Perinatal Infections Work Group

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Some Facts

- Syphilis
  - 2014-2018: rate among reproductive-aged women (15-44 yr) increased 165%
  - 2012-2018: rate of congenital syphilis cases increased 291%; further increase of 22% from 2018-2019
- HBV
  - An estimated 95% of pregnant women receive prenatal hepatitis B surface antigen (HBsAg) testing, but fewer than half of the expected births to HBsAg-positive women are identified
- HCV
  - New CDC guidelines recommend universal screening in pregnancy
  - Analysis suggests that universal screening will reduce HCV-attributable mortality by 16% and increased the proportion of infants born to mothers with hepatitis C identified as HCV-exposed from 44% to 92%.
- HIV
  - An estimated 5000 WLHIV give birth annually
  - HIV diagnoses declined 54% among children 2014-2018; in 2018 65cases of perinatal transmission reported

Workgroup Charge

- The Workgroup will advise CDC and HRSA regarding prevention, screening and diagnosis of perinatal infections, focusing on syphilis, HCV, HBV, and HIV in pregnancy and in women of reproductive potential

Focus Area #1: Aligning Perinatal ID Screening Recommendations

- Issue:
  - There is significant variation across jurisdictions and also variation across professional societies with regards to laws/regulations re: screening for relevant perinatal infections
- Findings:
  - There is a need for alignment as much as possible between major societies recommendations, to reduce confusion with providers and better standardize care, including standardized timing of relevant labs in pregnancy
  - It would also be helpful to achieve some standardization among state regulations

Current Professional Society Screening Recommendations in Pregnancy

	USPTF (2019)	CDC	ACOG (2017)	AAP (2017)	AAFP (2014)
HIV	1 time screen in pregnancy	Early in pregnancy; Repeat screen in 3rd trimester (women with risk factors and/or in high incidence areas—consider in all); expedited testing in labor with unknown HIV status; immediate postpartum (mother or newborn)if not previously tested	PCC; Initial antenatal visit (opt out); Repeat screen in 3rd trimester (women with risk factors and/or in high incidence areas); expedited testing in labor with unknown HIV status; immediate postpartum (mother or newborn)if not previously tested	Initial antenatal visit (opt-out); Repeat screen in 3rd trimester (women with risk factors and/or in high incidence areas); expedited testing in labor with unknown HIV status; immediate postpartum (mother or newborn)if not previously tested	Universal (pt may opt-out) Consider repeat screening in 3rd trimester

Current Professional Society Screening Recommendations in Pregnancy

	USPTF (2019)	CDC	ACOG (2017)	AAP (2017)	AAFP (2014)
syphilis	1 time screen in pregnancy	Screen in early pregnancy; repeat at 28 wk, at delivery for women at increased risk (based on prevalence, LHIV, CSW, hx incarceration	Screen 1st antenatal visit; repeat at 28 wk, at delivery for those at "high risk" of syphilis , live in areas of high syphilis morbidity, or previously untested, as well as after exposure to an infected partner. "Some states require all women to be screened at delivery. Test any woman who has had a stillbirth.	Screen 1st antenatal visit; repeat at 28 wk, at delivery for those at "high risk" of syphilis , live in areas of high syphilis morbidity, or previously untested, as well as after exposure to an infected partner. "Some states require all women to be screened at delivery. Test any woman who has had a stillbirth.	Universal Consider repeat testing at 28 wks

Current Professional Society Screening Recommendations in Pregnancy

	USPTF (2019)	CDC	ACOG (2017)	AAP (2017)	AAFP (2014)
HBV	Screen in early pregnancy; repeat at 28 wk, at delivery for women at increased risk (based on prevalence, LHIV, CSW, hx incarceration	Screen in early pregnancy; repeat at 28 wk; HBsAg+ infants: HBV vaccine +HBIG	Routine test in 1st trimester (even if previously tested or vaccinated); retest at delivery in women not tested earlier, those "at high risk" of infection (>1 sex partner in previous 6 mo, evaluation or treatment for STI, recent or current IDU, HBSAG+ partner)and with clinical hepatitis. Pregnant women at risk for HBV should be vaccinated Infants: born to HBsAg+ mothers: HBV vaccine +HBIG	routine test in 1st trimester (even if previously tested or vaccinated); retest at delivery in women not tested earlier, those "at high risk" of infection (>1 sex partner in previous 6 mo, evaluation or treatment for STI, recent or current IDU, HBSAG+ partner)and with clinical hepatitis. Pregnant women at risk for HBV should be vaccinated. Infants: born to HBsAg+ mothers: HBV vaccine +HBIG	Universal

Current Professional Society Screening Recommendations in Pregnancy

	USPTF (2020)	CDC	ACOG (2017)	AAP (2017)	AAFP (2014)
HCV	universal (2020)	Universal screening with each pregnancy (2020)	should be considered in women with opioid use/use disorder; repeat testing in 3rd trimester may be considered in women considered at increased risk; HIV-infected women	should be considered in women with opioid use/use disorder; repeat testing in 3rd trimester may be considered in women considered at increased risk; HIV-infected women	Not mentioned

Focus Area #1: Aligning Perinatal ID Screening Recommendations

- Findings (cont):
  - There should be consistent regulations and recommendations supporting universal baseline screening for HIV, HBV, HCV and syphilis in pregnancy
    - Repeat screening for HIV and syphilis in pregnancy likely more controversial across jurisdictions
  - For meaningful legislative changes to occur, it is critical that relevant professional societies buy-in regarding need for universal screening of these infections in pregnancy and the need for better standardization across professional society recommendations
    - There was consensus that CDC/HRSA consider convening a meeting with representatives of relevant professional societies to discuss this issue and its rationale and importance, to try to achieve consensus
    - Thru their advocacy arms, professional organizations may more effectively interact with legislators to educate them re: current recommendations and need for better alignment of laws and regulations around screening for infections in pregnancy

Focus Area # 2: Linkage Between Obstetrical and Pediatric Records

- Issue: There is a need to share maternal testing/screening results with baby's providers to assure appropriate screening, f/u and management of the baby
  - There is currently a "disconnect" between maternal and baby medical records, so that pediatricians cannot generally see what maternal screening was done and the results
- Findings:
  - This issue has been/is being addressed by PPRGLAC 2 Congressional Task Force with recommendations for implementation to improve medical record linkage-it was felt to likely strengthen their recommendations to have CHAC weigh in support as well
  - EMRs critical in initiatives to link maternal and neonatal charts
  - Have to address HIPAA concerns

Focus Area #3: Standardized Laboratory Pregnancy Panels

- Issues:
  - Lab reporting of pregnancy status for perinatal infection testing results uneven
  - Providers may not be aware of current recommendations and not infrequently order the wrong test
- Findings:
  - Development of universal pregnancy panels (and for exposed infants) to help standardize ordering would be extremely useful
    - Could serve as prompt to remind providers of screening recommendations
    - Remove the risk of ordering the wrong test
  - It would be helpful for CDC/HRSA to work with relevant professional societies (e.g., ACOG/SMFM) and CSTE to support coordination of standard pregnancy panels and timing of perinatal infection testing in pregnancy to support coordination of standard pregnancy panels thru commercial labs**.**
    - Providers could opt-out of individual tests
  - It would be helpful for major commercial labs to support laboratory reporting of pregnancy status when reporting results of HIV, syphilis, HCV and HBV screening

Focus Area #4: Reducing Silos Between Perinatal Infections

- Issue:
  - The vertical approach to different perinatal infections involves duplication of effort and ineffective use of funds
- Findings:
  - Case review boards may be a viable model to help reduce silos between different perinatal infections but many barriers (time, staff, money, need for structural changes)
  - Integration of case review boards across infections would allow more pooling and efficient use of resources
    - Consider pilot projects

People Are Still Having Sex. So Why Are S.T.D. Rates Dropping?

Public health officials believe many cases are going undetected as clinics close during the pandemic and testing supplies are diverted to coronavirus screening.

How COVID-19 Might Inform WG Considerations

- Increase in IPV, depression and substance abuse associated with COVID-19 lockdowns/stay at home, potentially increasing risk for STIs and infections related to substance abuse
- Rates of STIs (GC/CT/syphilis) have taken an abrupt downturn felt due to reductions in testing
  - Diversions of health and contact tracing personnel to COVID-19 work
  - Reduced access to health services and laboratory testing
  - Avoidance of services for fear of exposure
  - Shortages of test reagents and supplies
- Potential opportunities: expansion or home based/self testing
  - Barriers: availability of commercial home-based testing platforms; FDA approval; payment issues