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Infectious Mononucleosis in Pregnancy

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ABSTRACT

We present a case of a 30-year-old pregnant woman diagnosed with Epstein-Barr virus (EBV) infection presenting as infectious mononucleosis (IM) in the second trimester. Despite initial concerns about potential fetal effects, comprehensive maternal and fetal monitoring yielded a reassuring outcome, highlighting the importance of a balanced approach in managing such cases.

INTRODUCTION

Primary EBV infection during pregnancy, particularly presenting as IM, raises concerns about vertical transmission and potential fetal anomalies. This case report presents a rare instance of IM in pregnancy with a reassuring fetal outcome, emphasizing the importance of close monitoring and individualized management strategies (1-5).

CASE PRESENTATION

A 30-year-old primigravida woman at 22 weeks' gestation presented with fever, fatigue, cervical lymphadenopathy, and pharyngitis. Laboratory tests revealed leukocytosis, atypical lymphocytes, and positive EBV serology (immunoglobulin M (IgM) positive, IgG negative). A diagnosis of IM was confirmed. Ultrasound examination revealed a normal-appearing fetus with no evidence of congenital anomalies. Fetal cardiotocography and amniocentesis were performed, demonstrating reassuring results.

Management included supportive care with antipyretics, hydration, and symptomatic relief. Fetal surveillance using regular ultrasounds and cardiotocography was maintained throughout the remaining pregnancy. Maternal EBV serology monitored the viral course, which resolved spontaneously within 4 weeks. The patient delivered a healthy term neonate via spontaneous vaginal delivery with Apgar scores of 9 at 1

and 5 minutes. Postnatal examinations and EBV serology in the neonate were unremarkable, confirming no vertical transmission.

DISCUSSION

Primary EBV infection during pregnancy, especially IM, raises concerns about vertical transmission and fetal complications. The reported rate of EBV transmission to the fetus ranges from 0% to 30%, with risks increasing in the third trimester. Potential fetal effects include intrauterine growth restriction, preterm birth, and congenital malformations. However, several factors influence the risk of adverse outcomes, including maternal EBV antibody status, gestational timing of infection, and viral load (6-11).

In this case, the absence of maternal IgG antibodies at presentation suggested primary EBV infection and potential risk of vertical transmission. However, reassuring serial ultrasounds, negative amniocentesis, and absence of fetal anomalies ultimately suggested a low risk of congenital malformations. Additionally, the spontaneous resolution of IM within a few weeks indicated a controlled maternal viral response, further lowering the transmission risk. This case highlights the importance of a nuanced approach in managing EBV infection during pregnancy. While proactive fetal surveillance is crucial, unnecessary interventions should be avoided to minimize maternal and fetal stress. Comprehensive

evaluation considering maternal serology, gestational timing, clinical presentation, and fetal monitoring allows for individualized management and potentially reassuring outcomes.

This case report demonstrates the possibility of a reassuring fetal outcome even in a pregnant woman with IM. While close monitoring and a cautious approach are warranted, relying solely on the diagnosis of IM should not automatically predict adverse fetal effects. Individualized management based on comprehensive assessment and proactive fetal surveillance can play a significant role in optimizing both maternal and fetal well-being in such cases. Further research is needed to refine risk stratification and optimize management strategies for pregnant women with EBV infection.

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