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UNILATERAL LATEROTHORACIC EXANTHEM IN A PREGNANT WOMAN - CASE REPORT

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comment:

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We read with admiration the report by Chiriac et al. on the normal pregnancy outcome of a 32-year-old lady in Romania with unilateral laterothoracic exanthem (ULE) at the fifth month of her first pregnancy. Virological investigations revealed insignificant findings.

We wish to make three comments. Firstly, we have also reported two pregnant ladies with an exanthem which might be caused by viruses, namely pityriasis rosea (PR) [1]. Maternal and foetal outcomes were good on both occasions. However, a case series report followed 38 women with PR [2]. Nine had premature delivery, and five miscarried. Six neonates showed hypotonia, weak motility, and hyporeactivity [2].

We should therefore clearly document, and report if possible, maternal and foetal outcomes when pregnancy is complicated by exanthems which may be related to viral infections, not only ULE and PR, but also Gianotti-Crosti syndrome (papular acrodermatitis in adults), papular purpuric gloves and socks syndrome, eruptive pseudoangiomatosis, and other similar exanthems.

Secondly, the authors stated that "virological results were negative for *parvovirus B19*, *Epstein-Barr virus*, and *cytomegalovirus* (CMV)". We hope they meant that IgG against CMV was positive, for such conferred some reassurance that primary infection during the exanthematous period was less likely.

The seroprevalence against CMV in young ladies in developed countries is relatively low. For a pregnant lady to have an exanthem for which CMV infection is known to be associated with, no test exists to exclude primary CMV infection definitely. Serial IgG to document seroconversion (preferably performed in parallel in a reference laboratory), and IgM can be arranged, but the interpretation of results is difficult [3]. Serial ultrasound scans can monitor intrauterine growth and detect markers of foetal abnormalities, but the sensitivity is low [3]. If amniocentesis is being considered, such should be done at least seven weeks after presumed time of maternal infection and after 21 weeks of gestation [4].

The paediatrician might be informed of the history of the paraviral exanthem during pregnancy. However, clinical detection on the neonate is insensitive. Where clinically indicated, the blood, urine, and saliva of the neonate can be tested for CMV within the first three weeks of life [3].

However, we have no information on the seroprevalence of CMV in Romania. CMV infection is not strongly associated with ULE [5], and there exists no licensed active intervention for congenital CMV infection. We thus hesitate on how far one should proceed in clinical settings independent of academic discussions and speculations.

Thirdly, we have previously reported two patients with the reversed version of ULE – namely unilateral mediothoracic exanthem. The eruption occurs mainly on the anteromedial aspect of the chest, reaching but not crossing the midline of the thoracic cage [6]. Readers of your prestigious journal coming across similar syndromatology might consider reporting such to the journal.

We once again congratulate the authors for their successful outcome of their patients and for their outstanding case report.

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