CLINICAL GUIDELINE

Genital Infections in Pregnancy

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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Approval Group:	Sandyford Governance Group
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Important Note:

The online version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Genital Infections in Pregnancy

What's New:

References updates to newest versions of guidelines

Herpes: New guideline "HSV in Pregnancy Nov 2025"

Gonorrhoea: Changes to management of patients and contacts and follow up

Contents

Introduction

This guideline is designed to:

- highlight the impact of common STIs on the pregnant people and their child who may be exposed either in utero or during delivery
- Highlight any management recommendations which may be different in pregnancy
- This guideline should be used in conjunction with the guideline specific to the infection in question

It is beyond the remit of this guideline to advise on the management of HIV and hepatitis B during pregnancy.

Group B Streptococcus (GBS) is recognised as an important cause of severe early onset infection in new-borns. GBS is not a sexually transmitted infection but is present in the vagina of approximately 50% of all pregnant people. Therefore, guidance is included to assist with the management of pregnant people in whom GBS is considered to be an incidental finding.

General Points

- Discuss the advantages of details regarding diagnosis of an STI being included within maternity records and (where permission is granted) inform the obstetric team.
- The physiology of pregnancy can alter the natural history of an STI
- It is safe to perform vaginal examination and take cervical swabs in the pregnant people.
- Doxycyline and quinolones (e.g. ciprofloxacin/moxifloxacin) and treatment with Podophyllotoxin or Imiquimod preparations should **not** be used if there is a risk of pregnancy or on consultant/pharmacist advice.
- Partner notification is essential to reduce the possibility of re-infection
- Do not assume every pregnant person has had HIV / syphilis testing as part of antenatal testing. They may have opted out of testing or not yet had their booking bloods. Even if they have been tested earlier in the pregnancy, people presenting with STIs should be offered repeat testing for HIV/Syphilis
- Patients planning a pregnancy should be encouraged to be tested for HIV/syphilis.
- The finding of GBS in the vagina or urine of a person who is pregnant is significant and this information needs to be shared with their obstetric team.

Bacterial Vaginosis

Bacterial vaginosis (BV) may increase risk of late miscarriage, preterm birth, premature rupture of membranes and post-partum endometritis.

- There is no evidence to support screening asymptomatic pregnant women, for BV.
- Symptomatic pregnant women should be treated in the usual way; First line should be metronidazole 400mg oral twice daily 5-7days. The manufacturer recommends avoiding metronidazole 2g stat oral dose in pregnancy.

Metronidazole 400mg BD PO 5- 7days

- No teratogenic or mutagenic effects in infants have been found with metronidazole. Metronidazole enters breast milk and may affect its taste. The manufacturers recommend avoiding high doses if breastfeeding
- Women with asymptomatic BV in pregnancy should be discussed with the obstetrician as the evidence related to treating BV to prevent adverse pregnancy outcomes is conflicting.
- Women with additional risk factors for preterm birth may benefit from treatment before 20 week gestation
- Studies support screening for and treating BV with either metronidazole or clindamycin cream prior to termination of pregnancy, to reduce the incidence of subsequent endometritis and PID

Chlamydia

- Studies show an association between Chlamydia Trachomatis (CT) and miscarriage, preterm birth and low birth weight. They also suggest an increased risk of complications the earlier in the pregnancy the infection occurs.
- Infants born vaginally to mothers with untreated genital CT infection are at risk for developing CT conjunctivitis (15- 50%) and/or pneumonia (5-30 %).
- Up to 1/3 of woman with CT delivering vaginally will develop puerperal infection.
- Azithromycin use in pregnancy remains off label but its use is generally recommended for uncomplicated genital, rectal & pharyngeal infection.

Oral Azithromycin 1g immediately then 500mg once on days 2 and 3. If Azithromycin contraindicated use Erythromycin 500mg twice daily for 14 days OR Erythromycin 500mg four times daily for 7 days OR Amoxicillin 500mg three times daily for 7 days

- A BASHH statement from 2017 raised concerns that some antibiotics (including Azithromycin) may be associated with an increased risk of

spontaneous abortion when used in pregnancy. However, as Azithromycin is more effective and better tolerated than other antibiotics used to treat CT and using a less effective treatment which might result in a greater chance of pregnancy loss due to inadequately treated infection. As a result BASHH Clinical Effectiveness Group saw no reason to change guidance at this time. The potential risks and benefits should be discussed with the patient and documented in clinical notes.

- Doxycycline should not be used in pregnancy unless on consultant/pharmacist advice. A follow-up BASHH statement from 2024 advises that first trimester use of doxycycline may be considered if there are no other options (if full treatment course can be completed by 15 weeks gestation.
- A test of cure should be performed a minimum of 3 weeks after treatment. This is essential in rectal infection.
- A repeat test at 36 weeks gestation is recommended.
- Partner notification should be undertaken.

Genital Warts

- Genital warts often present during pregnancy.
- C-section is rarely indicated, and this tends to be due to obstruction– vaginal outlet/cervix. The lesions may avulse or haemorrhage, or cause shoulder dystocia during delivery. It is not indicated to prevent vertical transmission.
- A serious potential complication to the infant is recurrent respiratory papillomatosis (warts on larynx). This occurs very rarely in about 4/100,000 births.
- Treatment may not always be required, but aims to reduce the amount of lesions present at delivery and, therefore, neonatal exposure to the virus.
- Do **not** use Podophyllotoxin, Imiquimod or Catephen in pregnancy.
- Cryotherapy can be offered but this may not be effective.
- Warts often spontaneously resolve in the weeks following delivery.
- individuals with genital warts during pregnancy should be reassured of the low absolute risk of significant HPV-related complications in the neonate.

Consider Cryotherapy

Gonorrhoea

- Gonorrhoea has been shown to be associated with preterm rupture of membranes, pre-term birth, low birth weight and post-partum infection. There may be a greater rate of complications the earlier in pregnancy the infection occurs.
- Newborns may acquire gonococcal infection during delivery. The perinatal transmission rate is about 30 to 40 % in women with cervical infection. Intrauterine infection can also occur after rupture of the membranes.

- In the new born, the eye is the most frequent site of gonococcal infection. It is typically characterized by a purulent discharge. Without treatment, the infection can extend leading to ulceration, scarring, and visual impairment.
- Other localised gonococcal infections include infections of other mucosal surfaces (pharynx, vagina, urethra, and anus) and scalp abscess.
- In new-borns, systemic gonococcal infection (e.g. septic arthritis, sepsis, and/or meningitis) is rare and is usually a complication of localised infection.
- Throat swab should be included for anogenital infections and for contacts of gonorrhoea
- Cefixime and ceftriaxone are not thought to be harmful in pregnancy

Ceftriaxone 1g IM STAT

or

If true penicillin allergy: *Spectinomycin 2mg IM STAT*

Spectinomycin may be subject to supply issues. Consult Senior before use.

- Do **not** use quinolones e.g. ciprofloxacin in pregnancy and gentamicin should be avoided.
- For penicillin allergic clients, consult senior colleague for advice.
- If unable/refused IM injection then consult BASHH guidelines and discuss with a senior. Azithromycin 2g STAT can be considered in these cases but only when the isolate is known to be susceptible to Azithromycin and the manufacturer recommends this only when no other alternatives are available.
- Test of cure should **always** be offered 3 weeks after treatment.
- A repeat test at 36 weeks gestation is recommended to exclude re-infection.
- Partner notification should be undertaken.

For bacterial pharyngeal infections please discuss with GUM Doc of the day.

Herpes Simplex

See HSV in Pregnancy Nov 2025

Syphilis

Syphilis in pregnancy should be managed as clinically urgent by a multidisciplinary team including GUM, Obstetrics, Paediatrics and General Practice.

Screening

- All pregnant women are offered serological screening for syphilis at their initial antenatal appointment. This should be repeated if the woman is at risk of infection.
- Treponema pallidum can be transmitted transplacentally at any stage of pregnancy; the risk is dependent on the stage of maternal infection and duration of fetal exposure.
- Syphilis can cause polyhydramnios, miscarriage, pre-term labour, stillbirth, hydrops and congenital syphilis.
- Maternal co-infection with HIV may increase the transmission risk of syphilis.

Management

- See Appendix 1 for how positive results in pregnancy should be handled.
- Results are copied into the Failsafe system and managed by the Health Advising team as follows:

a) **Maternal treatment not indicated**
Biological false positive test
Syphilis adequately treated before this pregnancy and follow up complete

False positive results should be repeated after 2-4 weeks to confirm
If patient is within their treatment follow up period, this should continue as planned
GUM advice to be sought if result unclear

b) **Maternal treatment indicated**
Active syphilis of any stage
Unclear history of syphilis treated prior to this pregnancy

GU Physicians should make a clear diagnosis and communicate this clearly in a birth plan (Appendix 2).

Re-treatment in pregnancy is indicated where there is uncertainty of treatment or serologic cure is in doubt.

Partner notification is essential to reduce the possibility of re-infection.

Follow up serology should be undertaken as per BASHH guidelines on management of syphilis 2024. It may take several months to observe a four fold drop in RPR and many will deliver beforehand, so serological cure may not be demonstrable prior to birth.

If a pregnant person it as risk of re-infection more regular monitoring could be performed in order to enable rapid early treatment.

Serological testing may be helpful at delivery to identify reinfection and to aid the diagnosis of congenital syphilis but if re-infection is excluded, the woman requires no further treatment and the neonate will not require testing

Treatment

Patients should be treated appropriately for the stage of disease, according to the BASHH guidelines. See Syphilis CEG March 2024 guideline

A single dose of benzathine penicillin G 2.4 MU is effective in most early cases, however limited evidence suggests that a second dose of benzathine penicillin G 1 week after the first may be beneficial for fetal treatment in pregnant people.

Benzathine Penicillin G 2.4 MU Intramuscular on Day 1 & 8 For late latent syphilis treatment see Syphilis 2024 guideline See syphilis guideline for administration

- Those with penicillin allergy: A thorough history should be ascertained of the possible allergy and discussed with a GUM senior. If a history of true allergic reaction exists . But the patient is not allergic to ceftriaxone, ceftriaxone can be used. Alternatively an urgent referral to local immunology/allergy services for de-sensitisation and immediate penicillin treatment should be considered. This should be undertaken in conjunction with the GUM, obstetric and paediatric teams

- In pregnancy the rate of the Jarisch-Herxheimer reaction is the same as in the non-pregnant, circa 40%. This may cause uterine contractions and fetal heart decelerations, as a result of maternal fever. Therefore, there may be a theoretical increased risk of spontaneous and iatrogenic preterm delivery and fetal demise. However, these complications are also associated with Syphilis infection. Management should be supportive with antipyretics and fluids. Steroids are not effective in reducing these effects.

- If delivery occurs within 4 weeks after completion of therapy the neonate will require empirical treatment. This also applies in a suspected case of congenital syphilis, those born to mothers with non-penicillin treatment regimens and those born to mothers without documented evidence of inadequate treatment.

- Partner Notification should be undertaken to prevent re-infection.

Follow Up

- It may take several months to observe a four-fold drop in RPR and in many pregnancies labour will occur before these periods have elapsed.
- Moreover, women with late syphilis may have serofast RPR's. Hence, serological cure may not be demonstrable before birth of the neonate.

Trichomonas Vaginalis

- Trichomonas vaginalis (TV) has been associated with premature rupture of membranes, preterm delivery, and low birth weight. TV infection at delivery may predispose to maternal postpartum sepsis

- There is no evidence to support asymptomatic screening for TV in pregnancy.

- Symptomatic pregnant women should be treated at diagnosis, regardless of the stage of the pregnancy, although some clinicians have preferred to defer treatment until the second trimester

- Offer a full sexual health screen (if not already done).

- When a patient is asymptomatic some clinicians may recommend deferring therapy until after 37 weeks' gestation. Senior clinicians should counsel patients regarding the potential risks and benefits of treatment and communicate the option of therapy deferral in asymptomatic pregnant women until after 37 weeks' gestation.

- Metronidazole can be used in all stages of pregnancy and during breast feeding. 400 mg oral metronidazole twice daily for 7 days is used. High-dose regimens are **not** recommended during pregnancy.

Metronidazole 400mg bd PO 7 days

- No teratogenic or mutagenic effects in infants have been found with metronidazole. Metronidazole enters breast milk and may affect its taste. The manufacturers recommend avoiding high doses if chestfeeding.

- Partner notification should be undertaken to prevent re-infection.
- If symptoms do not resolve a test of cure is indicated

Vulvovaginal Candidiasis (VVC)

There is no evidence of any adverse effect of VVC on pregnancy if the patient is asymptomatic

Topical imidazoles (e.g. clotrimazole) have been found to be safe and effective in pregnant women with VVC but a longer treatment regimen is recommended

Clotrimazole 500mg vaginal pessary at night for up to 7 nights

Oral antifungals should be avoided during pregnancy (congenital abnormalities reported with high doses)

If symptoms persist, refer to GUM

Group B Streptococcal (GBS) Colonisation

- About 50% of all pregnant woman in the UK carry GBS in their vagina.
- GBS can be passed from mother to baby. When this happens it can occasionally cause severe illness in the new-born (known as neonatal GBS).
- Only 1 in every 1750 new-born babies born in the UK and Ireland is diagnosed with neonatal GBS.
- Women in whom GBS has been found in the urine or swabs from the vagina (or rectum) taken for other reasons are likely to be offered antibiotics during labour. **It is important that the pregnant women and their midwifery or obstetric team are made aware of the presence of colonisation.**
- Women with GBS in the vagina or rectum do not need antibiotics in pregnancy prior to labour unless they have a symptomatic infection (for example a urine infection).
- Women with GBS urinary tract infection during pregnancy should receive antibiotics at the time of diagnosis (on discussion with the women's obstetric team) as well as during labour.

- Antenatal prophylaxis for vaginal / rectal colonisation detected incidentally earlier in a pregnancy does not reduce the likelihood of colonisation at the time of delivery so is not recommended.

- There is no national screening programme for GBS in the UK as there is no clear evidence to show that screening all pregnant women in the UK would be beneficial overall.

- Vaginal swabs should not be taken in pregnancy unless there is a clinical indication to do so.

- The RCOG have written a patient information leaflet for women who are expecting a baby or planning to become pregnant about Group B Streptococcus infection which is available at: Group B Streptococcus (GBS) in pregnancy and newborn babies | RCOG

References

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UK National Guidelines on the Management of infection Chlamydia Trachomatis 2015 https://www.bashhguidelines.org/media/1192/ct- 2015.pdf [Accessed Nov 2025]

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British Association for Sexual Health and HIV National Guidelines for the Management of Vulvovaginal Candidiasis. 2019 https://www.bashh.org/_userfiles/pages/files/resources/vvc_ijsa_pdf. [Accessed March 2026]

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management of anogenital warts in adults agw_2024.pdf [Accessed March 2026]

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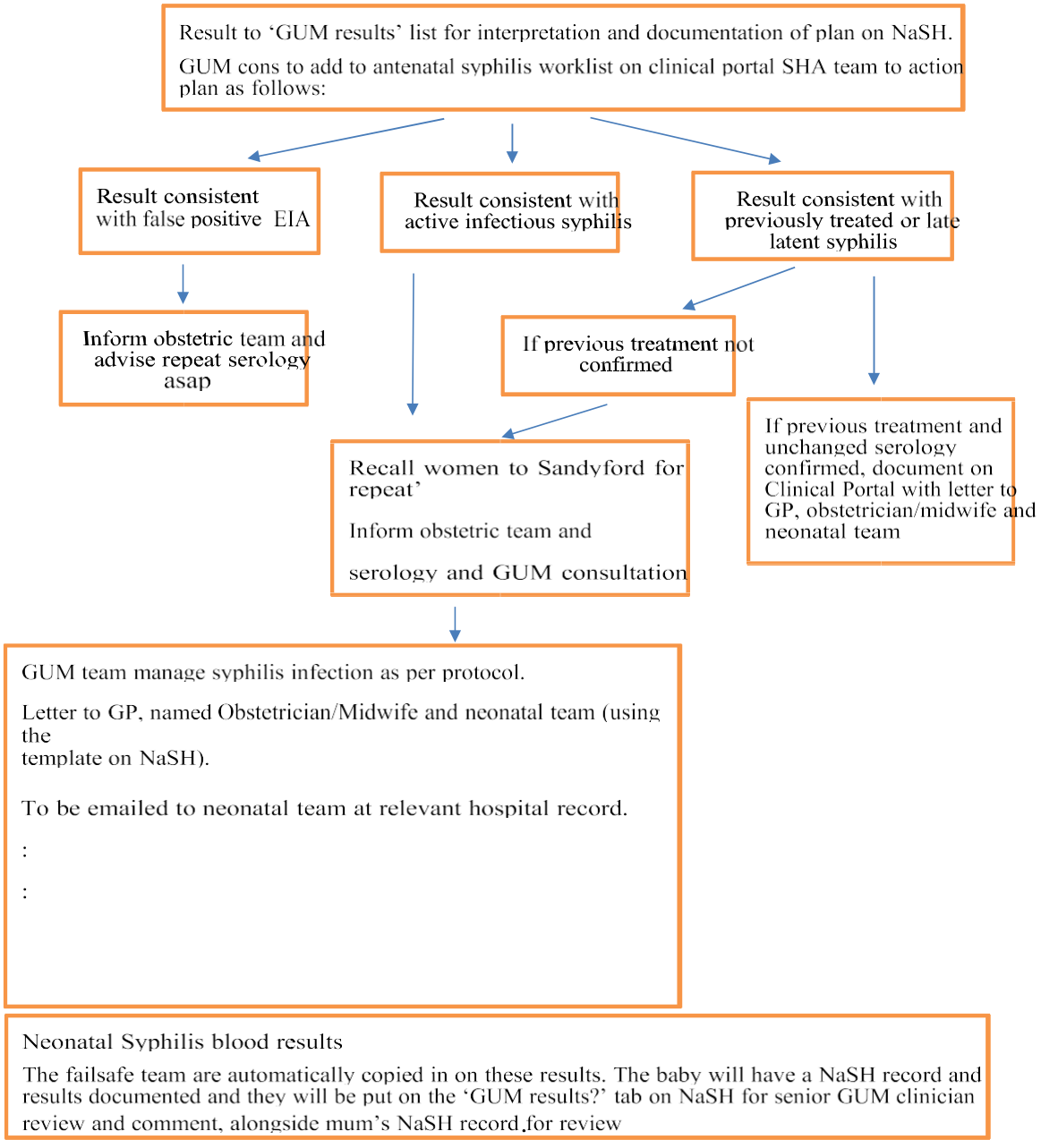
The Royal College of Obstetricians and Gynaecologists green top guideline Number 36 Third edition September 2017
'The Prevention of Early-onset Neonatal Group B Streptococcal Disease'
Prevention of Early-onset Group B Streptococcal Disease (Green-top Guideline No. 36) | RCOG [Accessed March 2026]

The Royal College of Obstetricians and Gynaecologists 2017 Group B Streptococcus (GBS) in pregnancy and newborn babies
Group B Streptococcus (GBS) in pregnancy and newborn babies | RCOG [Accessed March 2026]

Appendix 1

Antenatal Syphilis Management
Lab report EIA positive antenatal sample to Sandyford Shared Care team



Appendix 2

Letter to GP, Obstetrics & Neonatal team re: Antenatal Syphilis Diagnosis & Management - And to be uploaded to mum & baby's Badgernet and clinical portal records

Name: _____ CHI: _____ Date: _____

Date of syphilis diagnosis: _____ Pregnancy EDD: _____

Stage of syphilis diagnosed in pregnancy

_____

Additional Information

_____

HIV and other BBV status

_____

Treatment details

_____

Date treatment completed/due to complete _____

Syphilis serology results (date_____)	
EIA	

TPHA	

IgM	
RPR	

*Please note further serological follow up will be completed by Sandyford

GUM ADVICE TO PAEDIATRICIANS (tick as required)

See West of Scotland congenital syphilis guideline:

Please discuss infant blood test results with GUM (or Paediatric infectious diseases team if OOH or suspicion of neonatal infection).

Infant requires no physical examination above routine. No syphilis serology required	
Assess infant clinically: if no physical signs of syphilis, perform syphilis serology on infant serum (not cord blood) for EIA IgM and RPR. N.B. If physical signs are present consider additional investigations. Refer to West of Scotland Syphilis guideline and discuss with GUM or ID consultant	
Treat infant at birth with _____ after clinical assessment, perform syphilis serology on infant serum (not cord blood) for EIA IgM and RPR and additional tests as per guideline	

Follow Up

Infants who have serology tests at birth require follow up as per the three pathways detailed in the WoS guideline. Tick the appropriate follow-up pathway below once the infant's serology is known.

Baby Name _____ CHI _____

Age	Infants treated for congenital syphilis at birth	Infant not treated for syphilis and RPR <4x mother's and IgM negative at birth	Infant not treated for syphilis and RPR and IgM negative at birth
Select Follow up pathway	☐	☐	☐
1 month	RPR TP Syphilis IgM		
3 months	RPR TP Syphilis IgM	RPR TP Syphilis IgM	RPR TP Syphilis IgM If negative: discharge If positive: Repeat at 6 months
6 months	RPR	RPR If negative: discharge If positive: repeat at 12 months	RPR If negative: discharge If positive: discuss with GUM team.

12 months	RPR Discharge if RPR has achieved sustained 4x drop from peak level. If RPR remains higher, discuss with GUM team.	RPR If negative: discharge If positive: discuss with GUM team.	

For further information please contact Sandyford on 0141 211 8634. Yours

sincerely,

Signature: _____

Consultant in Genitourinary Medicine

Signature: _____ Consultant Neonatologist