Herpes zoster during pregnancy

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Abstract

Question One of my pregnant patients, a 32-year-old woman (gravida 2, para 1), has a flare up of herpes zoster (HZ) at the T11 to T12 dermatomes. This virus, the varicella-zoster virus, causes chickenpox, which can be teratogenic. Is this also true for HZ?

Answer Herpes zoster, unlike chickenpox, is not associated with increased fetal risk. In contrast, a nonimmune woman exposed to HZ by contact might contract chickenpox.

L’herpès zoster durant la grossesse

Résumé

Question Une de mes patientes enceintes, une femme de 32 ans (2 grossesses, 1 naissance) a une poussée active d’herpès zoster (zona) aux dermatomes T11 à T12. Ce virus, le virus varicelle-zona, cause la varicelle, qui peut être tératogène. Est-ce aussi le cas du zona?

Réponse L’herpès zoster, à l’encontre de la varicelle, n’est pas associé à des risques accrus pour le fœtus. Par contre, une femme non immunisée exposée au zona par contact peut contracter la varicelle.

Following a primary infection with the varicella-zoster virus (VZV), the virus can remain latent in the dorsal root ganglia and might cause herpes zoster (HZ) upon reactivation. Herpes zoster infection typically exhibits vesicular rash, pain, and itching in the dermatome distribution. Patients might suffer from postherpetic neuralgia for months after the rash subsides.

Herpes zoster is contagious only while the patient has lesions and until the lesions crust. Covering the lesions decreases transmission. Susceptible (nonimmunized) individuals might contract primary varicella infection (chickenpox) by direct contact with the zoster lesion.1,2

A prospective study reported on 474 women diagnosed with HZ during pregnancy.3 The 474 women had 466 live births, 5 miscarriages, and 3 therapeutic abortions. There were 2 children with malformations, but no cases of congenital varicella syndrome (CVS) among the live births and no serologic evidence of intrauterine infection. A smaller prospective report had 14 cases complicated with HZ with no adverse outcomes or CVS.4

There is a theoretical risk of intrauterine infection following HZ involving the T10 to L1 dermatomes (as sensory nerves to the uterus originate from these segments) during pregnancy. However, no such reports have been documented.5 There was a case of congenital malformations consistent with CVS (limb hypoplasia and skin scarring) in a child whose mother had disseminated zoster at 12 weeks of gestation, highlighting the possibility of infection caused by maternal viremia.6

There is no clinical or serologic evidence of VZV infection in infants whose mothers developed perinatal zoster. Newborns do not appear to be at risk of infection if maternal zoster occurs near delivery.7

If a susceptible pregnant woman (in any stage of pregnancy) is exposed to VZV, passive antibody prophylaxis with immunoglobulin preparation containing VZV immunoglobulin G is indicated within 96 hours of exposure.2

Herpes zoster infection during pregnancy is not associated with increased risk of congenital malformations above the general population baseline risk or of CVS. Individuals with HZ should cover lesions in order to reduce the risk of transmitting VZV to susceptible pregnant women.

References