Influenza and exanthematic viruses

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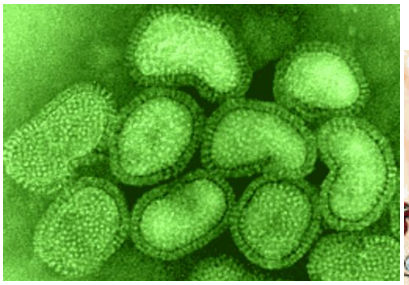
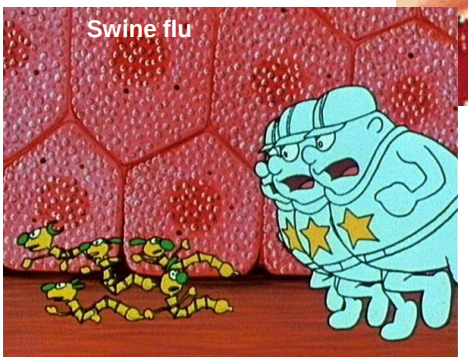
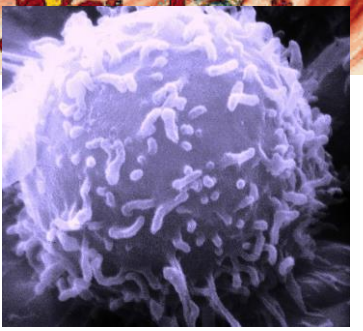
HSCT UNIT - PEDIATRICS PRAGUE CZECH REPUBLIC

Life is fight







Viruses described in immunosupressed patient

RNA viruses

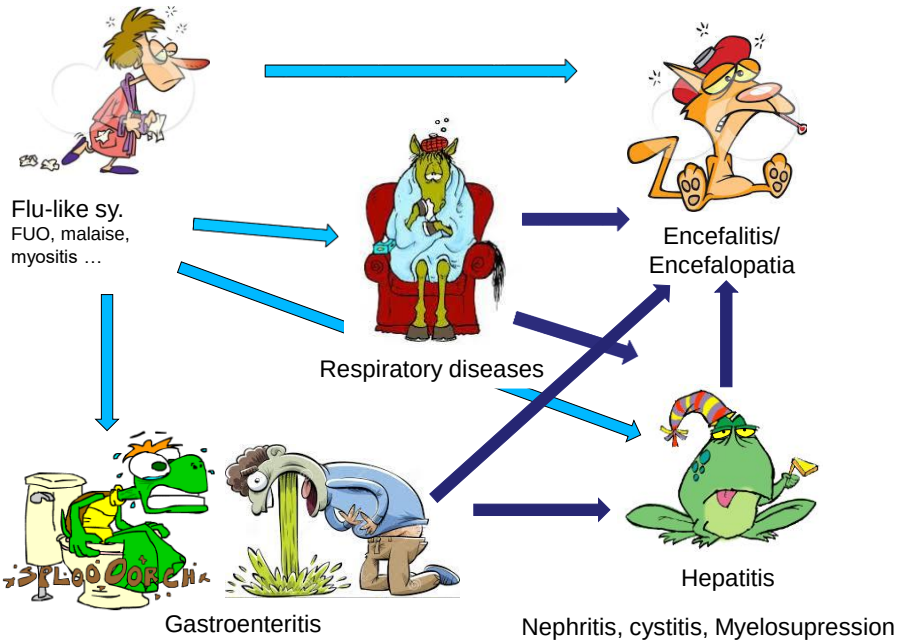
ss RNA

- ***Ortomyxoviridae*** → **Influenza A**, **Influenza B**
- ***Paramyxoviridae*** → **Paramyxovirus** → **PIV**; **Morbillivirus**; **Pneumovirus** → **RSV**, **hMPV**
- ***Coronaviridae*** → HCoV
- ***Picornaviridae*** → **Enteroviruses**; **Rhinovirus** → **HRV**
- ***Caliciviridae*** → Human caliciviruses
- ***Astroviridae*** → Astrovirus
- ***Rhadboviridae*** → Lyssa virus
- ***Flaviviridae*** → HCV…

ds RNA

- ***Reoviridae*** → **Rotavirus**, **Orbivirus**

Clinical consequences



What to aim during the process of dg? **Clinical symptoms**

Adapted ECDC Definitions of Respiratory Tract Infectious Disease (RTID)

Clinical criteria

- *New* onset of symptoms
  AND
  at least one of the following four respiratory symptoms:
  - Cough
  - Sore throat
  - Shortness of breath
  - Coryza

  AND
  - A clinician's judgement that the illness is due to an infection

Epidemiological Criteria

- An epidemiological link with human to human transmission

Laboratory Criteria

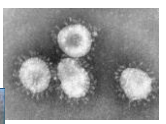
- Detection of CARV in a clinical specimen by at least *one* of the following:
  - Virus isolation by cell culture (VIC)
  - Direct virus antigen testing (DAT)
  - Nucleic acid amplification testing (NAT)

Case Classification

- **Possible case**
  - Any person meeting the clinical criteria of RTID
- **Probable case**
  - Any person meeting the clinical criteria of RTID *and* with an epidemiological link
- **Confirmed case**
  - Any person meeting the clinical of RTID *and* the laboratory criteria

Adapted from ECDC definitions for influenza
http://ecdc.europa.eu/en/activities/surveillance/EISN/surveillance/Pages/influenza_case_definitions.aspx

Respiratory viruses

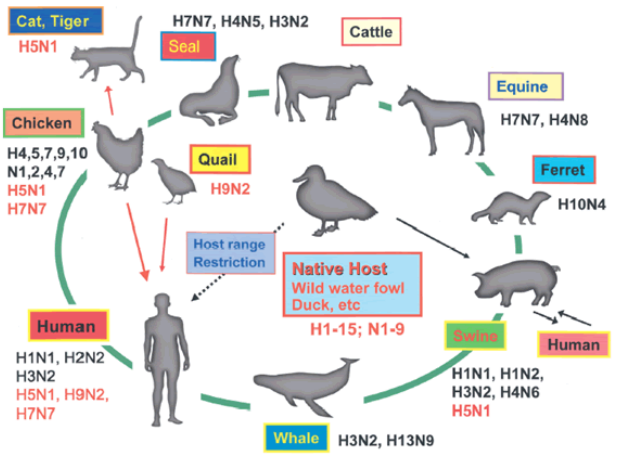


- Often zoonotic:
  - SARS – CoV
  - MERS - CoV
  - …

Bats – Horseshoe bat,…

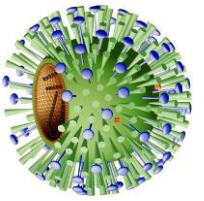
Civet

Leads to high Frequence of recombination of new life-threatening infections

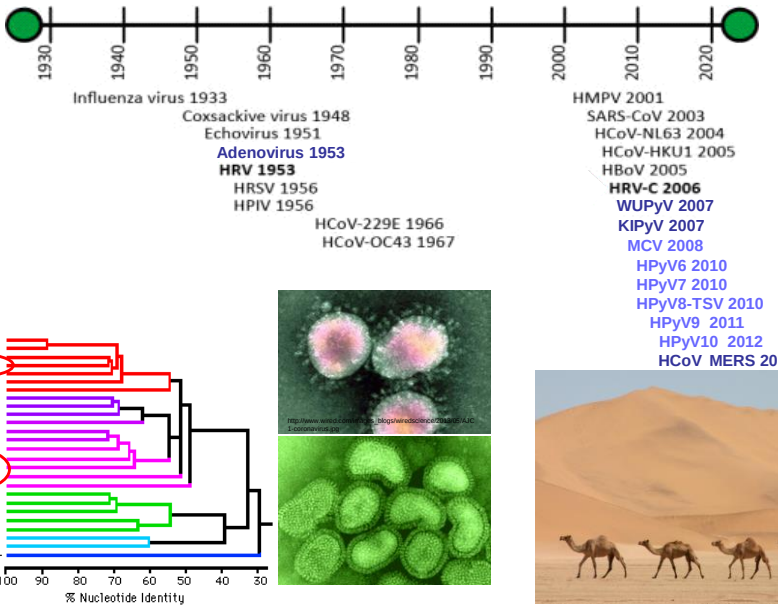


What is influenza?

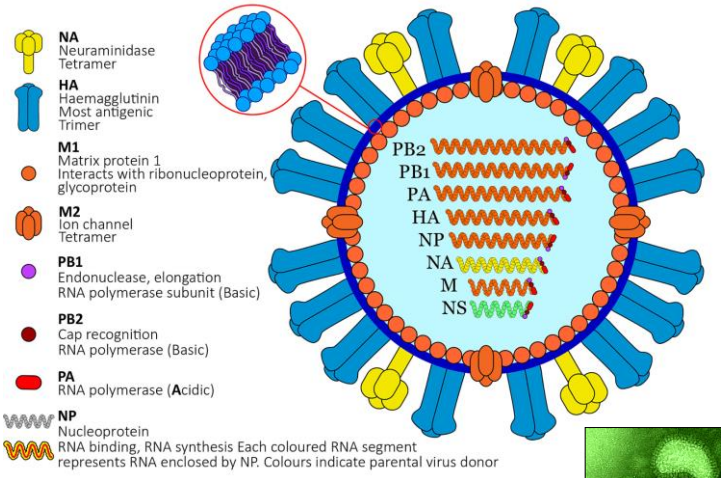
- An acute respiratory illness resulting from infection with an influenza virus (Orthomyxoviruses)
- Highly infectious and can spread rapidly from person to person
- Some strains cause more severe illness than others
- Highly infectious viral illness
- 412 BC - first mentioned by Hippocrates
- 1580 - first pandemic described
- 1580-1900 - 28 pandemics
- Virus first isolated in 1933



History of viral respiratory infections

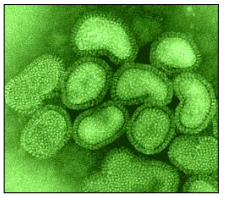


ORTHOMYXOVIRUSES



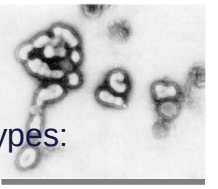
typ A, B, C : NP, M1 protein
sub-typy: HA nebo NA protein

https://figshare.com/articles/Influenza_virus/6817112



http://www.uct.ac.za/depts/mmi/stannard/fluvirus.html

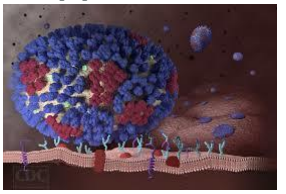
Types of influenza viruses



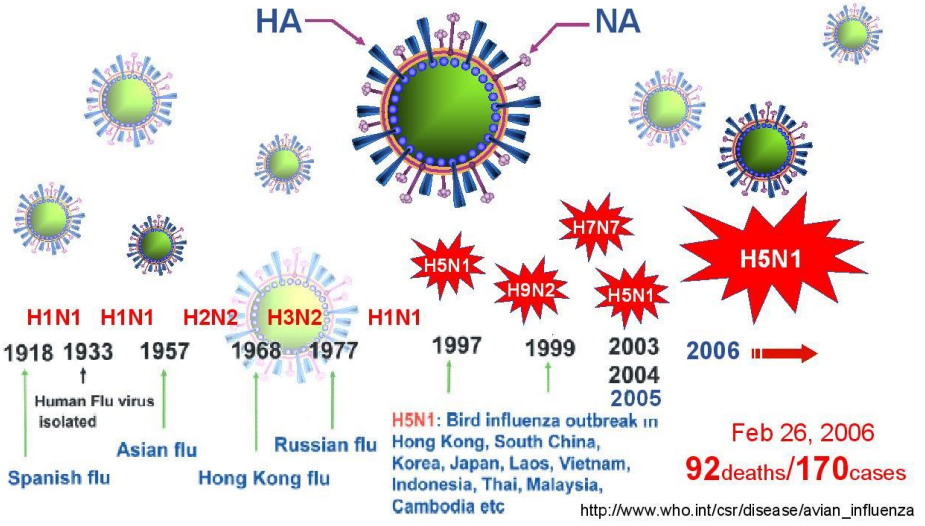
- Influenza viruses are divided into three main types: influenza A, B, and C
- **Group A** viruses
  - infect birds and other animals, as well as humans
  - source of seasonal influenza epidemics and all pandemics
  - moderate to severe illness
  - all age groups
  - humans and other animals
  - typed by NA and HA
- **Group B**
  - changes less rapidly than type A – no Ag shift
  - infects humans only, milder epidemics
  - primarily affects children
- **Group C** viruses
  - infect humans only and do not cause pandemics

Types of influenza viruses

	TYPE A	TYPE B	TYPE C
severity of illness	++++	++	+
animal reservoir	yes	no	no
human pandemics	yes	no	no
human epidemics	yes	yes	no (sporadic)
antigenic changes	shift, drift	drift	drift
segmented genome	yes	yes	yes
amantadine, rimantidine	sensitive	no effect	no effect
zanamivir	sensitive	sensitive	
surface glycoproteins	2	2	(1)



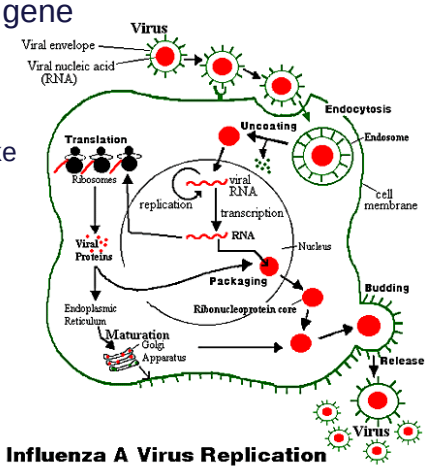
Influenza A viruses



Influenza Antigenic Changes

- **Antigenic Drift** - seasonal
  - Minor change, same subtype
  - Caused by point mutations in gene
  - May result in epidemic

Example of antigenic drift
- In 2003-2004, A/Fujian/411/2002-like (H3N2) virus was dominant
- A/California/7/2004 (H3N2) began to circulate and became the dominant virus in 2005

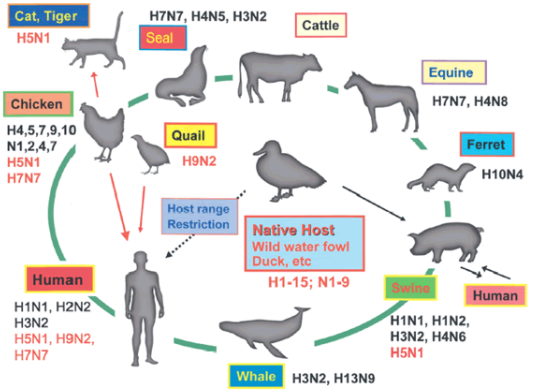


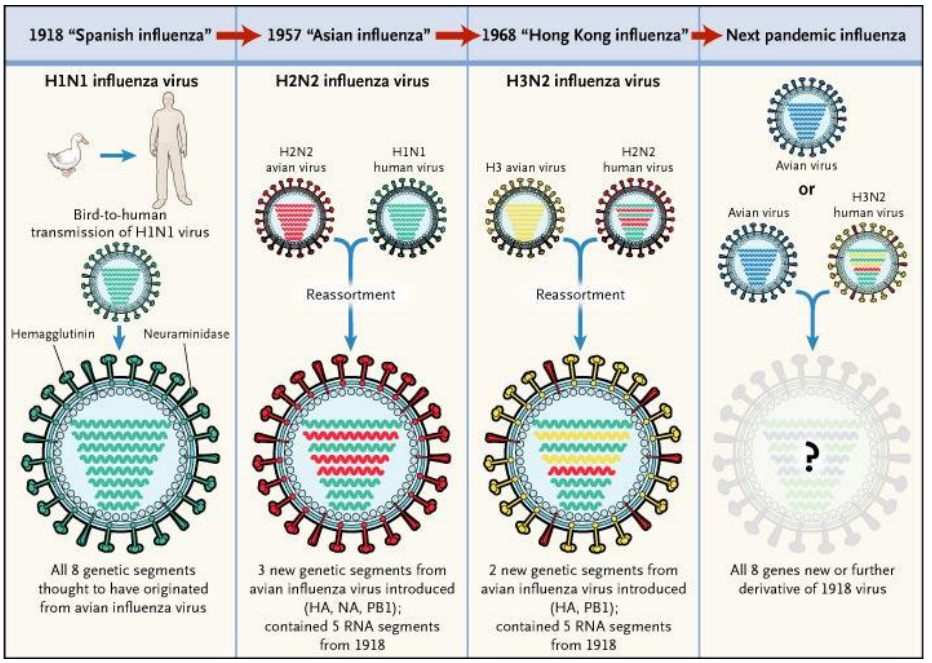
Influenza A Virus Replication

Influenza Antigenic Changes

- **Antigenic Shift**
  - Major change, new subtype
  - Caused by exchange of gene segments
  - May result in pandemic

- Example of antigenic shift
  - H2N2 virus circulated in 1957-1967
  - H3N2 virus appeared in 1968 and completely replaced H2N2 virus

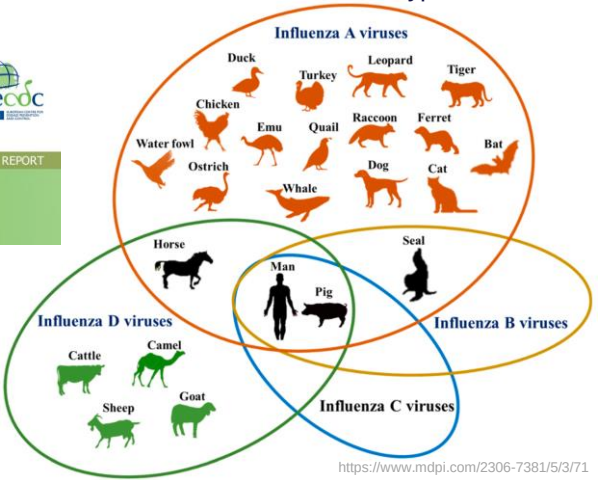




https://www.nejm.org/doi/full/10.1056/NEJMp058281

How many HA and NA?

- 13 types HA
- 9 types NA – all circulating in birds
- Pigs – might be infected both with human and bird's types



https://www.mdpi.com/2306-7381/5/3/71

Burden of Influenza

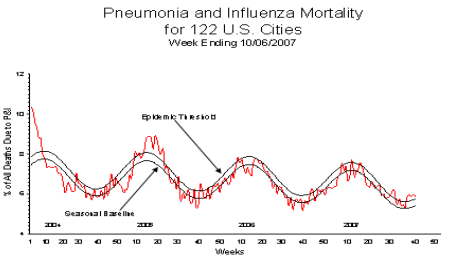
- 10% to 20% of the population is infected with influenza virus each year
- Average of more than 200,000 excess hospitalizations each year
  - Persons 65 and older and 2 years and younger at highest risk
- Average of 36,000 deaths each year
  - Persons 65 and older at highest risk of death

Influenza Associated Pulmonary and Circulatory Deaths, 1998

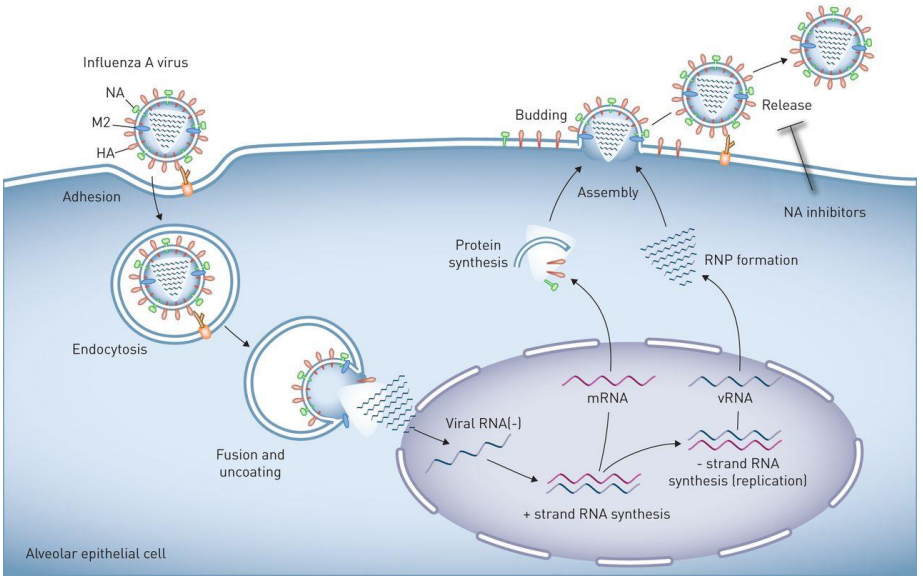
Age Group (yrs)	Rate (per 100,000)	
0 – 49	0.4 – 0.6	
50 – 64	7.5	
≥65	98.3	(>90% mortality rate)

Influenza Epidemiology

- Reservoir: Human, animals (type A only)
- Transmission: - inhaling respiratory aerosols containing the virus, produced when infected person talks, coughs, or sneezes
  100,000 - 1,000,000 virions/droplet
  » touching an infected person or an item contaminated with the virus and then touching your eyes, nose, or mouth
- Incubation: 18-72 hours
- Communicability: Maximum 1-2 days before to 4-5 days after onset



EUROPEAN RESPIRATORY journal
FLAGSHIP SCIENTIFIC JOURNAL OF ERS



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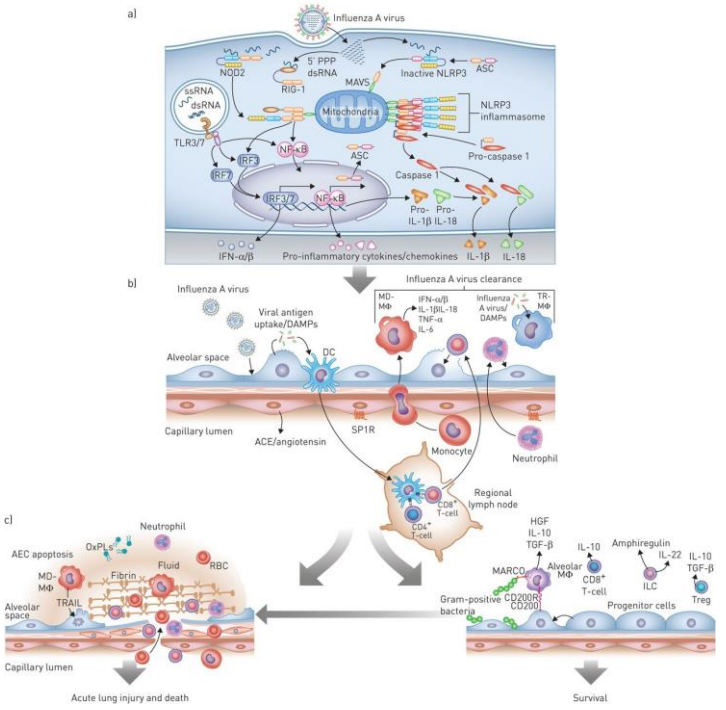

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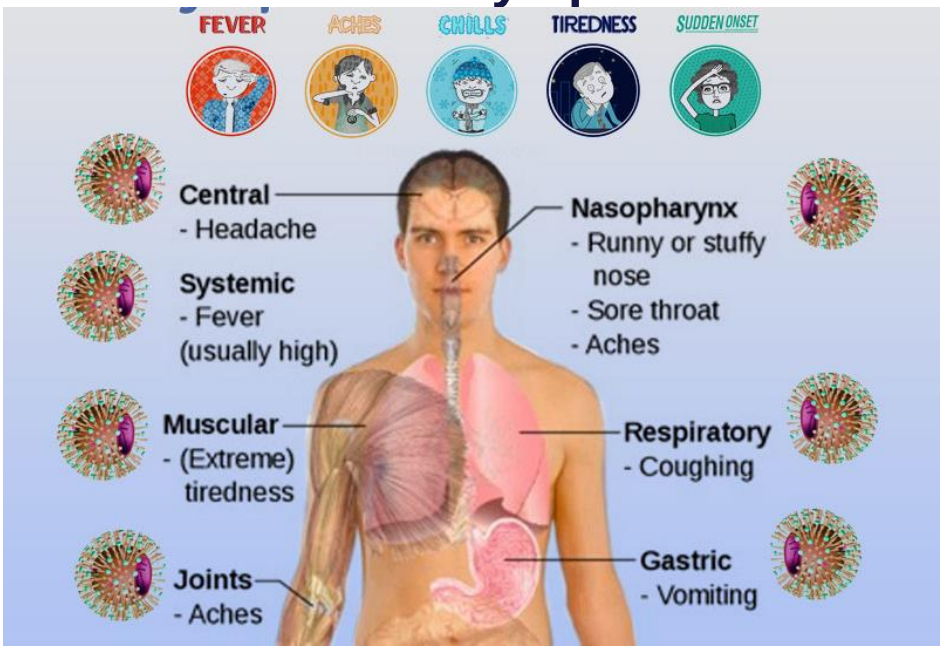
Influenza symptoms



Pandemic influenza in the 20th Century

1918 "Spanish Flu" 20-40 million deaths → H1N1

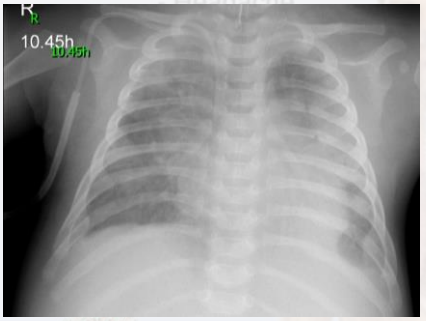
1957 "Asian Flu" 1 million deaths → H2N2

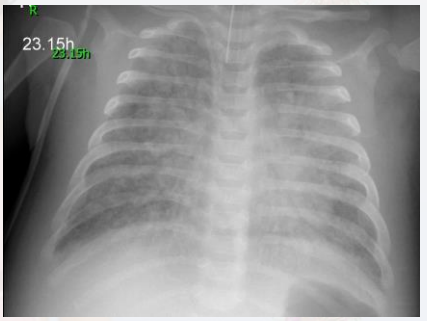
1968 "Hong Kong Flu" 1 million deaths → H3N2

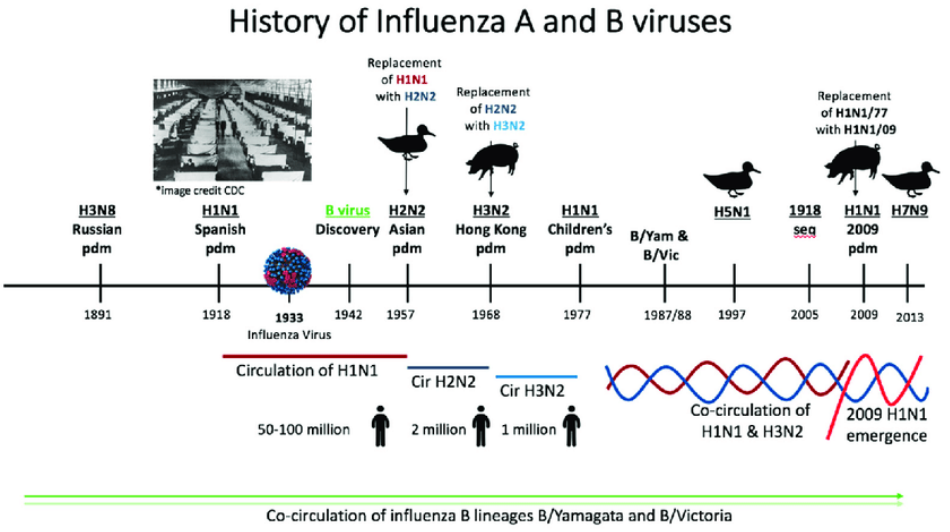
1920 1940 1960 1980 2000

Influenza symptoms

- **Severity**
  - Very young (neonates) or old patients
  - Immunocompromised patient
  - Lung or heart complications



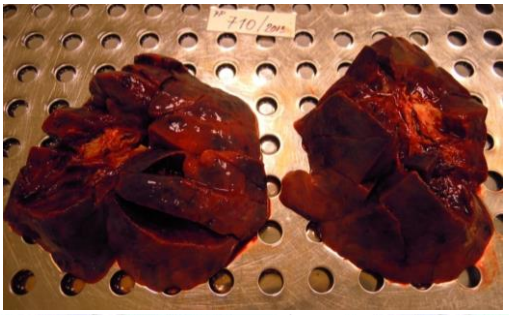




Francis, Magen & King, Morgan & Kelvin, Alyson. (2019). Back to the Future for Influenza Preimmunity—Looking Back at Influenza Virus History to Infer the Outcome of Future Infections. Viruses. 11. 122. 10.3390/v11020122.

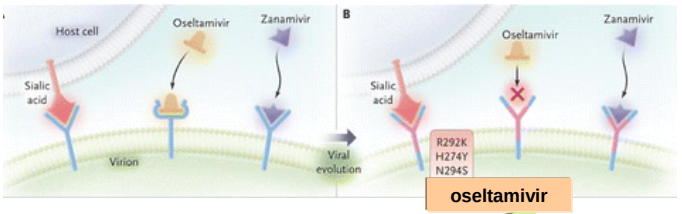
Patient 1

Influenza A virus

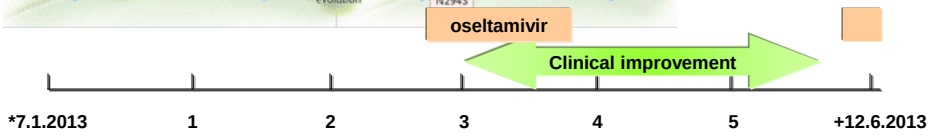


Macroscopic picture of influenza pneumonia.

1st proven oseltamivir resistance in the Czech Republic.



Resistance developed after 4 weeks of therapy.



Complications

- **Pulmonary**
  - CROUP (YOUNG CHILDREN)
  - PRIMARY INFLUENZA VIRUS PNEUMONIA
  - ***SECONDARY BACTERIAL INFECTION***
    - *Streptococcus pneumoniae*
    - *Staphlyococcus aureus*
    - *Hemophilus influenz*ae
- **Non-Pulmonary**
  - myositis (rare, > in children, > with type B)
  - ***cardiac complications***
  - recent studies report encephalopathy
    - studies of patients <21 yrs in Michigan - 8 cases seen last season
  - liver and CNS
    - Reye syndrome
  - peripheral nervous system
    - Guillian-Barré syndrome

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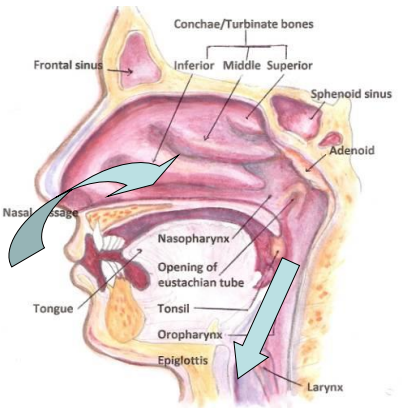
What to aim during the process of dg?

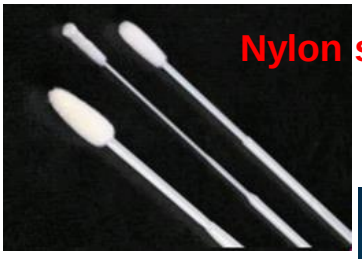
Good sampling of biological material

First proliferation at the mucos of upper respiratory tract.

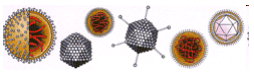
Virus	*Transmission from upper to lower RT*	*Mortality*
RSV	20-68%	17-70%
PIV	13-37%	10-30%
HRhV	<10%	<10%

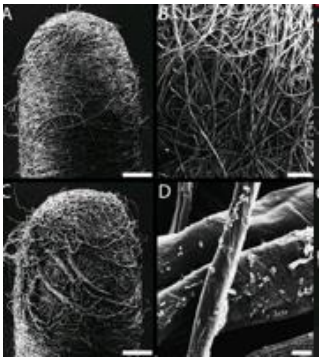


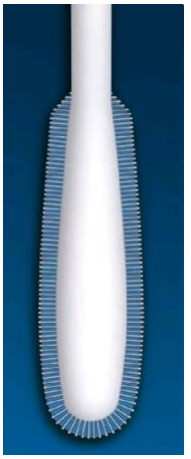
Type of swabs



Nylon swabs

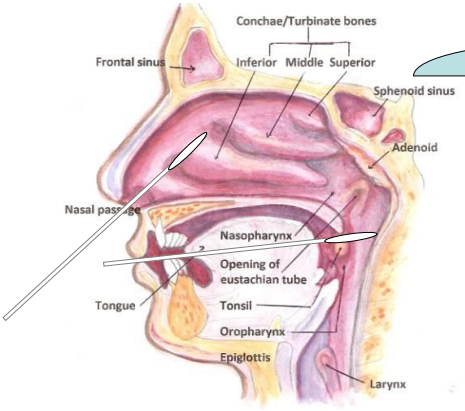


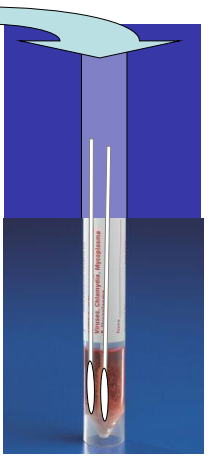




What to aim during the process of dg?

Good sampling of biological material





Diagnosis

- Virus isolation
  - Tissue culture or eggs
- Rapid tests (ussually antigen detection)
- Provisional - clinical picture + outbreak
- **PCR**

- Serology

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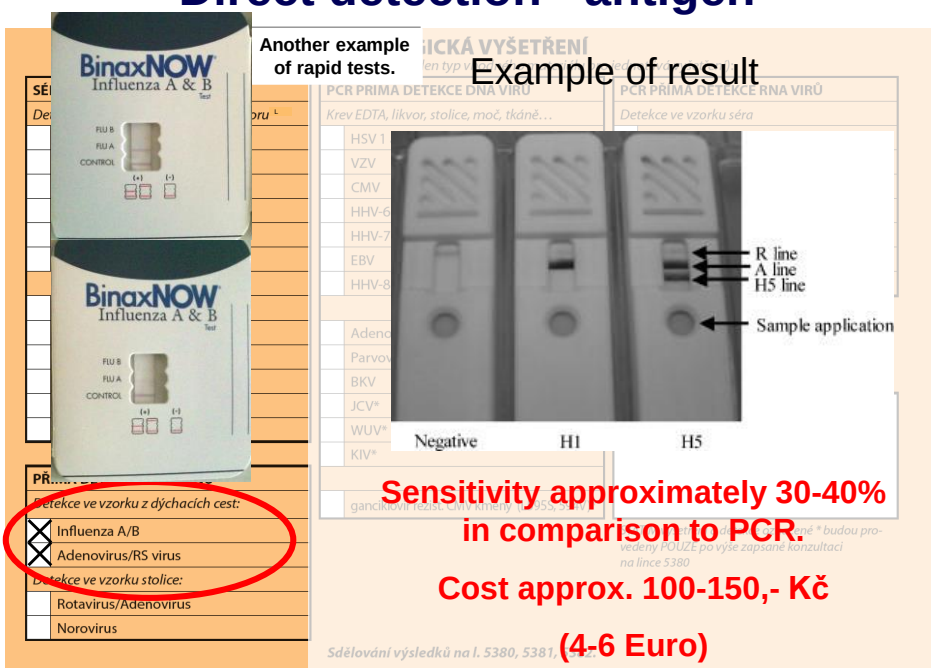
Direct detection - antigen



Sensitivity of antigen detection?

	Detection Ag			Detection PCR		
	No. tests	+	Discrep.	No. tests	+	Discrep.
IF-A	256	19	35	248	50	3
IF-B	256	1	3	248	4	0
RSV	207	19	47+14	248	85	1
AdV	207	3	29	248	34	2

% positive Ag vs. PCR

Influenza A = 38%

Influenza B = 25%

RSV = 22%

AdV = 8.8%

Using of imunochromatografi tests

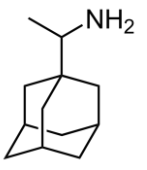
RapidVIDITEST

(RSV-Adeno, Influenza A+B)

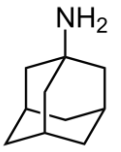
Treatment (prevention) - drugs

All virostatics have to be given early after infection

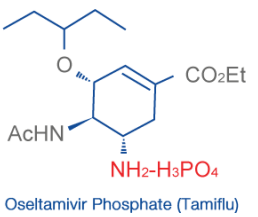
- rimantadine (M2)
  - Type A only
- amantadine (M2)
  - Type A only
- zanamivir (NA)
  - Type A and B
- oseltamivir (NA)
  - Type A and B
- peramivir (NA)
  - Type A and B



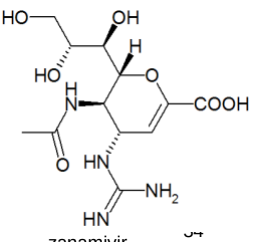
rimantadine



amantadine



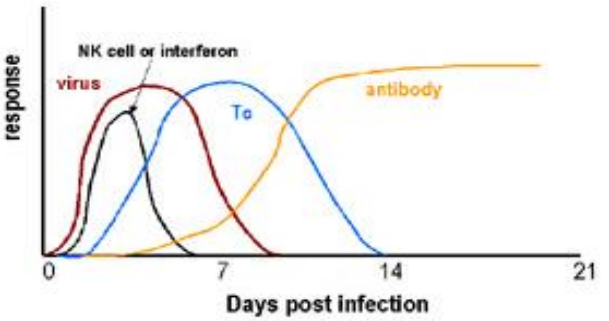
Oseltamivir Phosphate (Tamiflu)



zanamivir

Recovery

- **INTERFERON – side effects include**
  FEVER, MYALGIA, FATIGUE, MALAISE
- **CELL-MEDIATED IMMUNE RESPONSE**



Typical response to an acute virus infection

- **TISSUE REPAIR**
  can take some time

Protection against re-infection

- IgG and IgA
  - IgG less efficient but lasts longer
- antibodies to both HA and NA important
  - antibody to HA more important (can neutralize)

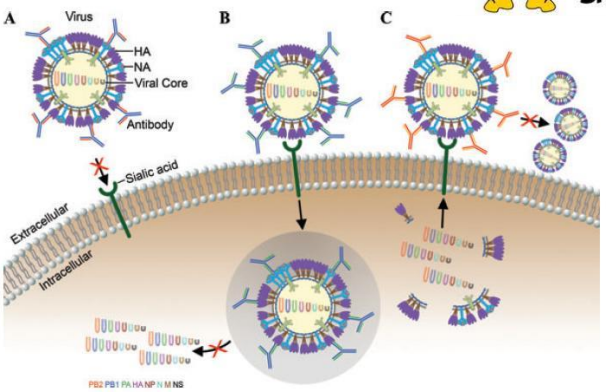
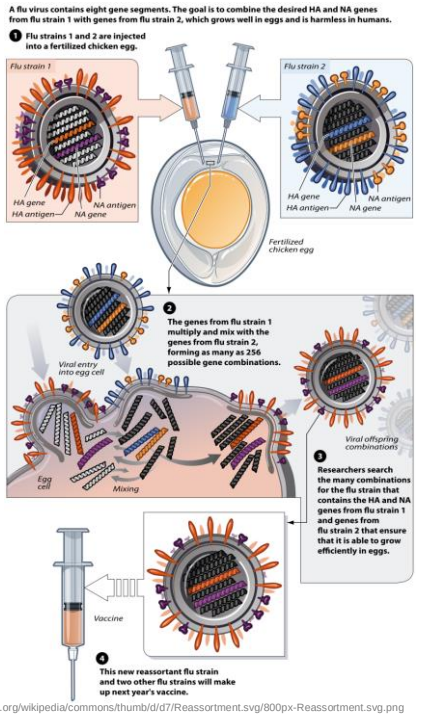


Figure 1. Mechanisms of antibody-mediated neutralization of the influenza virus. (A) Antibodies can block influenza HA1 glycoprotein binding to sialic acid residues of receptor proteins on host cells. (B) Antibodies specific to the HA2 glycoprotein of the virus can inhibit its low-pH triggered fusion activity in the endosome at the postbinding/prefusion stage, which inhibits replication of the virus. (C) Antibodies to surface neuraminidase can prevent the release of influenza virions from the infected cell surface.

Vaccination

- inactivated
- egg grown
- sub-unit vaccine for children

- reassortant live vaccine approved 2003
  - for healthy persons (those not at risk for complications from influenza infection) ages 5-49 years



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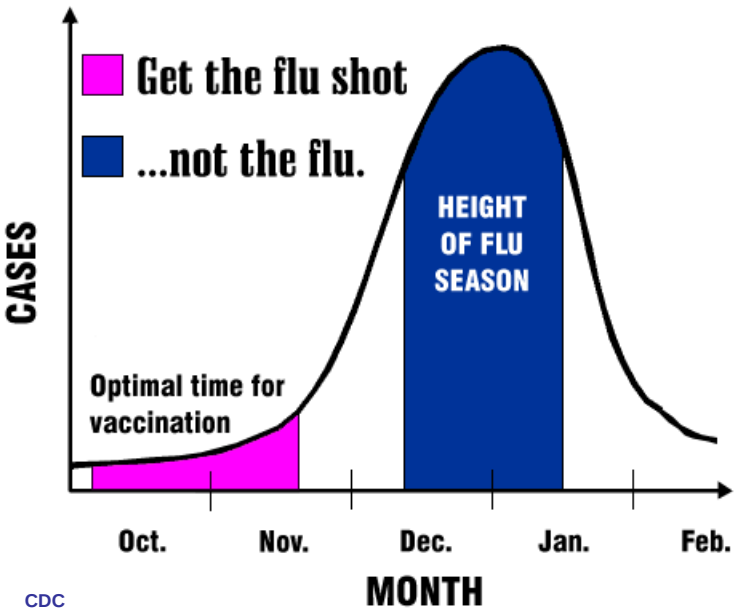


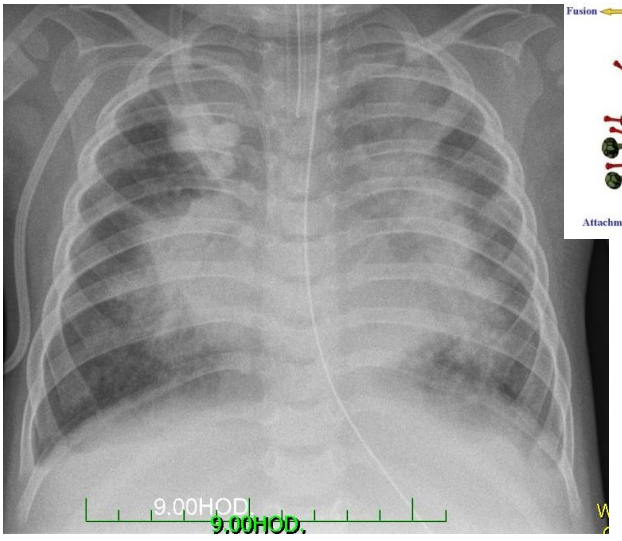
CDC

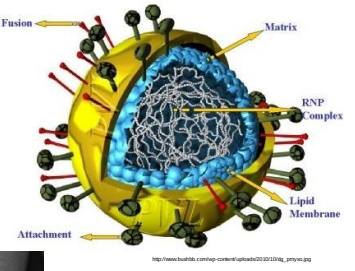
And what about Paramyxoviruses

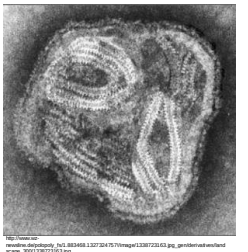
Paramyxoviridae

Respiratory-syntitial virus

RSV (boy treated for AML)



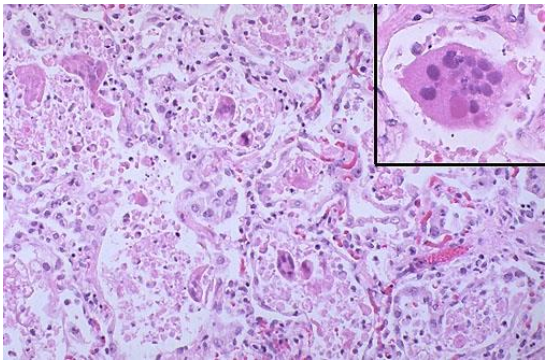




Paramyxoviridae

Pathophysiology

- Negative-strand RNA virus
- Family *Paramyxoviridae*
- RSV season late fall to early spring
- Peak in January/February
- Incubation 4-5 days
- LRI between days 5-7



RSV in a child. Note the giant cells which are part of the viral cytopathic effect. The inset demonstrates a typical giant cell with a round, pink intracytoplasmic inclusion. RSV accounts for many cases of pneumonia in children under 2 years, and can be a cause for death in infants 1 to 6 months of age or older.

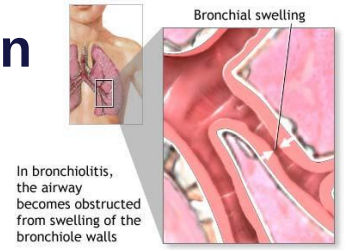
http://library.med.utah.edu/WebPath/jpeg1/LUNG158.jpg

- Most common cause of **bronchiolitis & pneumonia** in children under 1
- 25-40% of children develop bronchiolitis or pneumonia during first RSV infection
- 31/1,000 under 1 yr. are hospitalized with RSV
- 2% will die

Paramyxoviridae

Presentation

- Cold-like sx
- Audible wheezing
- SOB
- Anorexia
- Poor sleeping
- Irritability
- Vomiting
- Choking



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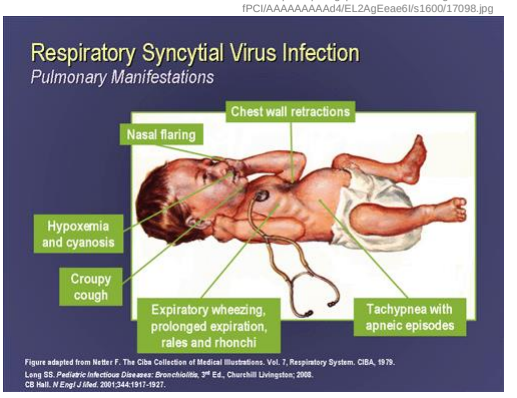


http://img.medscape.com/fullsize/migrated/editorial/cmecircle/2008/18697/flash/luedtke/images/slide9.png

Severity

- Inhibition of certain interferons
- Involvement of innate immune system
- Interleukins and chemokines
- Coinfection with other respiratory viruses

Inhibition of Interferons

- *Interferons believed to have antiviral properties*
- NS1 & NS2 inhibit IFN-alpha/beta
- Inhibition of IFN-gamma causes enhanced IgE production

Innate immune system

- *Activation contributes to inflammation & injury*
- RSV-F glycoprotein may inhibit T-cell activation
- RSV-infected CD8+ cells unable to release IFN-gamma

Interleukins & Chemokines

- *Infection induces expression*
- Chemokines mimic RSV glycoproteins
- Recruit monocytes, eosinophils, & neutrophils
- IL-8 levels positively associated with severity

Paramyxoviridae

Coinfection and Risk factors

- Rhinovirus contributes to increased severity in children with bronchiolitis
- Metapneumovirus (hMPV) enhances or mimics symptoms of RSV bronchiolitis
- 70% were coinfected w/ hMPV & required admission to PICU

Paramyxoviridae

Premature Birth

- Likely to have chronic lung disease
- Hypersensitive to stimuli
- Underdeveloped airway & immunity
- Lack adult maternal levels of IgG

Environmental & Demographics

- Male infants
- Age & birth month of infant
- Crowding & day care attendance
- Secondhand smoke

Factors NOT Positively Correlated

- Socioeconomic status
- Malnourishment
- Breastfeeding

Paramyxoviridae

Prophylaxis

- **RSV-IGIV (RespiGam)**
- Children under 24 mo. w/ CHD or less than 35 wks. gestation
- Given IV monthly during RSV season
- Volume overload possible
- Not for infants w/ hemodynamically significant heart disease.

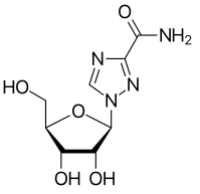
- **Palivizumab (Synagis)** – anti protein F antibody
- Given IM monthly
- Can reduce hospitalization of high risk infants by 45%
- Expensive
- Many providers reluctant to give
- Many parents unaware

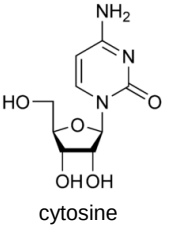
Paramyxoviridae

Treatment

- Mostly symptomatic
- Salbutamol MDI drug of choice
- Also use epinephrine, ipratropium bromide & oral steroids only if hospitalized

- **ribavirine in severely ill patients**





cytosine

Fourth European Conference on Infections in Leukaemia (ECIL-4): Guidelines for Diagnosis and Treatment of Human Respiratory Syncytial Virus, Parainfluenza Virus, Metapneumovirus, Rhinovirus, and Coronavirus

REVIEW ARTICLE

CID 2013

Hans H. Hirsch,[1,2] Rodrigo Martino,[3] Katherine N. Ward,[4] Michael Boeckh,[5] Hermann Einsele,[6] and Per Ljungman[7,8]

Oral ribavirin for treatment of respiratory syncitial virus and parainfluenza 3 virus infections post allogeneic haematopoietic stem cell transplantation

J Casey[1], K Morris[1], M Narayana[1], M Nakagaki[2] and GA Kennedy[1,3]

BMT 2011

p.o. ribavirine 10-30 mg/kg/D in 3 doses

Paramyxoviridae

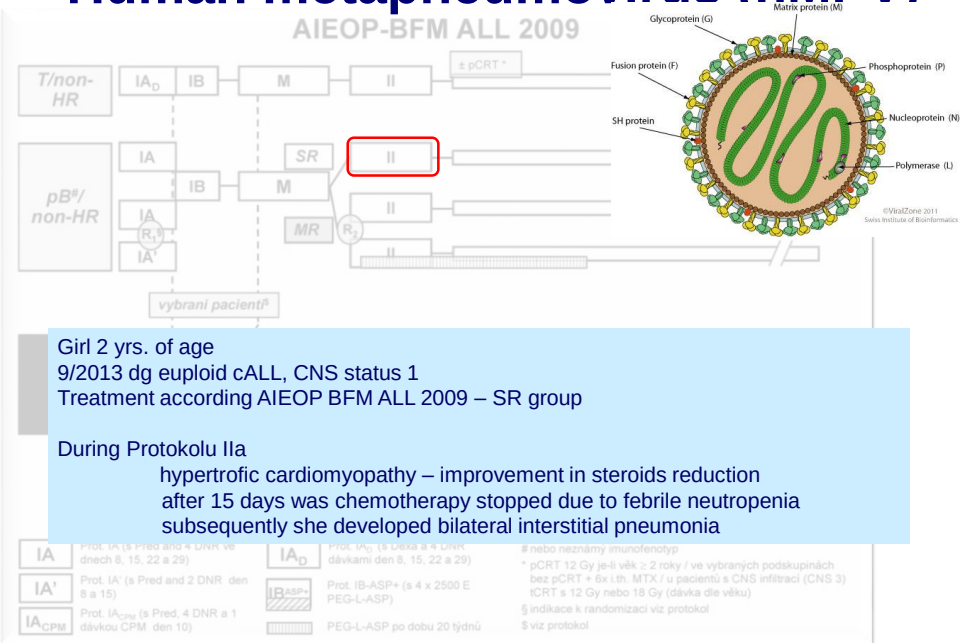
Morbidity & Mortality of RSV

- More likely to visit a specialist
- More likely to use respiratory therapy
- More likely to receive diagnostic or therapeutic procedures
- More likely to be hospitalized again
- Subsequent hospitalization will be 3x as long
- More likely to suffer recurrent infections
- Many have recurrent acute otitis media
- Many likely to be hospitalized with another episode of acute respiratory distress

- Adolescents suffer from allergic asthma, allergic rhinoconjunctivitis, & more sensitive to inhaled allergens
- More likely to have asthma, bronchial reactivity to methacholine, and reduced lung function
- RSV ind. risk factor for reduced FEV% (FEV1/FVC)

Paramyxoviridae

Human metapneumovirus (hMPV)

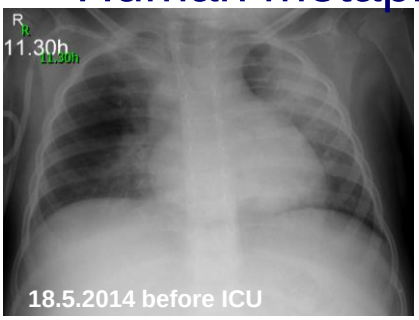


Girl 2 yrs. of age
9/2013 dg euploid cALL, CNS status 1
Treatment according AIEOP BFM ALL 2009 – SR group

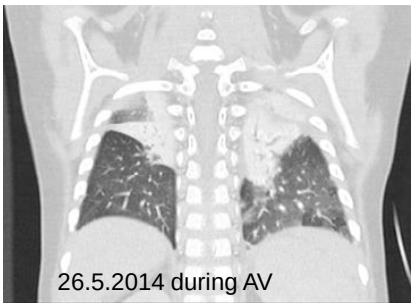
During Protokolu IIa
hypertrofic cardiomyopathy – improvement in steroids reduction
after 15 days was chemotherapy stopped due to febrile neutropenia
subsequently she developed bilateral interstitial pneumonia

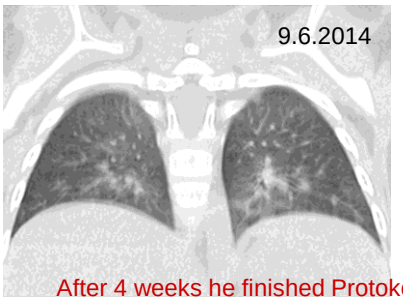
Paramyxoviridae

Human metapneumovirus (hMPV)



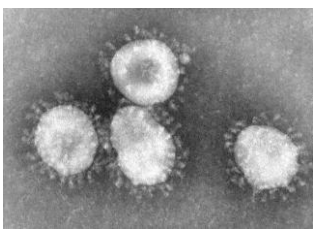
- 9.5.2014 positive NF swab for hMPV
- Treatment:
  - IVIG (substitution 0.3 g/kg - 4 doses)
  - ribavirine 6 mg/kg á 8 hod p.o. 5 weeks
- Respiratory failure with 8 days of AV (FiO_2 1,0)
- hMPV confirmed for ET tube
- hMPV positivity 4 weeks
- Control CT after 10 days of AV - regression





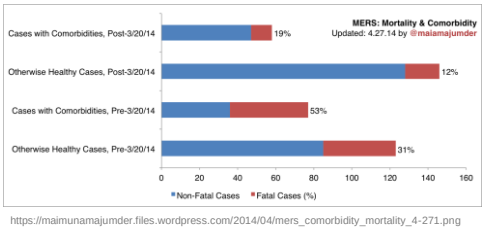
After 4 weeks he finished Protokol IIa.

Coronaviruses

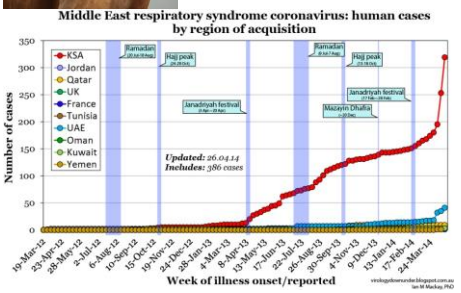


- Coronaviridae
- ss (+) RNA, 26-32 kb genone length (largest RNA)
- first identified in the mid-1960s
  - alpha – HCoV 229E and NL63
  - beta - HCoV OC43, HKU1, SARS-CoV (severe acute respiratory syndrome), and MERS-CoV (Middle East Respiratory Syndrome)
- **SARS**
  - Cellular receptor – ACE2
  - mortality rate – approx. 9.5%
- Incubation period – 2-4 days
- **Treatment symptomatic**

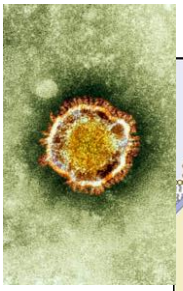
MERS - transmission through camels, their milk and cheese



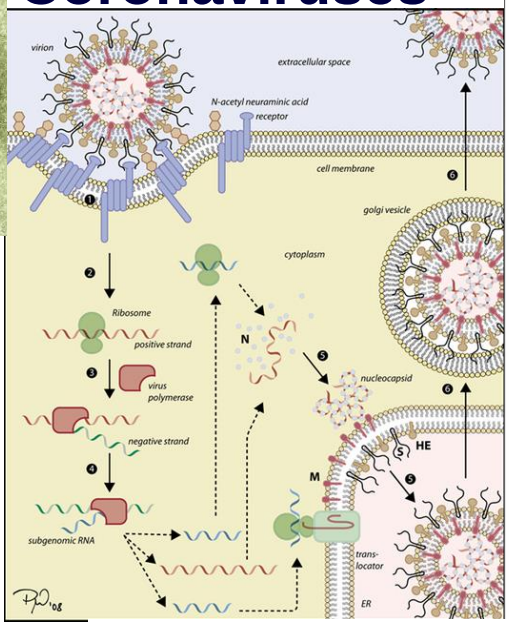
https://maimunamajumder.files.wordpress.com/2014/04/mers_comorbidity_mortality_4-271.png



Coronaviruses



http://www.nature.com/polopoly_fs/7.6657.1349187529!/image/1.11513_coronavirus_HPA.jpg_gen/derivatives/landscape_630/1.11513_coronavirus_HPA.jpg



Replication of Coronavirus

1 With their S-protein, coronaviruses bind on cell surface molecules such as the metalloprotease »amino-peptidase N«. Viruses, which accessorily have the HE-protein, can also bind on N-acetyl neuraminic acid that serves as a co-receptor.

2 So far, it is not clear whether the virus get into the host cell by fusion of viral and cell membrane or by receptor mediated endocytosis in that the virus is in-corporated via an endosome, which is subsequently acidified by proton pumps. In that case, the virus have to escape destruction and transport to the lysosome.

3 Since coronaviruses have a single positive stranded RNA genome, they can directly produce their proteins and new genomes in the cytoplasm. At first, the virus synthesize its RNA polymerase that only recognizes and produces viral RNAs. This enzyme synthesize the minus strand using the positive strand as template.

4 Subsequently, this negative strand serves as template to transcribe smaller subgenomic positive RNAs which are used to synthezise all other proteins. Furthermore, this negative strand serves for replication of new positive stranded RNA genomes.

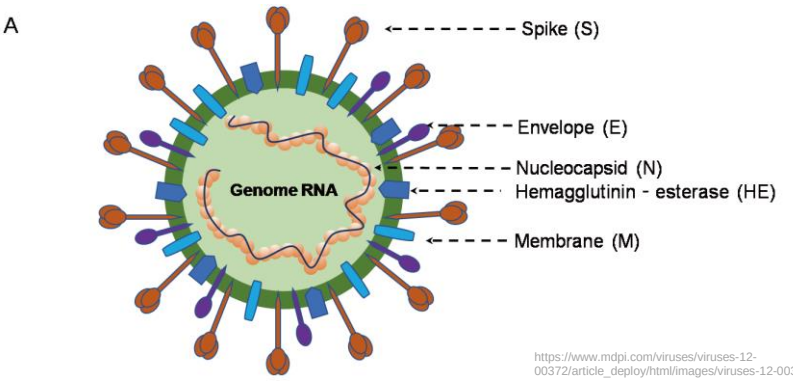
5 The protein N binds genomic RNA and the protein M is integrated into the membrane of the endoplasmatic reticulum (ER) like the envelope proteins S and HE. After binding, assembled nucleocapsids with helical twisted RNA budd into the ER lumen and are encased with its membrane.

6 These viral progeny are finally transported by golgi vesicles to the cell membrane and are exocytosed into the extracellular space.

Not drawn to scale! Not all cellular compartments and enzymes are shown. Colors: positive strand RNA (red), negative strand RNA (green), subgenomic RNAs (blue).
Based on: Lai MM, Cavanagh D (1997). The molecular biology of coronavirus. Adv. Virus Res (48) 1-100.

https://upload.wikimedia.org/wikipedia/commons/thumb/f/f4/Coronavirus_replication.png/800px-Coronavirus_replication.png

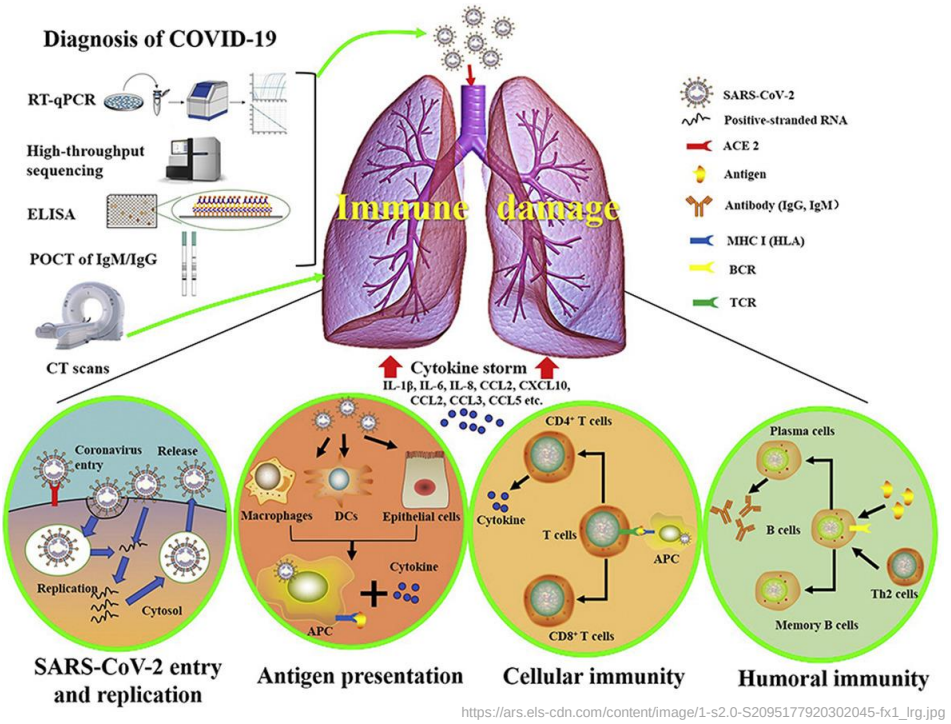
SARS-CoV-2



https://www.mdpi.com/viruses/viruses-12-00372/article_deploy/html/images/viruses-12-00372-g002.png

Confirmed cases	**37 109 851**
Confirmed deaths	**1 070 355**
Countries, areas or territories with	235

Last update: 11 October 2020, 02:00 CEST



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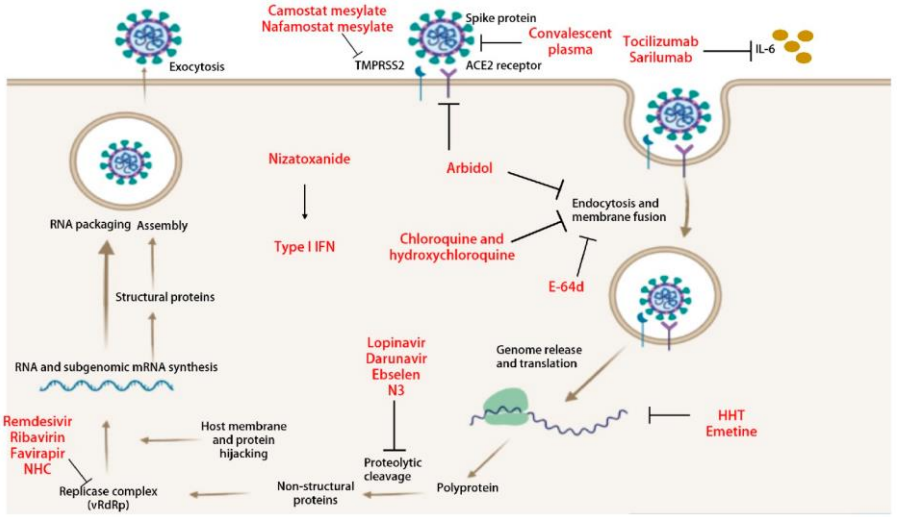
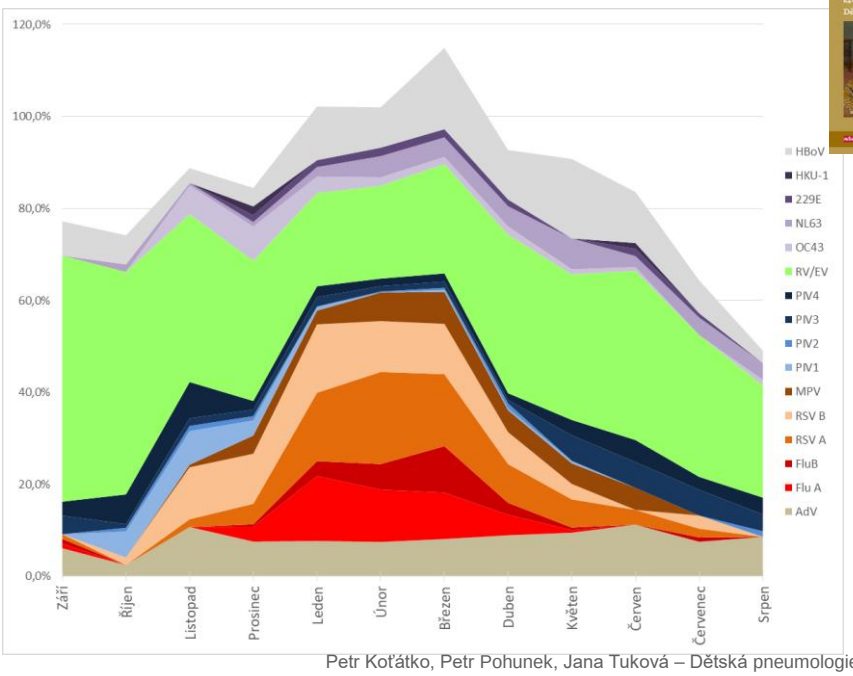
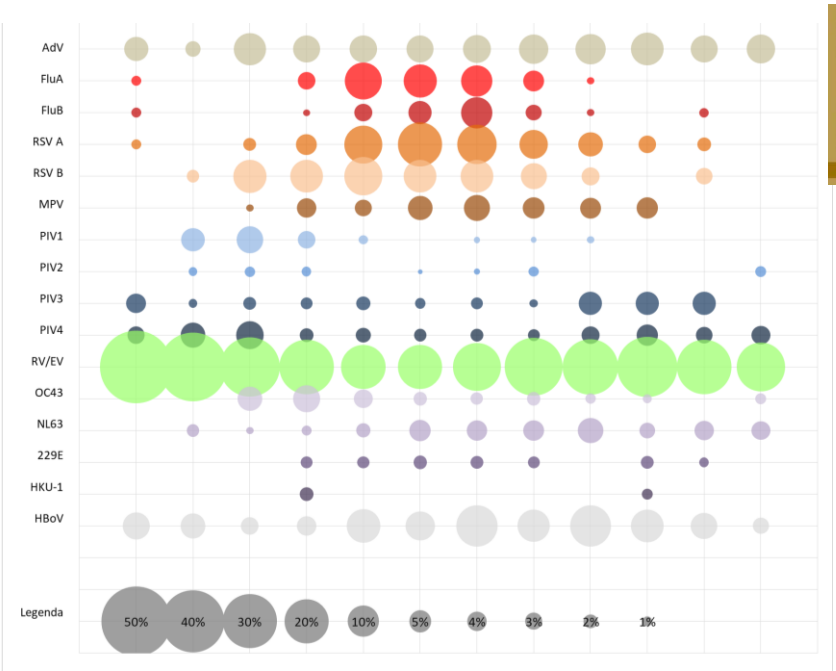
Possible treatment options



https://www.mdpi.com/pathogens/pathogens-09-00426/article_deploy/html/images/pathogens-09-00426-g003.png

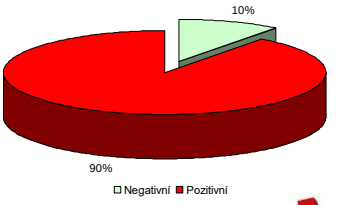


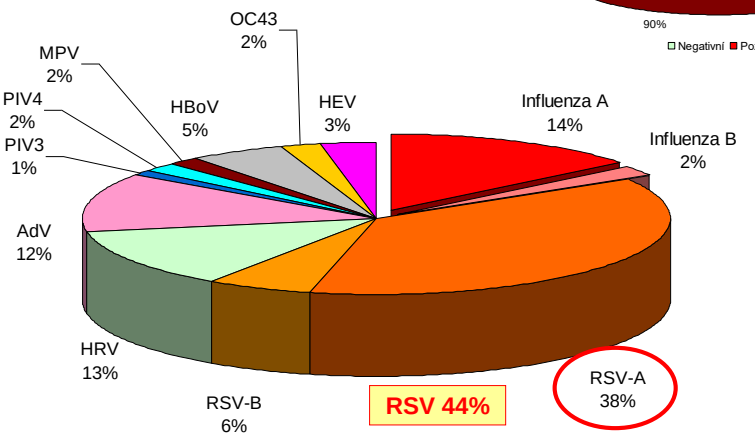
Petr Koťátko, Petr Pohunek, Jana Tuková – Dětská pneumologie MF2019



Petr Koťátko, Petr Pohunek, Jana Tuková – Dětská pneumologie MF2019

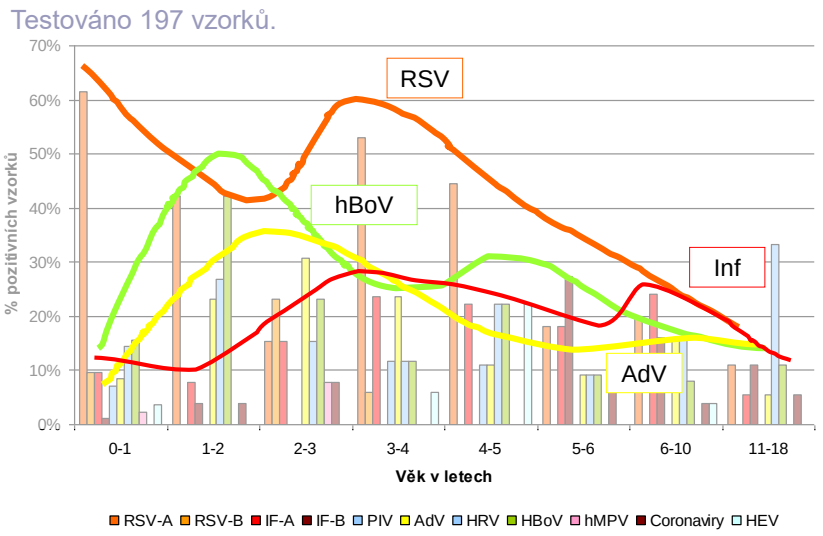
Frequency of respiratory viruses in Motol University Hospital Dept. of Paediatrics (PCR)



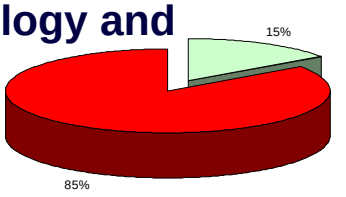


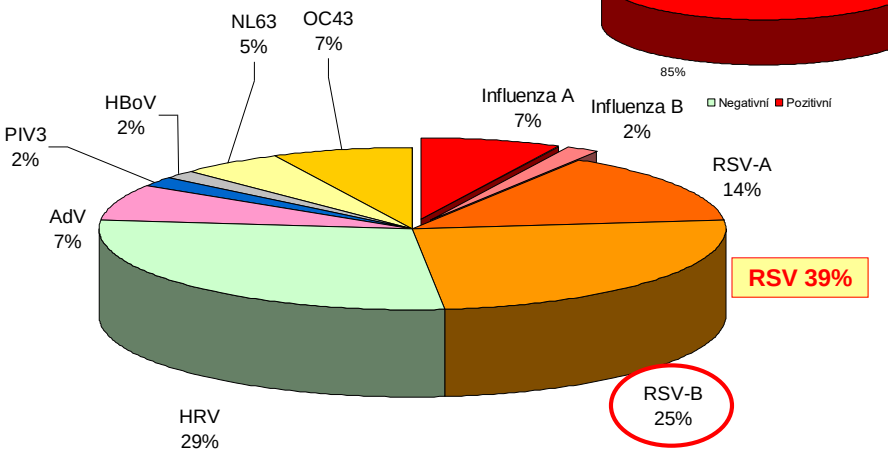
Flu in 16% only

Frequency of respiratory viruses in Motol University Hospital (PCR)



Frequency of respiratory viruses in Motol University Hospital
Dept. of Paediatric Haematology and Oncology (PCR)





CAVE

Every detection technique has limits!

Even molecular-biological = PCR!

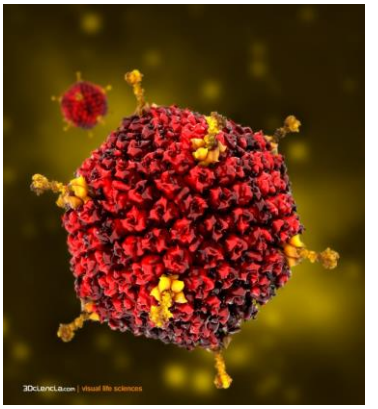
It is true also for commercial kits e.g. There is evidence that Anyplex RV16 detects only **10 out of 60 described serotypes.**

Most frequently detected,

but not the only!!!!

PCR negativity does not

neccesary omits AdV infection.



REVIEW ARTICLE 258 • CID 2013:56 (15 January) • Hirsch et al

Fourth European Conference on Infections in Leukaemia (ECIL-4): Guidelines for Diagnosis and Treatment of Human Respiratory Syncytial Virus, Parainfluenza Virus, Metapneumovirus, Rhinovirus, and Coronavirus

Hans H. Hirsch,[1,2] Rodrigo Martino,[3] Katherine N. Ward,[4] Michael Boeckh,[5] Hermann Einsele,[6] and Per Ljungman[7,8]

http://www.ebmt.org/Contents/Resources/Library/ECIL/Pages/ECIL.aspx

Viral exanthematic diseases

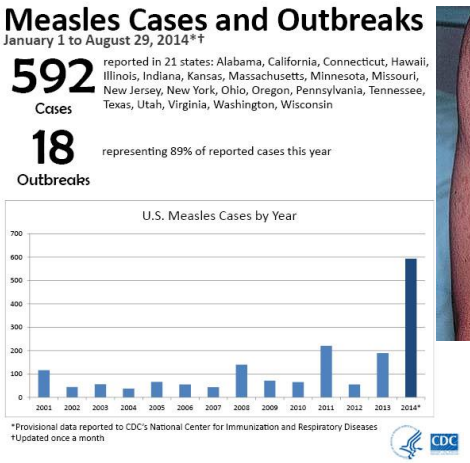
Childhood exanthema diseases

Classical name	**„systematic exant. name“**	**Pathogen**
Measles (rubeola)	1st childhood disease	morbillivirus
Scarlet fever	2nd childhood disease	Streptococcus pyogenes
Rubella (German measles)	3rd childhood disease	Rubivirus
Filatov-Duke‘s disease (pseudoscarlantina)	4th childhood disease	Coxackie and Echoviruses
Erythema infectiosum	5th childhood disease	Parvovirus B19
Exanthema subitum – Roseola infantum	6th childhood disease	HHV-6 and HHV-7

Chicken pox - VZV

Paramyxoviridae

Measles



Estimated cases – 20,000,000 / year.
Estimated kills - 164,000 people in world/year.

Paramyxoviridae

Measles

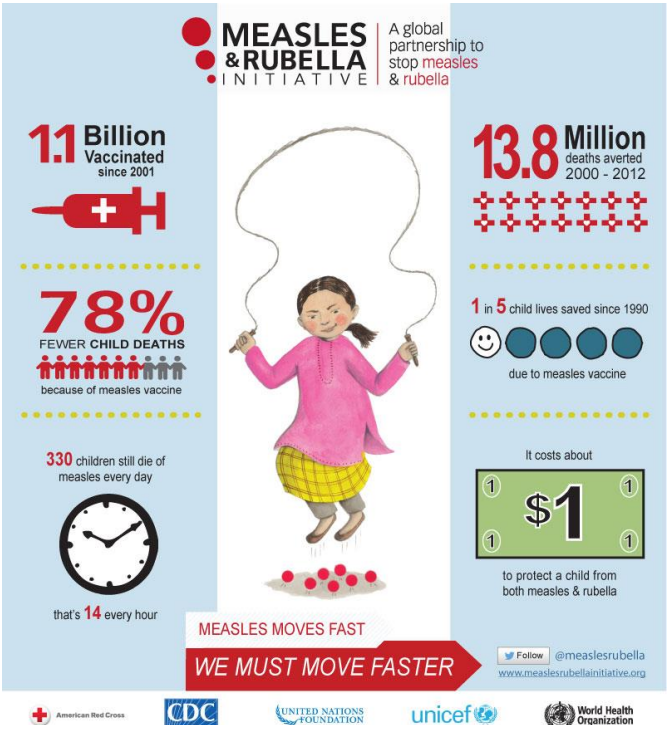
- Respiratory disease caused by a morbillivirus
- Measles virus normally grows in the cells that line the back of the throat and lungs
- ss (-) RNA virus of genome length 15-16 kb, coding 8 proteins
- spherical symetry of capsid and diameter of 100-300 nm
- incubation period 8-12 days

Symptoms
Measles causes fever, runny nose, cough and a rash all over the body. Rash starts at head and neck and spreads from this areas to whole body.

Complications
About 1 / 10 children gets an ear infection, and up to 1 out of 20 gets pneumonia.
About 1 out of 1,000 gets encephalitis, and 1-2 out of 1,000 die.

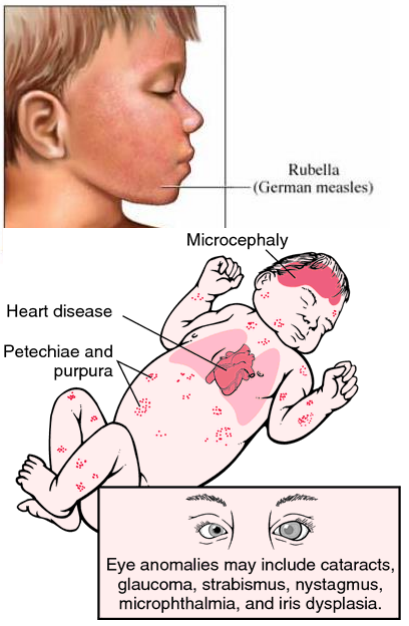
Transmission
Spreads through the air by breathing, coughing or sneezing.
It is so contagious that any child who is exposed to it and is not immune will probably get the disease.

There is vaccination against measles.



Togaviridae

Rubella - German measles



- Rubivirus (RNA)
- incubation period avr. 18 days (12-23)
- viraemia 5th-7th day after exposition with subsequent speading to the organs

Togaviridae

Rubella - German measles

The infection is usually mild with fever and rash. In pregnancy the virus can cause serious birth defects.

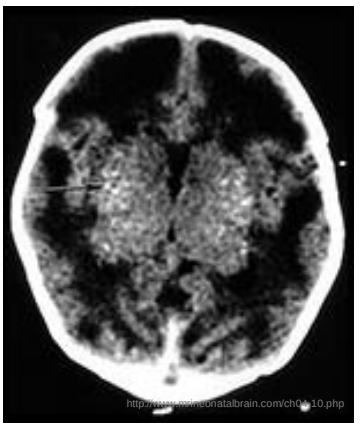
Symptoms: in children: Rash that starts on the face and spreads to the rest of the body, Low fever. Usually a mild disease
These symptoms last 2 or 3 days.
Older children and adults: swollen glands and symptoms cold-like sy. before the rash.
Aching joints occur in many cases, especially among young women.
About ½ of the people do not have symptoms.
In rare cases, serious problems can occur. These include brain infections and bleeding problems.

In pregnancy: miscarriage or birth defects like deafness, intellectual disability, and heart defects. 85% of babies born to mothers who had rubella in the first 3 months of her pregnancy will have a birth defect.
Spreading: through coughs or sneezes; most contagious when the person has a rash. But it can spread up to 7 days before the rash appears. People without symptoms can still spread rubella.

The MMR vaccine protects against rubella.

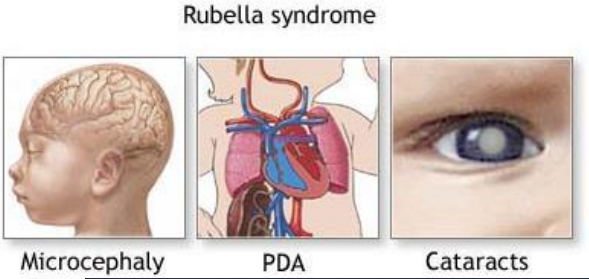
Togaviridae

Rubella - German measles



Infection between 8th-10th week of gestation leads to development of congenital rubella syndrome in 90%.

Congenital infections with Venezuelan Equine Encephalitis Virus are symptomatically similar.



Box 1: Clinical features of congenital rubella syndrome

Classic triad

- *Congenital heart disease* (e.g., patent ductus arteriosis, pulmonary artery stenosis, pulmonary valvular stenosis)
- *Ocular defects* (e.g., congenital cateracts, microphthalmos, pigmentary retinopathy, congenital glaucoma)
- *Hearing loss*

Congenital rubella syndrome is usually associated with a failure to thrive and developmental delay as well as microcephaly. Other common presentations at birth include:

- purpuric rash
- hepatosplenomegaly
- meningoencephalitis
- radiolucent bone
- hepatitis
- thrombocytopenia

http://www.cmaj.ca/content/172/13/1678/F1.expansion.html

Rubella and measles

Details e.g. also in:

http://ecdc.europa.eu/en/publications/Publications/systematic-review-incubation-period-shedding-children.pdf

Parvovirus B19

Described in Australia in 1975 by Yvonne Cossart, in microtitration plate „B19“.

Proliferation in erythroid cells of bone marrow (dysregulation of cell cycle through NS1 protein.

Transmission by droplets, mainly. Incubation: 2 weeks (4-28 day) lasting for a week.

Erythema infectiosum („slapped cheek“) – „Fifths disease“.

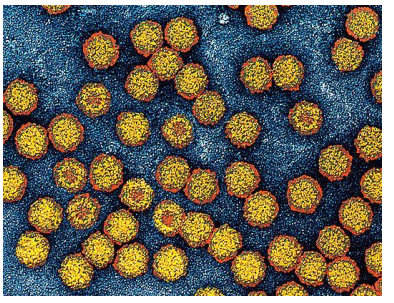
Teenage - "Papular Purpuric Gloves and Socks Syndrome".

Adults – urticas; Pregnant hydrops foetalis

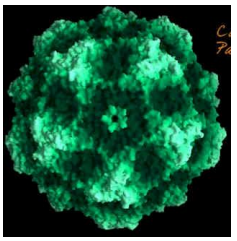
Immunosupressed patients - „pure red cell aplasia“.


http://snotty-noses.com/illnesses/parvovirus.html

Described possible related complication of B19 infection is myocarditis.

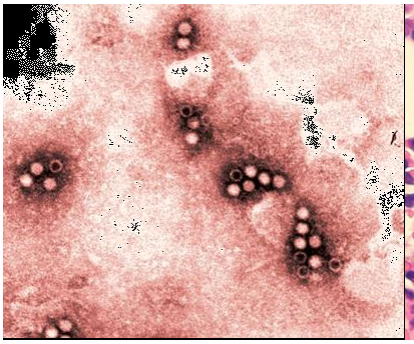

http://www.sciencephoto.com/images/download_lo_res.html?id=770500728

Parvovirus B19

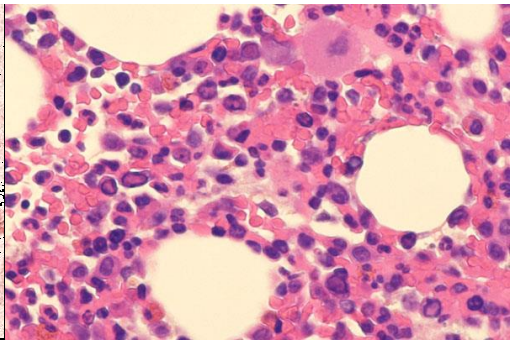


http://fai.unne.edu.ar/biologia/virologia/images/virolo6.jpg

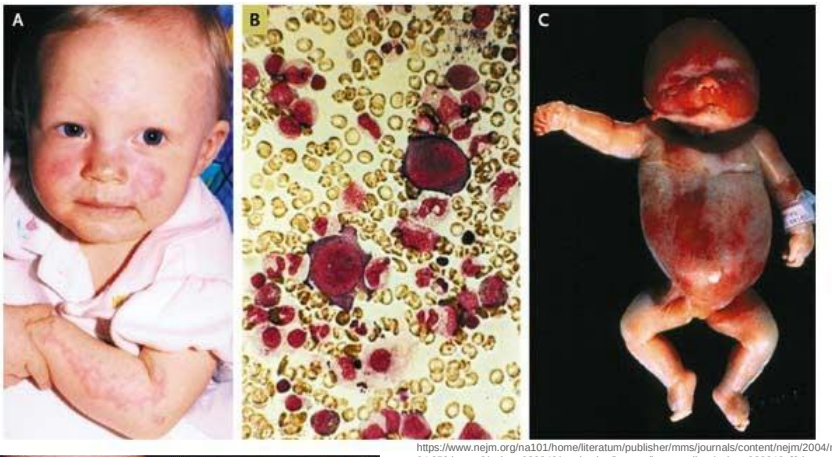
- small ss DNA +/-
- Capsid 20-26 nm, genome: 5 kbp
- E.g. Aplastic anaemia…



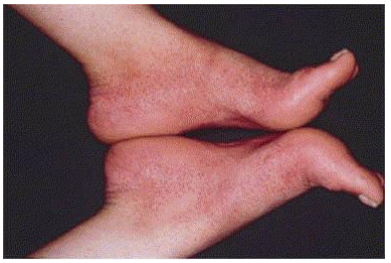
http://www.wadsworth.org/databank/hirez/gradyp2.gif



http://www.yamagiku.co.jp/pathology/image/210/1.jpg



https://www.nejm.org/na101/home/literatum/publisher/mms/journals/content/nejm/2004/nejm_2004.350.issue-6/nejmra030840/production/images/img_medium/nejmra030840_f3.jpeg



https://ars.els-cdn.com/content/image/1-s2.0-S0190962299700277-gr2.jpg

Human herpesvirus 6

Previously two variants of HHV-6.
Recently 2 distinct viral species

HHV-6 A

Unknown

„Orphan virus“

HHV-6 B

Immunocompetent host

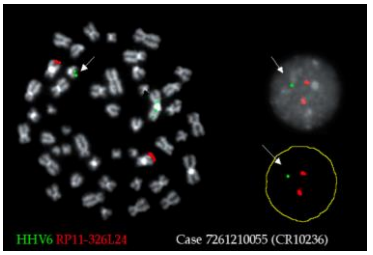
- **Sixth disease**
- **Febrile seizures**
- **Encephalitis**

Immunocompromised host

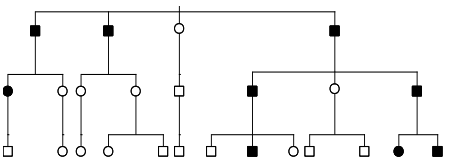
- **Encephalitis**
- **Myelosupression**
- Hepatitis
- Pneumonitis
- Pericarditis
- **Delayed engraftment after HSCT**

Chromosomally integrated HHV-6 (CI-HHV-6)

- **Viral DNA integrated into human chromosomes**
  - **Inherited from parents to child**
  - **Viral DNA is present in every body cell** (e.g.hair roots, nails)
  - **Ratio of viral DNA : human DNA = 1:1**
- **Described frequency in population between 0.2-2.9%** **(Tanaka-Taya 2004, Ward 2007)**
- **Both variants (A or B) integrates**
- **No clear observed reactivation CI-HHV-6 to active infection in vivo**
- **In vitro reactivations are doubtful**

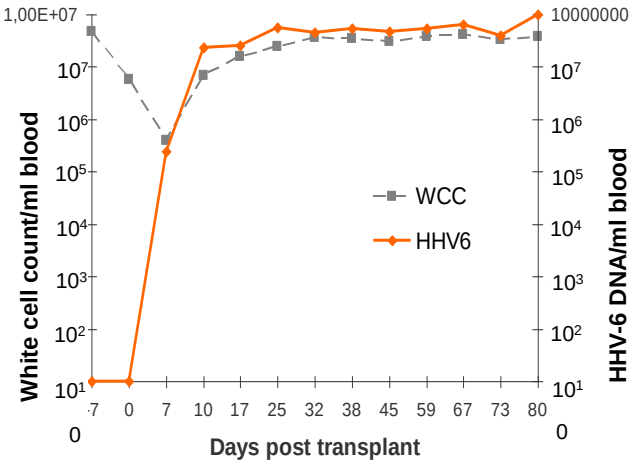


HHV-6 integration at 22q13.3 control probe on 9q34.4



HHV6 DNA in blood after HSCT

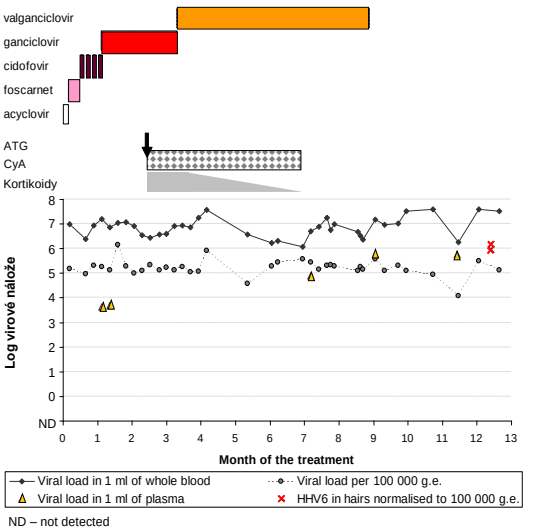
donor with Ci-HHV-6



Clark et al., JID 2006

Patient 2

Chromosomally integrated HHV-6 (Ci-HHV-6)



Patient with SAA

50 years

After start of the IS therapy– partial response only

Dependent of thrombocyte infusion

G-CSF therapy

Died due to peracute sepsis of *St. aureus*.

Detection of high HHV-6 DNA quantity is NOT NECESSARY an active infection.

Detection in hair, or nails detects Ci-HHV-6 safely.

And now what?