease with a distinctive erythematous scaly eruption that usually occurs in the second or third decade of life.[1] PR has been reported to occur more frequently in pregnancy than in the general population (18% versus 6%),[2] and in a recent case series study demonstrated that PR associated premature delivery and fetal demise particularly if it develops within first trimester.[3] Its origin is still debatable, but some evidence points to the endogenous reactivation of human herpesviruses (HHV)-6 and HHV-7.[4]

We report a pregnant woman with PR whose lesion onset is in first trimester and analyzed her blood and tissue samples using quantitative real time polymerase chain reaction (PCR) assays for HHV-6 and HHV-7 and discuss its implications for the mother and fetus.

Case Report

A 28-year-old women presented in the 7th week of her second planned pregnancy with a generalized eruption for 1 week. Mild itch was noted. The patient had not prodromal symptoms except mild loss of appetite. Her past health was good. She had a previous preterm birth. Drug history was unremarkable apart from folic acid and multivitamins.

Clinical examination revealed that discrete patches on her trunk and proximal aspects of her four extremities. The lesions were about 1-2 cm in diameter and some other smaller, mostly circular or oval-shaped. Peripheral collateral scaling was noted and some lesions were orientated along lines of skin cleavage (Figure 1). Face, scalp, genital region, and palmoplantar surfaces were unaffected. Her complete blood analysis, liver function tests and clotting profile were normal. We excluded the presence of Syphilis, Hepatitis B virus, Hepatitis C virus, Rubella, Cytomegalovirus, Parvovirus, Human immunodeficiency virus and Epstein Barr in blood specimen. In this study, HHV-6 and HHV-7 DNAs were investigated with PCR using HHV-6 or HHV-7 DNA specific primer sets. HHV-6 DNA was detected in saliva, whereas no evidence of HHV-6 or HHV-7 DNA was found in plasma or skin lesion. During the acute phase of her PR, serology demonstrated no anti-HHV-6 immunoglobulin G, and the antibody response remained unchanged after PR recovery. We could not examine HHV-7 antibodies status.

No interventions were undertaken. Her eruption remitted completely 6-7 weeks. During her 10th week of pregnancy she had minimal brown spotting. A girl with a birth weight 2000 kg was born at 34 weeks and 6 days. She had to stay in the neonatal intensive care unit for 5 days. The baby is now 6 months of age and is healthy.

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Figure 1: Trunk and proximal limb distribution, symmetry and rash orientation of skin cleavage in typical pityriasis rosea in a pregnant women.

Discussion

PR is a common papulosquamous skin disorders (average annual incidence, 172.2/100.000 person-year). Female patients slightly predominate and more than 75% of patients are between the ages of 10 and 35 years.

The aetiology of PR is unknown. Recent studies have reported no evidence of PR associated with Cytomegalovirus, Epstein-Barr virus, Parvovirus B19, Chlamydia pneumoniae, Chlamydia trachomatis, Legionella spp and Mycoplasma pneumonia infections.

We failed to identify an active HHV-6 or HHV-7 infection. Conflicting results on the association of PR and HHV-6 and HHV-7 infection have been reported by different investigators.[5]

PR infection in pregnancy give concerns to pregnant women of teratogenic effects associated with the rash. The lack of data about aetiological agents more often overestimated the true teratogenic risk, despite the limited data is unknown. Published few case reports found no increased risk for teratogenic and adverse pregnancy outcome associated with PR in pregnancy. But a recent case series showed that increased abortion rate, premature delivery, neonatal hypotonia, neonatal hiporeactivity, weak motility, and incubator needing is associated women with PR, especially when PR develops within the first weeks' gestation, and when the lesions are diffuse and constitutional symptoms are present.[3] However for this study it must be kept in mind that previous preterm birth is a risk factor for preterm birth. In order to evaluate whether PR is associated with adverse pregnancy outcome, further investigations are required.

Bir Gebede Pitriazis Rosea

Bu çalışmada gebeliğinin ilk trimesterinde Pitriasis rosea tanısı konulan bir gebe sunulmaktadır. Olguya herhangi bir müdahalede bulunulmamıştır ve lezyonlar 6-7 hafta içinde kendiliğinden kaybolmuştur. Vaka HHV-6 ve HHV-7 enfeksiyonu açısından incelenmiş, aktif HHV-6 ya da HHV-7 enfeksiyonu saptanmamıştır. Gebeliğinin 34 hafta 6 gününde 2000 kg ağırlığında kız bebek dünyaya getirmiştir. Yenidoğan 5 gün yenidoğan yoğun bakım servisinde tutulmuştur. Bebek şu anda 6 aylık olup sağlıklıdır. Pitriasis rosea'nin, özellikle ilk trimesterde meydana gelirse, gebelikte olumsuz etkilere yol açıp açmadığının aydınlığa kavuşturulması için ileri çalışmalara ihtiyaç duyulmaktadır.

Anahtar Kelimeler: Gebelik, Human herpesvirus-6, Human herpesvirus-7, Pitriazis rosea

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