Listeriosis in pregnancy

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1 Invasive listeriosis (bacteremia or meningitis) in pregnancy leads to major fetal consequences, including fetal loss, neonatal meningitis, and neonatal death[1,2]

Perinatal listeriosis can be asymptomatic or present with gastrointestinal symptoms, myalgias, fevers, sepsis, and acute respiratory distress syndrome.[1,3] In pregnancy, 29% of patients with invasive listeriosis experience fetal loss or neonatal death.[2]

2 Pregnant people should avoid foods at high risk of *Listeria monocytogenes* contamination[2,4]

Whereas certain foods have higher contamination risk (e.g., unpasteurized milk and cheeses, luncheon meats, refrigerated meat spreads, and premade salads),[2,5] it is important to also be aware of Health Canada recalls (https://recalls-rappels.canada.ca/en). Most exposures do not result in symptoms, but listeriosis is 20 times more common in pregnancy.[5,6]

3 In asymptomatic patients who have ingested possibly contaminated foods, investigations or treatment are not indicated[2,5]

Because the incubation period is up to 70 days, listeriosis can present 2–3 months after exposure.[5] If symptoms develop, patients should be managed based on the recommendations below.

4 In afebrile patients presenting with mild gastroenteritis or flu-like symptoms with possible exposure to *L. monocytogenes*, investigations and management are guided by expert opinion[2]

Whereas expectant management is reasonable, obtaining blood cultures[2] and/or starting a 14-day course of oral amoxicillin (500 mg 3 times daily)[4,5] could be considered. Patients with resolved symptoms should be treated as asymptomatic.

5 In febrile patients with possible exposure to *L. monocytogenes*, blood cultures should be immediately drawn and high-dose ampicillin initiated, with electronic fetal heart rate monitoring[2,4]

Intravenous ampicillin (6–12 g/d) should be given for 14 days with consideration for synergistic gentamicin.[2] Trimethoprim with sulfamethoxazole should be used in patients with penicillin allergy.[2,4] If delivery occurs, placental culture and pathology should be completed. Pediatric care providers should be informed to consider empiric antibiotics, laboratory investigations, cerebrospinal fluid sampling, and imaging.[2]

References

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