**Influenza Season Assessment and Treatment for Pregnant Women With Influenza-Like Illness**

Pregnant women are at high risk of serious complications of influenza (flu) infection such as intensive care unit admission, preterm birth, and maternal death. Patients with flu-like illness should be treated with antiviral medications presumptively regardless of vaccination status. Do not rely on test results to initiate treatment; treat presumptively based on clinical evaluation. The following algorithm is designed to aid practitioners in promptly assessing and treating flu-like illness in pregnant women.

### Confirm Patient Presents With Influenza-Like Illness

Flu-like symptoms typically include fever ≥37.8°C (100.0°F) and one or more of the following:

- Cough
- Sore throat
- Runny nose
- Headaches or body aches
- Fatigue
- Difficulty breathing or shortness of breath

If a patient does not report fever but has abrupt onset of symptoms suggestive of the flu, proceed with the algorithm.

### Conduct Illness Severity Assessment

- Does she have difficulty breathing or shortness of breath?
- Does she have new pain or pressure in the chest other than pain with coughing?
- Is she unable to keep liquids down?
- Does she show signs of dehydration such as dizziness when standing?
- Is she less responsive than normal or does she become confused?
- Did she have flu-like symptoms that improved but then returned or got worse?

Any Positive Answers

### Elevated Risk

Elevated Risk

Recommend she immediately seek care in an emergency department or equivalent unit that treats pregnant women. When possible, send patient to a setting where she can be isolated. Antiviral treatment should follow CDC guidelines*†‡.

### Moderate Risk

Moderate Risk

See patient as soon as possible in an ambulatory setting with resources to determine severity of illness. When possible, send patient to a setting where she can be isolated. Clinical assessment for respiratory compromise includes physical examination and tests such as pulse oximetry, chest X-ray, or ABG as clinically indicated. Antiviral treatment should follow CDC guidelines*†‡.

### Low Risk

Low Risk

Begin antiviral treatment over the phone or in person following CDC guidelines*†‡. Plan for follow-up within 24–48 hours.

Any Positive Answers

### Assess Clinical and Social Risks

- Comorbidities (eg, HIV or asthma)
- Obstetric issues (eg, preterm labor)
- Inability to care for self or arrange follow-up if necessary

Any Positive Answers

### No Positive Answers

- Cough
- Sore throat
- Runny nose
- Headaches or body aches
- Fatigue
- Difficulty breathing or shortness of breath

If a patient does not report fever but has abrupt onset of symptoms suggestive of the flu, proceed with the algorithm.

### Vaccination with seasonal influenza will help reduce incidence of flu. Check the College’s Immunization for Women website at www.immunizationforwomen.org for any future updates on this information.

Abbreviations: ABG, arterial blood gases; CDC, Centers for Disease Control and Prevention; HIV, human immunodeficiency virus.

*Oseltamivir (preferred) (75-mg PO twice per day for 5 days) or Zanamivir (two 5-mg inhalations [10 mg total] twice per day for 5 days).

†Check with institution to determine requirements for testing. Do not rely on test results to initiate treatment; treat presumptively based on clinical evaluation.

‡Treatment within 48 hours of the onset of symptoms is ideal but should not be withheld if the ideal window is missed. Because of the high potential for morbidity and mortality for pregnant and postpartum patients, the CDC advises that postexposure antiviral chemoprophylaxis can be considered for pregnant women and women who are up to 2 weeks postpartum (including after pregnancy loss) who have had close contact with infectious individuals. The chemoprophylaxis recommendation is oseltamivir 75 mg once daily for 10 days.

This information is designed to aid practitioners in assessing and treating influenza-like illness during pregnancy. This guidance should not be construed as dictating an exclusive course of treatment or procedure. Variations in practice may be warranted based on the needs of the individual patient, resources, and limitations unique to the institution or type of practice.

Please be advised that this guidance may become out-of-date as new information on influenza in pregnant women becomes available from the Centers for Disease Control and Prevention (CDC). Copyright February 2017 The American College of Obstetricians and Gynecologists and the Society for Maternal–Fetal Medicine.