Rubella

Screening for all

@ Booking visit

IgG → Negative → Avoid exposure

T1 severe, 90% < 11w

After 20w CRS rare ≈ 0%

Vertical transmission

Congenital anomalies, Cardiac, Neurological, Auditory, Ophthalmic, Hemat.

Offer termination

Diagnosis

1. Presence of IgM
   - Acute infection
   - High risk of CRS
   - Confirmatory of CRS
2. 4 fold rise of IgG
   - Low risk

Fetal infection

No need to confirm by PCR

- CVS < 12w
- Amniocentesis 14-16w

Prevention

1. Vaccination
   - School girls
   - CI in pregnancy (Teratogenic)
   - **Accidental vaccination → OK**
2. IVIG - No reduction of fetal defects
   - If refuse termination
3. Prepregnancy screening
4. Contraception
5. Pregnancy screening
   - Avoid exposure

Toxoplasmosis

Vertical transmission only during 1ry infection

Highest infection risk in T3

Severe Dx in T1

↓ Severity ō PoG

Congenital Toxoplasmosis

Chorioretinitis, Hydrocephalus, Intracranial calcifications, Convulsions, Hepato-Splenomegaly, IUGR

1. Do **USS**
2. **Screening**
   - Presence of IgM
   - 4 fold rise in IgG
     - Recent infection

Negative → Amniocentesis

Maternal infection

Spiramycin

Prevent vertical transmission

Fetal infection

Combination Rx

Non pregnant exposure

Avoid pregnancy for 6m

Syphilis

1. **VDRL** @ Booking visit
2. **Treponema pallidum Ab absorption test**
   - To exclude false positives
   - If negative, do auto Ab for SLE, APLS

Rx

Single dose of IM Benzathene Penicillin

- Prevent VT

If allergy → Azithromycin

CMV

No routine screening

30-40% vertical transmission

20-25% postnatal sequale

Similar to other infections

Diagnosis

1. Serology
   - 1ry infection
     - IgM, IgG
   - 2ry Infection
     - Significant rise in IgG
     - Low vertical transmission risk
2. Amniocentesis after 7w & 21w of infection

Best confirmatory test for VT

3. Serial USS (2-4w)
   - IUGR, Intracranial calcifications, Ventriculomegaly, Ascites, Oligohydroamnios, µcephaly, Hyperechogenic bowel, Pleural effusions, Hydrops fetalis, Liver calcifications

Mx

1. Termination of pregnancy
2. CMV specific hyperimmunoglobulin

Group B Streptococcus

No routine screening

Indications for Intrapartum ABX Prophylaxis

1. GBS Bacteriuria
   - Rx @ time of diagnosis
   - IAP
2. Asymptomatic bacteriuia
3. Vaginal infection
4. PROM @ or after 37w
5. Maternal pyrexia in labour
   - Broad spectrum ABX
6. Past neonatal GBS
7. SRM @ term in known carriers

No need of IAP for

1. EL LSCS ō intact membranes
2. Preterm labour ō out GBS

IAP

1. 3g of IV Benzylpenicillin ASAP after onset of labour
2. 1.5g 4hrly till delivery

If allergy

- IV Clindamycin