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1 **Causes of fever in pregnant women with acute undifferentiated fever:**
2 **a prospective multicentric study**

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4 Caroline Charlier^{1,2,3,4}, Elodie Perrodeau⁵, Camille Levallois^{1,2}, Thierry Cachina^{1,2}, Marc Dommergues⁶,
5 Laurent J. Salomon⁴, Elie Azria^{2,7}, François Goffinet^{3,8}, Philippe Ravaud^{3,5} and Marc Lecuit^{1,2,3,4}

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8
9 ¹ Institut Pasteur, Biology of Infection Unit, Paris, France

10 ² Inserm U1117, Paris, France

11 ³ Institut Pasteur, French National Reference Center and WHO Collaborating Center for *Listeria*, Paris-France

12 ⁴ Université de Paris, Hôpital Universitaire Necker-Enfants Malades, Division of Infectious Diseases and Tropical Medicine,
13 Assistance Publique-Hôpitaux de Paris, Institut Imagine, Paris, France

14 ⁵ Centre of Research in Epidemiology and Statistics Sorbonne Paris Cité, METHODS Team, UMR 1153, Inserm, Université
15 de Paris, Paris, France

16 ⁶ Pierre et Marie Curie University, Pitié Salpêtrière University Hospital, Assistance Publique-Hôpitaux de Paris, Paris, France

17 ⁷ Maternity Unit, Paris Saint Joseph Hospital, Université de Paris, Paris, France

18 ⁸ Université de Paris, Hôpital Cochin Port Royal, Port Royal Maternity, Department of Obstetrics, Cochin Port Royal
19 Hospital, Assistance Publique-Hôpitaux de Paris, Paris, France

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24 **Correspondence to:**

25 Caroline Charlier, caroline.charlier@pasteur.fr

26 Marc Lecuit, marc.lecuit@pasteur.fr

27 Unité de Biologie des Infections, Institut Pasteur, Inserm U1117, 28 rue du Dr Roux, 75015 Paris, France

28 Phone: +33 1 40 61 34 20

29 Fax: +33 1 40 61 34 21

30

31 **Abstract**

32

33 *Purpose* — The etiologies of undifferentiated fever in pregnant women have not been studied
34 thoroughly. Because of its non-specific presentation but severe prognosis, listeriosis is often suspected
35 in this setting, but in most cases not confirmed. We studied the causes of undifferentiated fever in
36 pregnant women who received preemptive listeriosis treatment.

37 *Methods* — We conducted from November 1st 2011 to June 30th 2013 a prospective multicentric
38 observational cohort study of pregnant women referred to obstetrical wards with undifferentiated fever
39 and who received listeriosis preemptive treatment. Clinical and biological features, treatment, outcome
40 and final diagnosis were collected.

41 *Results* — We enrolled 103 febrile pregnant women. A cause was identified in 77/103 (75%): viral
42 infection in 52/103 (50%, influenza in 21 (20%)), bacterial infection in 22 (21%, including 16
43 pyelonephritis (16%) and 3 pneumonias (3%)), TORCH infection in 3 (3%, varicella, toxoplasmosis
44 and cytomegalovirus primo infections). Viral infections collected during influenza outbreaks
45 (December-March) accounted for 43/57 (75%) cases. Two fetal losses were reported in the context of
46 febrile pneumonia. Final diagnoses required adapting medical care in 46/77 (60%) of cases, for bacterial,
47 influenza or TORCH infections.

48 *Conclusions* — A large array of benign to potentially severe infections manifest as acute
49 undifferentiated fever in pregnant women, requiring careful repeated evaluation.

50

51 **Introduction**

52 Undifferentiated fever, i.e. without organ-specific symptoms, is a challenging symptom that has not
53 been thoroughly studied in pregnant women [1,2]. Initial evaluation of febrile pregnant women aims at
54 (i) evaluating emergency (sepsis, intra-uterine infection, pyelonephritis, meningitis, malaria), (ii)
55 identifying infections requiring interventions (pneumonia, sinusitis, TORCH infections, chickenpox),
56 and (iii) identifying benign illnesses (viral gastro-enteritis or pharyngitis) [3]. In pregnant women,
57 undifferentiated fever often leads to consider listeriosis, given its non-specific presentation and poor
58 outcome (fetal loss, prematurity and neonatal infection) [4-7]. Recommendations favor empirical
59 amoxicillin in this setting, especially after documented exposure [8,9] or during an outbreak [10,11].
60 However, as listeriosis is rare, with incidence of 10/10⁶ pregnant women [12], fever is in most cases not
61 attributable to listeriosis. We prospectively enrolled pregnant women referred to the obstetrical ward for
62 undifferentiated fever, and studied the causes of fever.

63

64 **Material and methods**

65 *Study design and patients* — The study took place from November 2011 to June 2013 in 4 Parisian
66 tertiary maternity wards.

67 The MONALISA study is registered at Clinical.Trials.gov (NCT01520597). It is an ongoing prospective
68 French observational study compiling all microbiologically-proven cases of listeriosis since 2009. The
69 study also included from 2011 to 2013 a control cohort of patients with symptoms evocative of
70 listeriosis, for whom this diagnosis was not confirmed [4]. Among these, we prospectively enrolled
71 pregnant women referred for undifferentiated fever (>37.7°C), leading to preemptive listeriosis
72 treatment, according to French guidelines [13]. Data on past medical history, features at admission,
73 results of repeated evaluations and tests, treatments, final diagnosis and outcome were collected.

74 *Statistical analysis* — Quantitative variables were described with the median and interquartile range
75 [25th–75th percentile]. Mann-Whitney tests were used to compare quantitative variables.

76

77

78 **Results**

79 *Cohort* — 103 pregnant women were included (Table1). Median term was 32 weeks (interquartile range
80 [28-36]). All patients reported the consumption of ≥ 1 food at risk of listeriosis.

81 *Biochemical results* — Inflammatory markers were significantly higher in bacterial than in viral
82 infections, with higher median leucocytes count (10,435/mm³ [8,775-13,675] vs. 8,000/mm³ [6,390-
83 10,250], p=0.004), polymorphonuclear cells count (9,615/mm³ [6,010-11,630] vs. 5,925/mm³ [4,630-
84 8,260], p=0.004) and C-reactive protein (CRP) level (74 mg/L [49-122] vs. 40 mg/L [20-50], p=0.0001).
85 Inflammatory markers in patients without final diagnosis were significantly higher than in viral
86 infections (median leucocytes count 8,100/mm³ [6,400-10,550] (p=0.009), median polymorphonuclear
87 cells count 8,990/mm³ [5,270-12,220] (p= 0.04) and median CRP level 49 mg/L [33-74] (p=0.01)), but
88 not different from patients with bacterial infections (data not shown). Twelve patients with RT-PCR-
89 confirmed influenza (12/21, 57%) had CRP level > 20 mg/L.

90 *Microbiological results* — Blood, urine and vaginal sample cultures were performed in all cases.
91 Additional tests were performed according to local protocols or new clinical findings. No patient had
92 *Listeria* positive culture or PCR results. 42 patients had microbiologically-confirmed infections: 21 had
93 positive influenza RT-PCR on nasopharyngeal swabbing, 16 with pyelonephritis had positive urine
94 culture. Other results included: varicella PCR on skin swabbing, enterovirus RT_PCR in cerebrospinal
95 fluid, documentation of *Salmonella sp.* in stool culture, evidence for *cytomegalovirus* or toxoplasmosis
96 seroconversion (n=1, each).

97 *Diagnoses* — Altogether, a diagnosis was made in 77/103 cases (75%) (Table 1). Diagnoses were
98 confirmed microbiologically (see above), radiologically (chest X-ray for pneumonia) or clinically
99 (repeated evaluations in dental abscesses and pharyngitis). Viral infections accounted for 52/103 (50%)
100 of cases, with seasonal variations: 43/57 cases during the flu epidemic (December-March, 75%,
101 including 21 influenza), but only 9/46 (20%) cases outside this timeframe (p < 0.0001).
102 In 26 patients (26/103, 25%), fever remained unexplained but resolved within 1-4 days under
103 amoxicillin.

104 *Maternal treatment* —All patients received anti-*Listeria* antibiotic treatment for a median of 7 days [6-
105 7]. Most patients with pyelonephritis required antibiotics changes: 10/16 with amoxicillin-resistant
106 pathogen were switched to 3rd generation cephalosporins (n=9) or amoxicillin-clavulanate (n=1); 3
107 received aminoglycoside. Patients with RT-PCR-confirmed influenza, toxoplasmosis and varicella had
108 amoxicillin switched to oseltamivir, cotrimoxazole or valaciclovir. 46/77 patients diagnosed with
109 bacterial, influenza virus or TORCH infection required management or follow-up changes (60%).

110 *Outcome* —One mother with meningo-encephalitis required ICU management and then fully recovered.
111 Data on delivery were available in 98 cases: 11 prematurely (median 35 WG [33.5-36]), including 2
112 with fetal losses at the moment of fever (at 21 WG in the context of lobar pneumonia and at 32 WG in
113 unexplained fever). Infants showed no sign of infection.

114

115 **Discussion**

116 In this multicentric prospective study, we analyzed the causes of fever in pregnant women with
117 undifferentiated fever in whom anti-*Listeria* preemptive therapy was prescribed. A diagnosis was made
118 in 75%, with viral infections accounting for most cases, etiologies varied according to seasons and 60%
119 of cases with a diagnosis required management/follow-up changes. Infections exhibit non-specific and
120 sometimes misleading presentation in pregnancy [2]. In this study, most patients with confirmed
121 influenza had elevated CRP rates. This underlines the need for repeated evaluations, as specific
122 symptoms may appear and help identify the cause of fever.

123

124 Twenty-six patients (23%) with undifferentiated fever had no final diagnosis but good evolution under
125 anti-*Listeria* therapy. They actually may have had maternal listeriosis despite negative cultures, as blood
126 cultures are reported negative in 45% of maternal listeriosis[4]. Indeed, they all reported food exposure
127 and exhibited inflammatory blood parameters compatible with bacterial infections. Administration of
128 anti-*Listeria* therapy for undifferentiated fever during pregnancy could prevent the development of
129 microbiologically proven maternal-neonatal listeriosis, and account, on top of food prevention
130 measures, for the sharp decline in maternal-fetal listeriosis [12].

131 A limitation of this study is its observational nature. However it shows that undifferentiated fever in
132 pregnant women reflects a large array of benign to potentially severe infections, and may warrant
133 preemptive anti-*Listeria* treatment together with careful repeated evaluation.

134

135 **Table 1.** Features of the 103 pregnant women with acute undifferentiated fever

Parameter	N= *
Epidemiological features	
Median age [Q1; Q3]	32 [29-35]
Median gestity [Q1; Q3] and parity (range)	2 [1-3]; 1 [1-1]
Twin pregnancy n= (%)	6/103 (5%)
Median term at the moment of infection (weeks of gestation) [Q1; Q3]	32 [28-36]
Geographical origin	
France	45/103 (44%)
Europe	10/103 (10%)
Maghreb	22/103 (21%)
Sub-Saharan Africa	22/103 (21%)
Other	4/103 (4%)
At least one immunosuppressing comorbidity	
HIV infection [†]	4/103 (4%)
Auto-immune disease [‡]	6/103 (6%)
Sickle cell disease	2/103 (2%)
Another comorbidity [§]	27/103 (26%)
Final diagnosis	
Bacterial infections	
Pyelonephritis [¶]	16/103 (16%)
Pneumonia	3/103 (3%)
Periapical or dental abscess	2/103 (2%)
Digestive tract salmonellosis	1/103 (1%)
Viral seasonal infections	
Upper respiratory tract infections ^{**}	23/103 (22%)
Influenza ^{††}	21/103 (20%)
Gastroenteritis	6/103 (5%)
Viral meningitis	2/103 (2%)
TORCH infections ^{**}	
Toxoplasmosis	1/103 (1%)
Varicella	1/103 (1%)
CMV primo-infection	1/103 (1%)
No final diagnosis	
26/103 (25%)	

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*The study population included the 103 pregnant women.

[†] Mean CD4 cells count in HIV infected patients ranged from 112-870/mm³.

[‡] Auto immune diseases were: type I diabetes (n= 2), multiple sclerosis (n= 2), Crohn diseases and erythematous systemic lupus (n=1, each). Of them, one patient with multiple sclerosis reported concomitant corticosteroid therapy at the moment of infection.

[§] Other comorbidities included: Asthma (n=5), Bipolar disease and Schizophrenia (n= 2, each), hypertension (n=2), epilepsy, Charcot-Marie-Tooth disease, vitiligo, narcolepsy, chronic hepatitis B (n= 1, each). Each patient reported 0 to 3 comorbidities.

[¶] Among the 16 patients with pyelonephritis, only 6 reported minor pain when urinating or pollakiuria. Ultrasound evaluation documented pyelitis in 4 cases, and acute ureteral obstruction in 3 cases. Bacteriological documentation was available in 9 cases and included amoxicillin resistant *Escherichia coli* (n= 6), *Klebsiella pneumoniae* (n=2) and *Streptococcus agalactiae* (n=1).

^{||} Chest x-ray was performed in each case and evidenced focal consolidation area (n= 2) or alveolo-interstitial infiltrate (n= 1).

^{**} Upper respiratory tract infections included pharyngitis, tracheitis or bronchitis. Patients reported contact with index case and subsequent cough and nasal discharge.

^{††} Among the 21 patients with influenza, influenza A was confirmed by PCR in 14, Influenza B in 5; data was not available for 2 patients.

^{**} TORCH infections denote a cluster of symptoms caused by congenital infection with *Toxoplasma gondii*, *Rubella virus*, *Cytomegalovirus*, *Herpes simplex virus*, and other organisms including *Treponema pallidum*, *Parvovirus B19*, and *Varicella zoster virus*.

152 **Compliance with Ethical Standards**

153

154 Funding: Programme hospitalier de recherche clinique, Institut Pasteur, Inserm, Santé Publique France

155 Conflict of Interest: none.

156

157 Ethical approval: In accordance with French legislation, the study received Institutional Review Board
158 approval by an ethical committee (Comité de Protection des Personnes Ile-de-France 3, November 6th
159 2009).

160

161 Informed consent: All participants provided written informed consent.

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163 **References**

164 1. Surgers L, Bleibtreu A, Burdet C, Clermont O, Laouenan C, Lefort A, Mentre F, Carbonne B, Bingen E,
165 Meynard JL, Denamur E (2014) Escherichia coli bacteraemia in pregnant women is life-threatening for fetuses.
166 Clin Microbiol Infect 20 (12):O1035-1041. doi:10.1111/1469-0691.12742

167

168 2. Le Gouez A, Benachi A, Mercier FJ (2016) Fever and pregnancy. Anaesth Crit Care Pain Med 35 Suppl 1:S5-
169 S12. doi:10.1016/j.accpm.2016.06.007

170

171 3. Mallart E, Charlier C (2018) [Main complications of pregnancy. Fever and pregnancy]. Rev Prat 68 (7):e277-
172 e282

173

174 4. Charlier C, Perrodeau E, Leclercq A, Cazenave B, Pilmis B, Henry B, Lopes A, Maury MM, Moura A, Goffinet
175 F, Dieye HB, Thouvenot P, Ungeheuer MN, Tourdjman M, Goulet V, de Valk H, Lortholary O, Ravaud P, Lecuit
176 M (2017) Clinical features and prognostic factors of listeriosis: the MONALISA national prospective cohort study.
177 Lancet Infect Dis 17 (5):510-519. doi:10.1016/S1473-3099(16)30521-7

178

179 5. Mylonakis E, Paliou M, Hohmann EL, Calderwood SB, Wing EJ (2002) Listeriosis during pregnancy: a case
180 series and review of 222 cases. Medicine 81 (4):260-269

181

182 6. Elinav H, Hershko-Klement A, Solt I, Glikman D, Nir-Paz R (2015) Pregnancy-associated listeriosis: many
183 beliefs, few facts. Lancet Infect Dis 15 (10):1128-1130. doi:10.1016/S1473-3099(15)00302-3

184

185 7. Elinav H, Hershko-Klement A, Valinsky L, Jaffe J, Wiseman A, Shimon H, Braun E, Paitan Y, Block C, Sorek
186 R, Nir-Paz R (2014) Pregnancy-associated listeriosis: clinical characteristics and geospatial analysis of a 10-year
187 period in Israel. Clin Infect Dis 59 (7):953-961. doi:10.1093/cid/ciu504

188

189 8. Janakiraman V (2008) Listeriosis in pregnancy: diagnosis, treatment, and prevention. Rev Obstet Gynecol 1
190 (4):179-185

191

192 9. Charlier C, Goffinet F, Azria E, Leclercq A, Lecuit M (2013) Inadequate management of pregnancy-associated
193 listeriosis: lessons from four case reports. Clin Microbiol Infect. doi:10.1111/1469-0691.12281

194

195 10. Benshushan A, Tsafirir A, Arbel R, Rahav G, Ariel I, Rojansky N (2002) Listeria infection during pregnancy:
196 a 10 year experience. Isr Med Assoc J 4 (10):776-780

197

198 11. Committee on Obstetric Practice ACoO, Gynecologists (2014) Committee Opinion No. 614: Management of
199 pregnant women with presumptive exposure to Listeria monocytogenes. Obstet Gynecol 124 (6):1241-1244.
200 doi:10.1097/01.AOG.0000457501.73326.6c

201

202 12. de Valk H, Tourdjman, M., Leclercq, A., Maury, M., Moura, A., Laurent, E., Chenal-Francisque, V., Goulet,
203 V., Brisse, S., and Lecuit, M. Changes in epidemiology and surveillance of listeriosis in France. In: International
204 Symposium On Problems of Listeriosis., Paris, 2016. Institut Pasteur,

205
206
207
208
209
210

13. Caron F, Galperine T, Fleteau C, Azria R, Bonacorsi S, Bruyere F, Cariou G, Clouqueur E, Cohen R, Doco-Lecompte T, Elefant E, Faure K, Gauzit R, Gavazzi G, Lemaitre L, Raymond J, Senneville E, Sotto A, Subtil D, Trivalle C, Merens A, Etienne M (2018) Practice guidelines for the management of adult community-acquired urinary tract infections. *Med Mal Infect* 48 (5):327-358. doi:10.1016/j.medmal.2018.03.005