Fifth stage
Dermatology **Lec12**
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Dermatoses of Pregnancy

The specific dermatoses of pregnancy are a heterogeneous group of pruritic skin disorders that, for decades, represented a confusing group of overlapping entities, understood largely through anecdotes and case reports.

Physiologic changes during pregnancy

1. PIGMENTARY:
-Hyperpigmentation (areolae, linea nigra).
-Melasma.
2. HAIR:
-Hirsutism.
-Postpartum telogen effluvium.
-Postpartum androgenetic alopecia.
3. NAIL:
-Subungual hyperkeratosis.
-Distal onycholysis.
-Transverse grooving.
-Brittleness.
4. GLANDULAR:
-Increased eccrine function (except palms).
-Increased sebaceous function.
-Decreased apocrine function.
5. CONNECTIVE TISSUE:
-Striae gravidarum develop in up to 90% of patients and often resolve . Both hormonal factors and physical stretching of the skin appear to be relevant in their development.
6. VASCULAR:
-Spider angiomas.
-Palmar erythema.
-Non-pitting edema.
-Varicosities.
-Vasomotor instability.
-Purpura.

-Gingival hyperemia or hyperplasia.
-Pyogenic granuloma.
-Hemorrhoids.

Dermatoses of pregnancy

Pemphigoid gestationis (herpes gestationis)

Onset:

*Typically second or third trimester or immediately post-partum.

Appearance:

*Pruritic papules and plaques that progress to blisters and bullae mainly on trunk (involving umbilicus).

Treatment/Course:

*Topical or systemic corticosteroids depending on severity (taper once blisters resolve).
*Spontaneously resolves but may flare/recur around delivery, with menstruation, or OCPs.
*May take weeks to months after delivery to entirely resolve.
*Typically recurs in future pregnancies (more severe/earlier).

Risk to Fetus:

*↑risk prematurity and small for gestational age.
*Baby may have mild transient pemphigoid lesions.
*Risks to fetus correlate with disease severity.

Interesting Facts:

*May occur with choriocarcinoma.
*↑ risk of Graves' disease
*Due to IgG1 autoantibodies against BP180, so DIF with linear C3 along perilesional BMZ.
*Strongly a/w HLA-DR3 and DR4.

Polymorphic eruption of pregnancy

Onset:

*Third trimester or immediately post-partum.

Appearance:

*Urticarial, pruritic papules and plaques which prefer striae distensae (spares umbilicus).
*Usually spares face and extremities.

Treatment/Course:

*Topical steroids and antihistamines may help.
*Resolves over 4 wks.
*Typically does not recur.

Risk to Fetus:
*None.
Interesting Facts:
*Mainly seen in primiparous women.
*↑risk in multiple-gestation pregnancies.

Intrahepatic cholestasis of pregnancy

Onset:
*Third trimester.
Appearance:
*Extreme generalized pruritus without primary rash.
*Worse at night.
*Bad on palm/sole.
*Excoriations/ prurigo typically seen on extensor surfaces.
*Jaundice in 10%.
Treatment/Course:
*MUST ↓ serum bile acid levels – oral ursodeoxycholic acid.
*May recur in future pregnancies and can flare with OCPs.
*May have steatorrhea and vitamin K deficiency → postpartum hemorrhage.
*Pruritus resolves shortly after delivery.
Risk to Fetus:
*↑risk of premature birth, intrapartum fetal distress, stillbirth.
*Risks correlate with bile acid levels (i.e., >40 μmol/L).
Interesting Facts:
*↑total serum bile acid levels (>11 μmol/L) due to ↓ excretion.

Atopic eruption of pregnancy (prurigo of pregnancy)

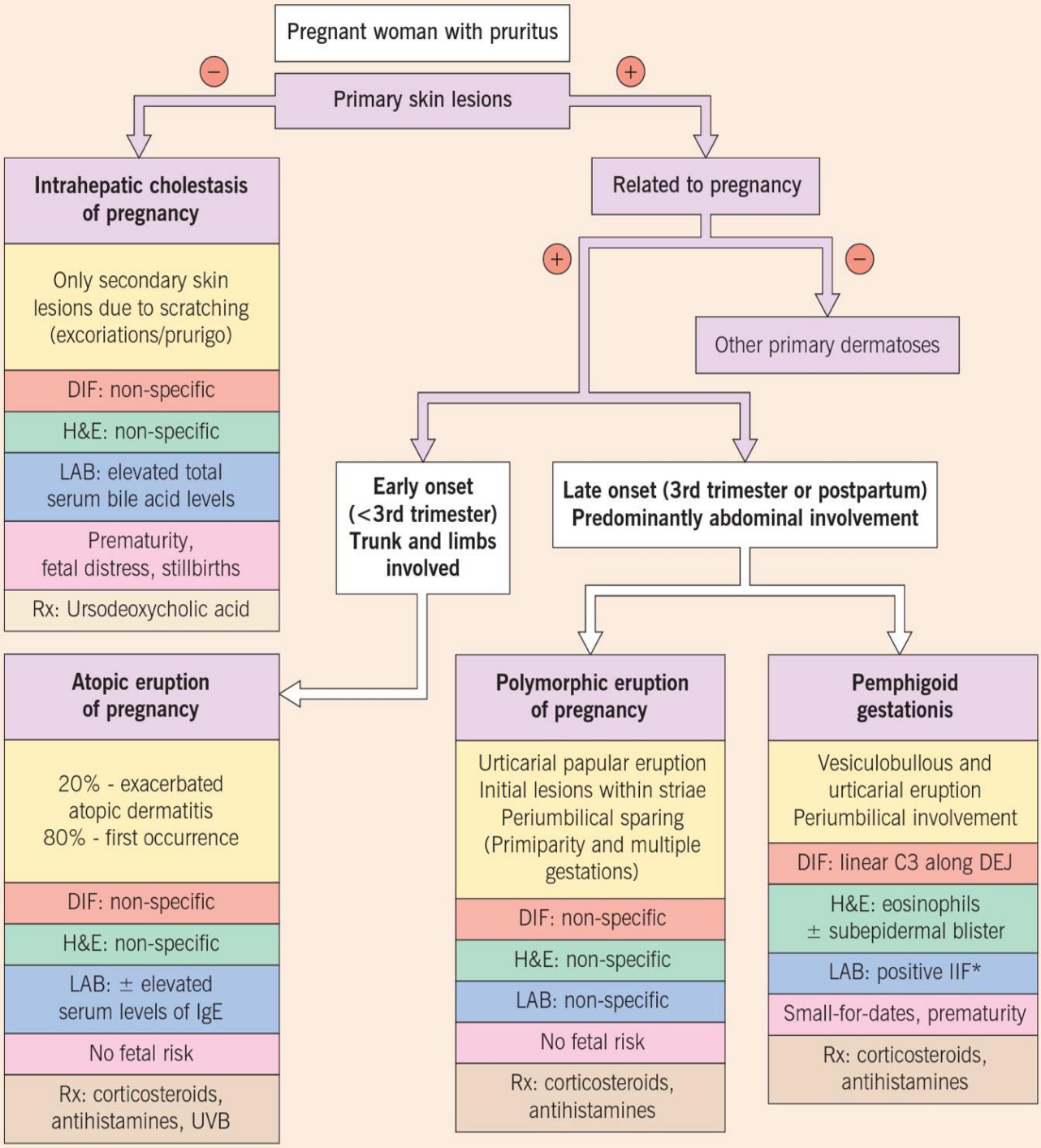
Onset:
*Usually first or second trimester.
Appearance:
*Eczematous or papular eruption usually in typical sites (e.g., flexural surfaces) typically in pts with atopic history.
*May be flare of pre-existing dermatitis or first time they have had dermatitis (80%).
Treatment/Course:
*Topical steroids, emollients, antihistamines, UVB for symptom control.
*Usually recurs with future pregnancies.
Risk to Fetus:
*None.

Interesting Facts:
*Most have ↑IgE.
*May be Th2 mediated.
*Most common pruritic disorder of pregnancy.

Impetigo herpetiformis

Onset:
*Usually third trimester.
Appearance:
*Generalized pustular psoriasis starting in flexures (groin mainly).
Treatment/Course:
*Supportive, prednisone.
*Resolves with delivery typically.
*Recurs with future pregnancies and OCPs.
Risk to Fetus:
*Placental insufficiency, stillbirth, neonatal death in bad disease.
Interesting Facts:
*Hypocalcemia and ↓vitamin D.
*Mom may have cardiac/renal failur.

APPROACH TO THE PREGNANT WOMAN WITH PRURITUS



DEJ, dermo-epidermal junction; DIF, direct immunofluorescence; H&E, hematoxylin and eosin-stained histologic sections; IIF, indirect immunofluorescence; LAB, laboratory findings.
*Conventional - 30%; complement-added - nearly all.