

1) Screening for maternal CMV seroconversion in pregnancy
or
2) Potential Maternal CMV exposure/acute infection

***universal screening not recommended in US or Canada^{6,12,13}**

SMFM: We do not recommend routine screening of all pregnant women for evidence of primary CMV infection at this time (grade 1B)¹²
 Consensus statement from **SOCCG⁶**:
 A) Routine screening of pregnant women for CMV by serology testing is currently not recommended. (III-B)
 B) Serologic testing for CMV may be considered for women who develop influenza-like illness during pregnancy or following detection of sonographic findings suggestive of CMV infection. (III-B)
 C) Seronegative health care and child care workers may be offered serologic monitoring during pregnancy. Monitoring may also be considered for seronegative pregnant women who have a youngchild in day care. (III-B)⁶

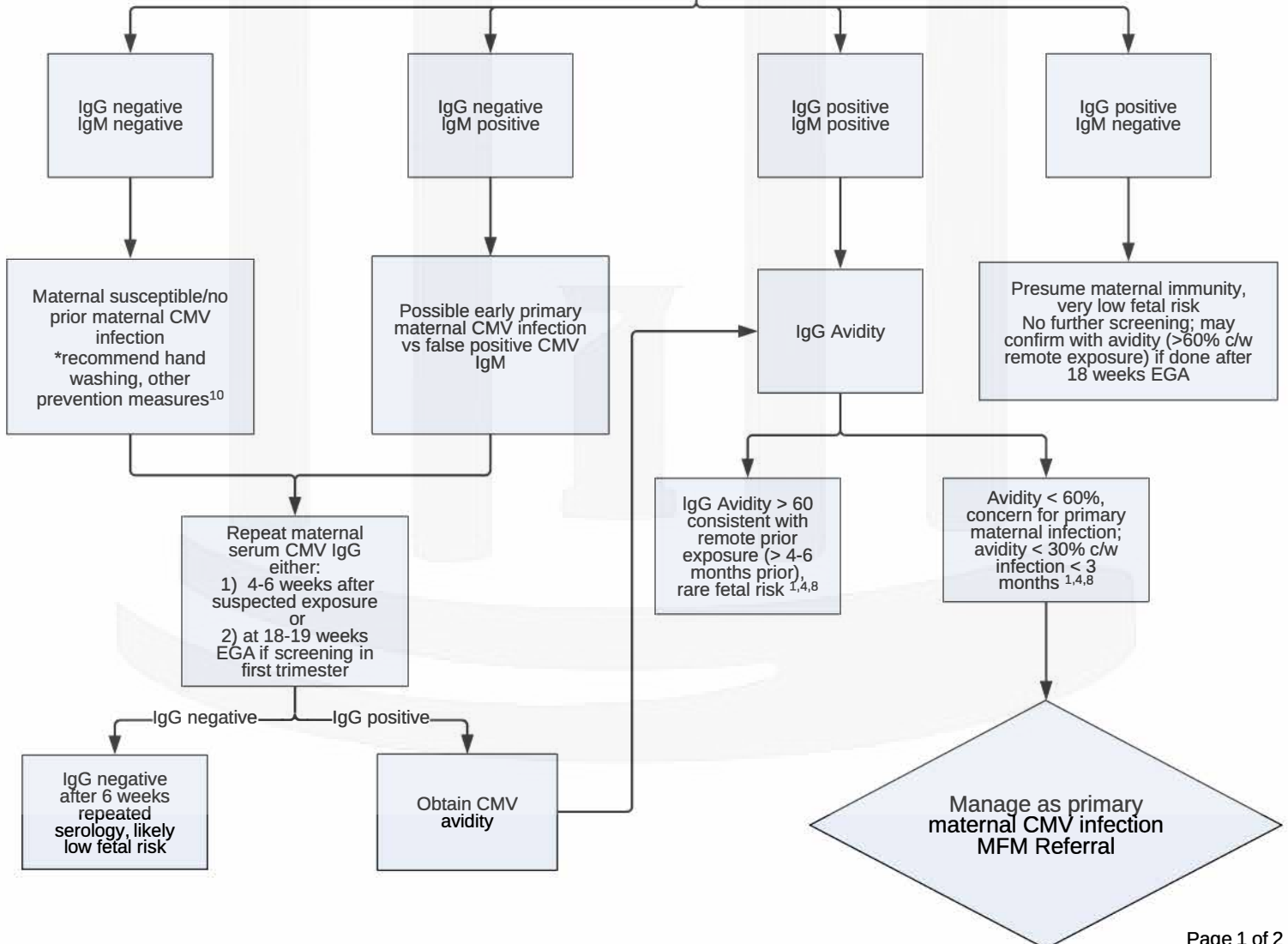
CMV facts: ^{1,2,6,12}

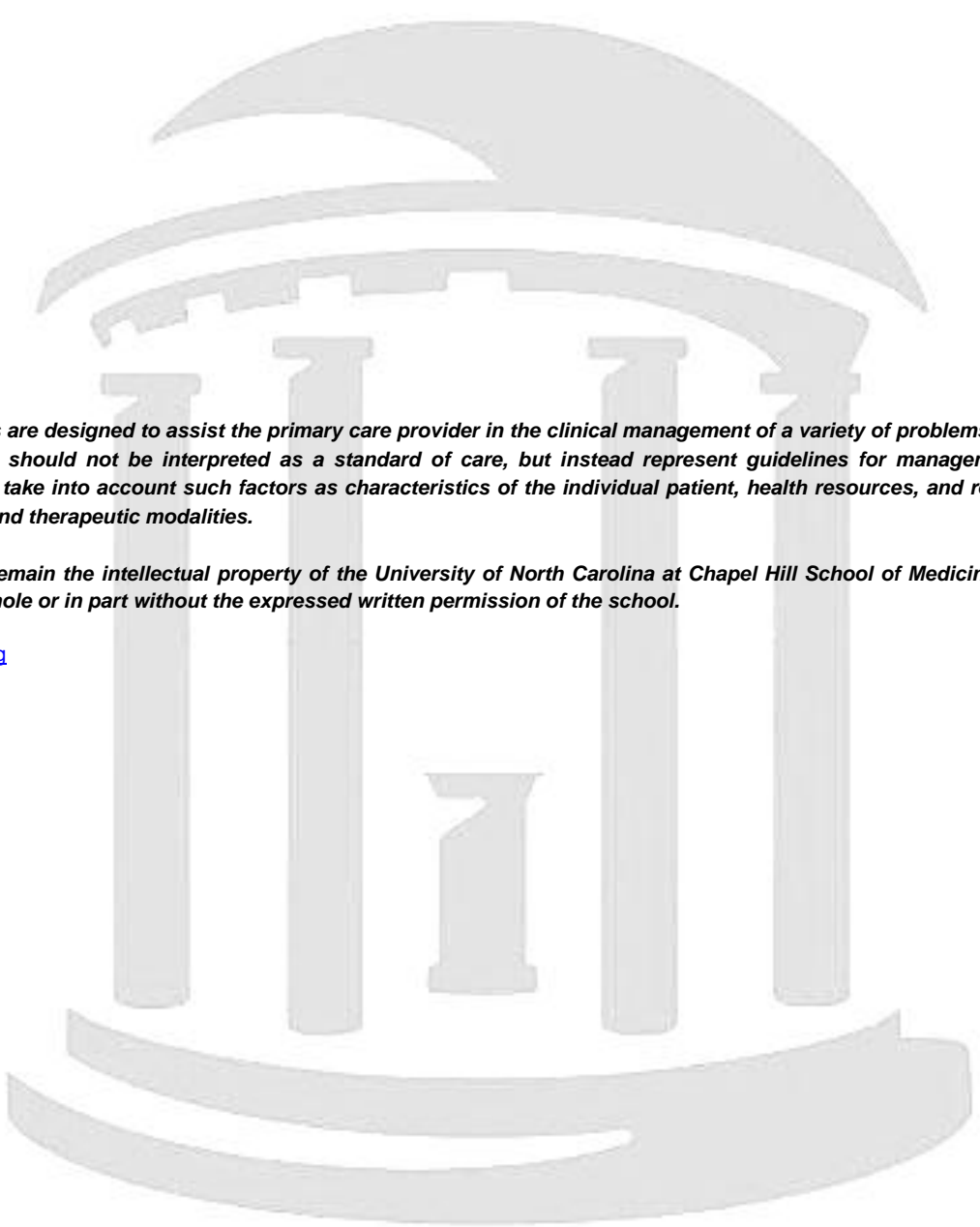
- Congenital CMV – 0.2-2.2% live births – most common congenital infection
- Maternal seroconversion rate in pregnancy 1-4%
- Intrauterine transmission
 - primary infection – 30-40%
 - secondary infection – 1%
- Congenital infection (positive urine < 2 weeks of life)
 - 10-15% symptomatic at birth
 - 85-90% no s/s at birth
 - 5-15% develop sequelae
- Risk factors for maternal CMV seroconversion in pregnancy⁶
 - Child < 4 years of age in daycare
 - Maternal at-risk occupation
 - Health care worker
 - Day care/child care provider
 - Primary school teacher

Possible scenarios for maternal CMV serologic screening:
 1) at time of suspected maternal exposure
 2) at the provider's discretion, at initial prenatal visit in high-risk for CMV women after counseling
 3) abnormal US findings (see CMV fetal diagnosis protocol)

Maternal serum CMV
IgG, IgM ^{3,4,12,13}

At UNC order 'OBGYN CMV' which will obtain IgG and reflex positive IgG to Avidity





These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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