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Adenopathy and pregnancy: a case report

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Detection of cytomegalovirus (CMV) infection is not included in the routine screening during pregnancy.

A 19-year-old woman was admitted to a primary care center (PCC) reporting asthenia, amenorrhea and some blackout episodes for 10 days.

Medical history: vitiligo. Three months earlier she had consulted in another PCC for mononucleosis syndrome and amenorrhea. Blood-test: positive cytomegalovirus immunoglobulin M(IgM) and immunoglobulin G(IgG) with low IgG avidity, positive Epstein Barr virus(EBV) IgM, AST 58, ALT 86 and positive beta-HCG urine test. Afterwards, the patient had a miscarriage.

On examination she had a painless, elastic and mobile right submandibular adenopathy of 1.5 cm. Beta-HCG urine test was negative. Blood test: positive CMV IgG of high avidity and doubtful levels of EBV IgM. A new beta HCG urine test requested was positive.

The patient had a primary CMV infection with EBV cross-react and had a miscarriage in the early infection. Two months later she gets pregnant again. She was monitored with ultrasound and amniocentesis was requested at week 21 but it is considered to have a low risk. Cytomegalovirus (CMV) infection is now the commonest congenital form of infective neurological handicap. The prevalence of congenital cytomegalovirus infection is 0.3% to 2,4%. CMV infected infants who are symptomatic at birth have a 5-10% neonatal mortality rate and, among survivors consequences may be severe and lifelong.

At the finding of positive CMV IgG or IgM in the first trimester of pregnancy, IgG avidity testing should be performed. Depending on the degree of avidity amniocentesis with CMV-PCR must be considered to determine fetal infection. If the CMV-PCR is positive management options may include CMV hiperimmune-globulin or termination of pregnancy.

The prevalence of infection in fertile women ranges from 60-95%. In this sense, efforts should be made to inform women who have a CMV infection not to get pregnant.