

A disciplinary alliance between obstetrics and infectious diseases: Building integrated perinatal safety systems

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ABSTRACT

Aim: To summarize contemporary evidence and guideline-informed approaches for integrating infectious diseases expertise into perinatal care, to describe practical alliance models that improve maternal–neonatal infectious outcomes while supporting antimicrobial stewardship, and to propose measurable endpoints for audit and quality improvement.

Materials and Methods: A narrative review was conducted using structured searches in PubMed/MEDLINE and the Cochrane Library (2015–2026; emphasis 2021–2026) and hand-searching key guidance repositories (WHO, ACOG, CDC, RCOG, NIH). Search terms included combinations of maternal sepsis, intraamniotic infection, congenital syphilis, group B streptococcus, perinatal HIV, cytomegalovirus, antimicrobial stewardship, and maternal immunization. Evidence was synthesized with attention to implementation feasibility, workflow triggers, and measurable quality metrics. Sources were included if they provided clinical definitions, diagnostic/therapeutic pathways, stewardship frameworks, or prevention cascades relevant to prenatal, intrapartum, or postpartum care. A total of 30 sources were included in the final synthesis.

Conclusions: Integrating infectious diseases expertise into perinatal systems improves diagnostic precision, accelerates appropriate therapy for true infection, strengthens prevention cascades, and reduces unnecessary antibiotic exposure. Standardized triggers, shared protocols, microbiology support, and audit-feedback are the core implementation ingredients.

KEY WORDS: Maternal sepsis; intraamniotic infection; antimicrobial stewardship; vertical transmission; maternal immunization

Wiad Lek. 2026;79(5):1121–1126. doi: 10.36740/WLek/220829 

INTRODUCTION

Maternal and neonatal infections remain a major contributor to preventable morbidity, yet many maternity services still treat infection expertise as an “on-call add-on” rather than a built-in safety function. The WHO consensus definition frames maternal sepsis as life-threatening organ dysfunction from infection during pregnancy, childbirth, post-abortion, or postpartum, emphasizing that timely recognition and system readiness are decisive. Maternal outcomes and neonatal consequences are tightly linked, so delays or imprecision affect two patients simultaneously [1].

The consensus definition of maternal sepsis was developed through systematic review and expert consultation and underpins current obstetric sepsis terminology [2]. Pregnancy alters physiology and laboratory baselines, which can mask early deterioration and complicate standard sepsis screening; therefore, obstetric services often adapt general sepsis guidance to pregnancy-specific con-

texts and escalation pathways [3]. In parallel, obstetric infection syndromes such as suspected intraamniotic infection (IAI) sit on a spectrum that includes both microbial invasion and sterile inflammation, meaning that “fever equals infection” is clinically unsafe [4,5]. These realities make a stable obstetrics–infectious diseases (OB–ID) alliance a practical necessity rather than an academic preference.

AIM

The aim of this review is to synthesize current evidence and guidance on integrating infectious diseases expertise into perinatal care across antenatal, intrapartum, and postpartum settings. A second aim is to describe operational alliance models that balance rapid treatment for likely infection with antimicrobial stewardship tailored to pregnancy. A final aim is to propose measurable endpoints that allow maternity services to audit safety gains and stewardship performance over time.

MATERIALS AND METHODS

A narrative review design was selected to integrate heterogeneous evidence spanning obstetric guidance, critical care sepsis frameworks, antimicrobial stewardship policy, and prevention cascades for vertical transmission. We searched PubMed/MEDLINE and the Cochrane Library for English-language publications from 2015 to 2026, prioritizing 2021–2026 to reflect contemporary practice. We additionally hand-searched WHO, ACOG, CDC, RCOG, and NIH perinatal HIV guideline repositories for updated definitions and pathways, because clinical implementation depends heavily on authoritative guidance cycles. A total of 30 sources were included in the final synthesis.

Search terms included “maternal sepsis,” “obstetric sepsis,” “intraamniotic infection,” “chorioamnionitis,” “congenital syphilis,” “group B streptococcus,” “perinatal HIV,” “cytomegalovirus pregnancy,” “antimicrobial stewardship,” and “maternal immunization.” We prioritized guidelines, systematic reviews, and high-quality observational studies that explicitly informed integrated workflows, microbiologic sampling strategies, antibiotic selection/duration, or measurable prevention cascades.

ETHICS

This review used publicly available sources and did not involve collection of new patient data.

REVIEW AND DISCUSSION

The OB–ID alliance should be understood as a perinatal safety system that embeds infectious diseases reasoning into everyday obstetric workflow. In a mature model, infectious diseases specialists co-design protocols, interpret “grey-zone” microbiology and serology, and lead stewardship processes, while obstetric teams integrate these outputs into triage, fetal surveillance, delivery decision-making, and postpartum follow-up. This structure reduces both under-treatment of true infection and over-treatment driven by uncertainty. Persistent missed opportunities for preventing congenital syphilis illustrate how system reliability and follow-through can be more decisive than episodic consultation [6,7]. The balance is especially important in perinatal settings because antibiotic choices are constrained by fetal safety and exposure has downstream effects on maternal and neonatal microbiota.

Maternal sepsis is the clearest domain where integration changes outcomes, because time-critical deterioration coexists with pregnancy-specific diagnostic ambiguity. The Surviving Sepsis Campaign recommends early recognition, prompt cultures when feasible, and

timely antimicrobials when clinical likelihood is high, while recognizing that treatment must be adapted to context and source control. In obstetrics, source control may involve uterine evacuation or delivery decisions, which require coordinated planning across OB, ID, anesthesia, and neonatology [3]. A shared pathway prevents “parallel practice,” where antibiotics are started without a coordinated plan for evaluation and stop rules, or where escalation is delayed because findings are misattributed to pregnancy physiology.

RCOG Green-top Guideline No. 64 operationalizes maternal sepsis management across antenatal, intrapartum, and postpartum periods, supporting pregnancy-specific recognition and escalation standards. Its value in an alliance model is not only clinical content but also governance: it legitimizes standing triggers for ID involvement and structured reassessment rather than ad hoc consultation. When such guidance is translated into triage prompts, early warning workflows, and shared documentation, the alliance becomes measurable and teachable rather than person-dependent [8].

Suspected intraamniotic infection is another high-impact integration domain because diagnostic criteria influence both maternal treatment and neonatal evaluation. ACOG updated criteria for suspected IAI in 2024, reflecting the need for consistent thresholds and associated findings, and explicitly building on earlier committee guidance. This matters because inconsistent labeling of “chorioamnionitis” can drive unnecessary broad-spectrum antibiotics or, conversely, delayed therapy when infection is likely. An OB–ID pathway improves precision by aligning clinical criteria, sampling strategy, antibiotic selection, and postpartum stop rules with microbiologic and epidemiologic reality [4,5].

The earlier ACOG Committee Opinion No. 712 emphasized that recognition and implementation of intrapartum treatment recommendations can reduce morbidity, but real-world practice often struggles with heterogeneity in fever etiologies. Epidural-associated maternal fever, viral illness, dehydration, and sterile inflammation can mimic infection, and without an alliance, “defensive prescribing” becomes common [5]. The OB–ID partnership adds disciplined reassessment and diagnostic anchoring, reducing the risk that an initial empirical decision becomes an unexamined multi-day course. In this context, reassessment is not a luxury but part of safe obstetric care.

Prevention of vertical transmission provides a complementary demonstration of alliance value because it depends on system reliability more than diagnostic brilliance. Congenital syphilis is preventable with timely screening and treatment, yet CDC analyses of U.S. cases highlight that missed opportunities—late or absent

testing, inadequate or delayed treatment, and gaps in prenatal access-dominant case pathways. In a functioning alliance, obstetrics owns the screening touchpoints while infectious diseases and public health expertise strengthens linkage to treatment, partner management logic, and cascade monitoring. The goal is not simply “test once,” but to build a repeatable, auditable cascade that closes the gap between detection and cure [6]. CDC reports show missed prevention opportunities persist despite effective therapy, indicating an implementation failure. Alliances can address this with retesting triggers, fast-track treatment, and simple cascade dashboards for accountability [7].

Group B streptococcus (GBS) prevention illustrates how a standardized OB-led protocol supported by microbiology and stewardship can deliver population-level benefit. ACOG recommends universal screening at 36 0/7–37 6/7 weeks and defines intrapartum prophylaxis indications, creating a workflow that is predictable and teachable [9]. In an alliance, infectious diseases stewardship oversight helps distinguish appropriate prophylaxis from unnecessary treatment and supports regimen selection for penicillin allergy scenarios. The broader lesson is that perinatal infection prevention works best when embedded in routine workflow rather than triggered by crisis.

Perinatal HIV demonstrates a different integration challenge: decisions are scenario-dependent and must synchronize maternal intrapartum management with neonatal prophylaxis and follow-up. NIH perinatal guidance provides detailed intrapartum recommendations based on maternal viral load, antiretroviral history, and timing of diagnosis. The alliance matters because obstetrics controls labor and delivery decisions, while HIV/ID specialists ensure regimen appropriateness, drug interactions, resistance considerations, and continuity into postpartum care. When guideline updates occur, a governance structure that translates them into local protocols prevents drift between evidence and practice [10]. “Update awareness” is a safety issue because perinatal HIV guidance evolves with evidence and policy [11]. NIH “What’s New” summaries support rapid protocol updates, with ID leads translating changes and OB teams implementing them across clinics and labor wards.

Antimicrobial stewardship is the connective tissue that allows the alliance to improve outcomes without amplifying resistance and iatrogenic harm. IDSA/SHEA stewardship guidelines emphasize that optimal antibiotic use requires systems, leadership, and measurement, not only prescriber education. In perinatal care, stewardship must incorporate fetal safety, lactation compatibility, and the microbiome consequences of exposure, while still supporting rapid therapy when se-

vere infection is likely [12]. A practical alliance standard is a documented antibiotic plan that states indication, intended duration, and a mandated reassessment point, typically within 48–72 hours.

The WHO AWaRe classification provides a widely adopted framework to monitor antibiotic consumption and set targets that encourage use of “Access” agents when appropriate. AWaRe fits maternity services because it converts prescribing patterns into measurable stewardship metrics that can be audited alongside clinical outcomes. When combined with local susceptibility data, AWaRe-informed dashboards can identify drift toward broad-spectrum “Watch” agents without clear indication. This is especially relevant for postpartum prescribing patterns, where unnecessary continuation after prophylaxis is a common stewardship failure [13].

Policy-to-practice translation is strengthened by explanatory literature linking essential medicines policy and AWaRe stewardship goals. Contemporary reviews describe AWaRe as a tool not only for classification but also for setting system targets and monitoring stewardship intervention effects [14]. For perinatal services, the alliance can operationalize these concepts as monthly reports: antibiotic-days per 100 deliveries, proportion of Access agents, and the rate of documented 48–72 hour reassessments.

STI management in pregnancy is another area where integration reduces both overtreatment and undertreatment. CDC STI treatment guidelines provide pregnancy-specific considerations, including syphilis screening logic, recommended regimens for common infections, and management of pathogens with emerging resistance. The alliance is helpful because STI management frequently requires partner therapy planning, retesting intervals, and interpretation of complex serology or NAAT results. Integrating ID expertise into antenatal pathways can reduce recurrences and prevent downstream obstetric complications associated with untreated or inadequately treated infections [15].

Prevention extends beyond screening into immunization, where the OB–ID alliance has increasing relevance due to vaccine hesitancy, evolving schedules, and the need for consistent counseling. ACOG’s 2026 committee statement on maternal immunizations emphasizes routine assessment and recommends vaccines such as influenza, COVID-19, and Tdap during pregnancy, positioning prenatal care as the primary platform for protection of both mother and infant [16]. Systematically delivering these recommendations requires workflow design, standing orders, and consistent messaging across clinicians. In an alliance model, ID/public health expertise supports risk communication and program evaluation, while obstetrics ensures delivery at point of care.

CDC guidance for vaccinating pregnant women provides practical scheduling considerations and supports incorporation of vaccination into prenatal care workflows [17]. Surveillance data also show gaps in coverage and measurable hesitancy for influenza, Tdap, and COVID-19 vaccination among pregnant women, indicating that aligned provider recommendations and consistent messaging are key implementation determinants [18]. Practical alliance deliverables include standardized counseling scripts, staff training, and monitoring of coverage gaps by clinic site or demographic group.

Understanding microbiome-linked obstetric risk strengthens the alliance because it explains why indiscriminate antibiotic use can be harmful. Network meta-analysis evidence links low-lactobacilli vaginal community states with increased preterm birth risk, suggesting that microbial ecology is clinically relevant, not merely descriptive. More recent systematic reviews continue to evaluate associations between vaginal microbiota composition and preterm birth outcomes, reinforcing that microbial states during pregnancy can carry prognostic information [19,20]. These findings support stewardship discipline in pregnancy, because altering microbiota without clear indication can plausibly worsen dysbiosis-associated risks.

Cytomegalovirus (CMV) illustrates alliance value in uncertainty management and prevention counseling rather than routine screening [21,22]. ACOG notes that routine serologic screening of all pregnant individuals is not recommended and emphasizes hygiene-based prevention counseling to reduce acquisition risk. CDC similarly provides practical prevention advice focused on reducing contact with saliva and urine from young children, which is central to real-world risk reduction. In alliance terms, obstetrics delivers counseling and surveillance, while ID expertise supports serology interpretation (including false positives) and diagnostic pathway design when primary infection is suspected.

Guideline synthesis and appraisal literature on congenital CMV management highlights variability across recommendations and the need for structured pathways that integrate fetal surveillance, neonatal evaluation, and follow-up. Such variability is exactly where an alliance improves care, because it can translate heterogeneous guidance into a single local pathway with explicit decision points and referral triggers. This avoids the common pattern where CMV testing is performed but results are not followed by consistent counseling, imaging surveillance, or neonatal planning. In practice, the alliance defines who owns each step and when escalation is mandatory [23].

The alliance's stewardship arm is supported by conceptual frameworks that define stewardship as a clinical

and ethical practice rather than a restrictive policy [24]. Core stewardship concepts emphasize that optimal antibiotic use improves outcomes, reduces adverse events, and preserves antibiotic effectiveness. In perinatal care, this is amplified because the same antibiotic course can influence maternal health, fetal exposure, and neonatal colonization. A stewardship-literate alliance therefore treats reassessment and de-escalation as clinical care, not administrative oversight.

WHO's AWARe antibiotic book extends the stewardship concept by providing evidence-based guidance on drug choice, dose, route, and duration for common infections, reinforcing the "right drug, right duration" principle in an implementable format. The companion Lancet Infectious Diseases commentary further positions the AWARe book as a policy and practice tool for improving empiric antibiotic prescribing aligned with essential medicines logic. In maternity services, these resources help standardize empiric choices while still allowing escalation when severe infection or resistance risk is high. The alliance can adapt these resources to local susceptibility patterns and obstetric safety constraints [25,26].

Several maternal sepsis reviews emphasize diagnostic difficulty and the need for obstetric-specific frameworks, supporting the argument that alliance design matters. The sepsis literature also reinforces that "one-size-fits-all" screening tools may misclassify pregnant patients if obstetric physiology is not considered [27]. In the WHO Global Maternal Sepsis Study, multiple early warning systems (EWS) were evaluated in women with suspected or confirmed infection across many countries, and obstetric- and sepsis-specific approaches generally performed better than non-obstetric tools; importantly, no single score demonstrated sufficient diagnostic accuracy to be used alone, which argues for framework-based escalation rather than score-only decisions [28].

A practical implication is that maternity services should pre-define (and repeatedly train) escalation thresholds, microbiology sampling sets, and early antibiotic decision rules so that care is teachable, repeatable, and consistent across shifts. The AIM "Sepsis in Obstetric Care" bundle explicitly frames preventable maternal deaths as being driven by delays in recognition, treatment, and escalation, and it recommends unit-level readiness plus facility-wide standard protocols for assessment, treatment, and escalation, supported by tools such as standardized order sets, "sepsis alert" workflows that mobilize teams, and processes that prioritize laboratory turnaround and timely antimicrobial administration [29]. In parallel, antibiotic selection in maternal sepsis requires attention to pregnancy-related

physiologic changes that alter pharmacokinetics and complicate diagnosis; contemporary reviews emphasize common pathogens in pregnancy (e.g., *E. coli* and Group A *Streptococcus*) and summarize empiric regimens and dosing considerations, reinforcing the need for pre-agreed antibiotic decision rules embedded into the obstetric sepsis pathway [30].

CONCLUSIONS

The disciplinary alliance between obstetrics and infectious diseases is a modern requirement for perinatal safety because infection care in pregnancy requires

both speed and precision under physiologic and therapeutic constraints. The alliance has greatest impact in maternal sepsis and suspected intraamniotic infection, where pregnancy-adapted pathways can reduce delays while stewardship prevents unnecessary exposure. Prevention of vertical transmission, especially for syphilis, HIV, and GBS—demonstrates that system design and follow-through can outperform episodic decision-making. A standardized, team-based model with defined triggers, microbiology support, 48–72 hour reassessment discipline, and audit-feedback linked to measurable endpoints is the most reproducible pathway to sustained improvement.

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CONFLICT OF INTEREST

The Authors declare no conflict of interest

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RECEIVED: 16.01.2026

ACCEPTED: 20.04.2026

