Placental Malaria

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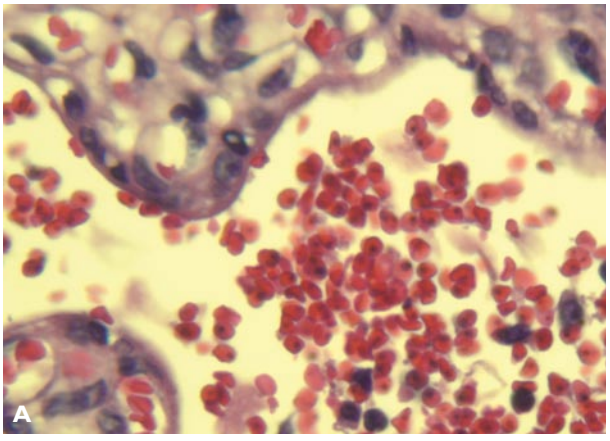

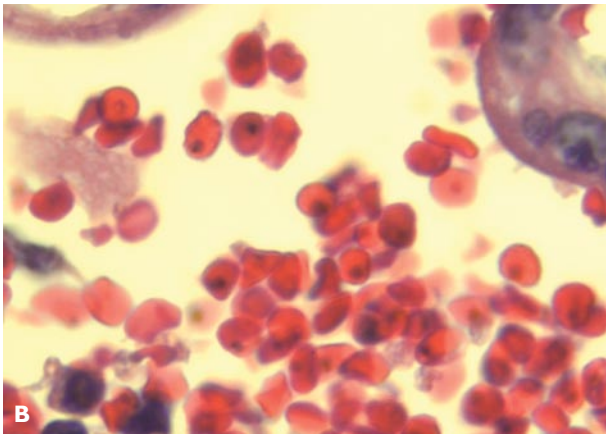

A 29-year-old gravida 2, primiparous woman in her thirty-fifth week of pregnancy presented to the emergency department with diffuse abdominal pain, fever, and chills for 2 days. She had arrived from Uganda 3 days prior. She developed irregular uterine contractions, and labor was induced with oxytocin. She delivered a healthy baby boy. Peripheral smear was negative for any parasites, but the placental histology showed abundant ring forms consistent with *Plasmodium falciparum* parasitemia (**Image A** and **Image B**). Blood smears from the infant did not show malarial parasites. HIV serological testing was negative in the mother.

Pregnant women are more susceptible to malaria than nonpregnant women.[1] The prevalence of placental malaria is higher in primigravid than multigravid women.[2] In holo-endemic regions such as the sub-Saharan Africa, *P. falciparum* is the most commonly encountered malarial species in pregnancy. Transmission of malaria to the fetus is thought to be prevented due to adhesion of the parasite to chondroitin sulfate A present in the placenta. Hence, there is a greater parasitic load in the placenta than in peripheral blood. However, this placental barrier cannot completely prevent transmission of malaria, particularly if there are tears induced during delivery or if there are coexisting infections. Awareness of risk of malaria in pregnant women is essential, as international travel to malaria endemic areas has increased lately. The World Health Organization and the Centers for Disease Control and Prevention both recommend that pregnant women not travel to areas where malaria is endemic. For pregnant women who decide to travel or must travel, mefloquine is the drug of choice for chloroquine-resistant malaria.[3] Dismal perinatal outcomes like low birth weight, perinatal death, and premature labor should be anticipated in patients with placental parasitemia, as their risk for these complications is increased up to sevenfold.[4] All pregnant females with malaria should be screened for HIV as dual infection with malaria and HIV significantly increases infant mortality.[5] **HP**

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