Children are often febrile, but their appearance is viral illnesses in the absence of the classic exanthema. B19 infection may be indistinguishable from other diseases occurring most frequently in school-aged children. Clinical manifestation of parvovirus B19 infection, erythema of the proximal extremities is the most common from measles, rubella, exanthem subitum, scarlet fever, and infectious erythema, systemic rashes are also found in other bacterial infections, including leptospirosis, mycoplasma infection, and disseminated gonococcal infection. In addition, systemic rashes are found in trench versicolor, enteroviral infections, Gianotti-Crosti syndrome and papular-purpuric gloves and socks syndrome. Infection due to parvovirus B19 is self-limiting and has an excellent prognosis. However, in high-risk pediatric groups (e.g. immunocompromised patients, children with hemolytic anemia or prenatal infection), clinical manifestations are of pure red-cell aplasia (PRCA) resulting in chronic or recurrent anemia with reticulocytopenia. Bone-marrow involvement can also manifest as neutropenia, agranulocytosis, pancytopenia, thrombocytopenia, and hemophagocytosis. Treatment is aimed at symptomatic relief, and a vaccine currently is under investigation. Red-cell transfusions may be required till the immune system can reconstitute. If immune reconstitution is not expected or will be delayed, passive administration of B19 antibodies will lead to virus neutralization, resumption of reticulocytosis, and a rise in hematocrit. However, relapses may occur as the passive antibody wanes if the host has not yet been able to produce neutralizing antibody. In the majority of reported cases, only one course of IVIG has been needed for long-term remission. B19V still lacks a specific antiviral therapy although the antiviral activity of cidofovir is shown to be effective.

Compliance with Ethical Standards
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References: