

Towards a consensus definition of maternal sepsis: results of a systematic review and expert consultation

Bonet, Mercedes; Pileggi, Vicky; Rijken, Marcus J ; Coomarasamy, Aravinthan; Lissauer, David; Souza, Joao Paulo; Gulmezoglu, Ahmet Metin

DOI:

[10.1186/s12978-017-0321-6](https://doi.org/10.1186/s12978-017-0321-6)

License:

Creative Commons: Attribution (CC BY)

Document Version

Peer reviewed version

Citation for published version (Harvard):

Bonet, M, Pileggi, V, Rijken, MJ, Coomarasamy, A, Lissauer, D, Souza, JP & Gulmezoglu, AM 2017, 'Towards a consensus definition of maternal sepsis: results of a systematic review and expert consultation: consensus definition of maternal sepsis', *Reproductive Health*, vol. 14, no. 67. <https://doi.org/10.1186/s12978-017-0321-6>

[Link to publication on Research at Birmingham portal](#)

Publisher Rights Statement:

Checked for eligibility: 31/03/2017

General rights

Unless a licence is specified above, all rights (including copyright and moral rights) in this document are retained by the authors and/or the copyright holders. The express permission of the copyright holder must be obtained for any use of this material other than for purposes permitted by law.

- Users may freely distribute the URL that is used to identify this publication.
- Users may download and/or print one copy of the publication from the University of Birmingham research portal for the purpose of private study or non-commercial research.
- User may use extracts from the document in line with the concept of 'fair dealing' under the Copyright, Designs and Patents Act 1988 (?)
- Users may not further distribute the material nor use it for the purposes of commercial gain.

Where a licence is displayed above, please note the terms and conditions of the licence govern your use of this document.

When citing, please reference the published version.

Take down policy

While the University of Birmingham exercises care and attention in making items available there are rare occasions when an item has been uploaded in error or has been deemed to be commercially or otherwise sensitive.

If you believe that this is the case for this document, please contact UBIRA@lists.bham.ac.uk providing details and we will remove access to the work immediately and investigate.

Reproductive Health

Towards a Consensus Definition of Maternal Sepsis: Results of a Systematic Review and Expert Consultation

--Manuscript Draft--

Manuscript Number:	REPH-D-17-00051	
Full Title:	Towards a Consensus Definition of Maternal Sepsis: Results of a Systematic Review and Expert Consultation	
Article Type:	Review	
Funding Information:	UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research	Dr. Mercedes Bonet Mrs. Vicky Nogueira-Pileggi Dr. João Paulo Dias de Souza
	Utrecht University Medical Centre	Dr. Marcus Rijken
	University of Birmingham	Professor Arri Coomarasamy Dr. David Lissauer
Abstract:	<p>Background: There is a need for a clear and actionable definition of maternal sepsis, in order to better assess the burden of this condition, trigger timely and effective treatment and allow comparisons across facilities and countries. The objective of this study was to review maternal sepsis definitions and identification criteria and to report on results of an expert consultation to develop a new international definition of maternal sepsis.</p> <p>Methods: All original and review articles and WHO documents, as well as clinical guidelines providing definitions and/or identification criteria of maternal sepsis were included. A multidisciplinary international panel of experts was surveyed through an online consultation in March-April 2016 on their opinion on the existing sepsis definitions, including new definition of sepsis proposed for the adult population (2016 Third International Consensus Definitions for Sepsis and Septic Shock) and importance of different criteria for identification of maternal sepsis. The definition was agreed in an expert face-to-face meeting convened by WHO and Jhpiego.</p> <p>Results: Standardizing the definition of maternal sepsis and aligning it with the current understanding of sepsis in the adult population was considered a mandatory step to improve the assessment of the burden of maternal sepsis by the expert panel. The literature review and expert consultation resulted in a new WHO consensus definition "Maternal sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, child-birth, post-abortion, or post-partum period". Plans are in progress to validate the new WHO definition of maternal sepsis in a large international population.</p> <p>Conclusion: The operationalization of the new maternal sepsis definition requires generation of a set of practical criteria to identify women with sepsis. These criteria should enable clinicians to focus on the timely initiation of actionable elements of care (administration of antimicrobials and fluids, support of vital organ functions, referral) and improve maternal outcomes.</p>	
Corresponding Author:	Mercedes Bonet World Health Organization Regional Office for Europe SWITZERLAND	
Corresponding Author Secondary Information:		
Corresponding Author's Institution:	World Health Organization Regional Office for Europe	
Corresponding Author's Secondary Institution:		
First Author:	Mercedes Bonet	
First Author Secondary Information:		
Order of Authors:	Mercedes Bonet	

	Vicky Nogueira-Pileggi
	Marcus Rijken
	Arri Coomarasamy
	David Lissauer
	João Paulo Dias de Souza
	Ahmet Metin Gülmezoglu
Order of Authors Secondary Information:	
Author Comments:	
Opposed Reviewers:	

[Click here to view linked References](#)**Title**

Towards a Consensus Definition of Maternal Sepsis: Results of a Systematic Review
and Expert Consultation

Short title

Consensus Definition of Maternal Sepsis

Mercedes Bonet^{1*}, Vicky N Pileggi², Marcus J Rijken³, Arri Coomarasamy^{4,5}, David
Lissauer⁶, João Paulo Souza¹, Ahmet Metin Gülmezoglu¹

1. UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research,
Development and Research Training in Human Reproduction (HRP), Department of
Reproductive Health and Research, World Health Organization, Geneva, Switzerland
(bonetm@who.int; souzaj@who.int)
2. Department of Social Medicine and Department of Paediatrics, Ribeirão Preto Medical
School, University of São Paulo, Ribeirão Preto, SP, Brazil (vicky.pileggi@gmail.com)
3. Utrecht University Medical Centre – Department of Obstetrics and Gynaecology and
Julius Global Health, Julius Center for Health Sciences and Primary Care, Utrecht, The
Netherlands (mrijken2@umcutrecht.nl)
4. School of Clinical and Experimental Medicine, University of Birmingham, Birmingham,
United Kingdom (A.Coomarasamy@bham.ac.uk)
5. Birmingham Women's National Health Service (NHS) Foundation Trust, Birmingham,
United Kingdom.
6. Birmingham Centre for Women's and Children's Health, College of Medical and Dental
Sciences, University of Birmingham, Birmingham, United Kingdom
(D.M.Lissauer@bham.ac.uk)

***Corresponding author**

Abstract

Background: There is a need for a clear and actionable definition of maternal sepsis, in order to better assess the burden of this condition, trigger timely and effective treatment and allow comparisons across facilities and countries. The objective of this study was to review maternal sepsis definitions and identification criteria and to report on results of an expert consultation to develop a new international definition of maternal sepsis.

Methods: All original and review articles and WHO documents, as well as clinical guidelines providing definitions and/or identification criteria of maternal sepsis were included. A multidisciplinary international panel of experts was surveyed through an online consultation in March-April 2016 on their opinion on the existing sepsis definitions, including new definition of sepsis proposed for the adult population (2016 Third International Consensus Definitions for Sepsis and Septic Shock) and importance of different criteria for identification of maternal sepsis. The definition was agreed in an expert face-to-face meeting convened by WHO and Jhpiego.

Results: Standardizing the definition of maternal sepsis and aligning it with the current understanding of sepsis in the adult population was considered a mandatory step to improve the assessment of the burden of maternal sepsis by the expert panel. The literature review and expert consultation resulted in a new WHO consensus definition “Maternal sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, child-birth, post-abortion, or post-partum period”. Plans are in progress to validate the new WHO definition of maternal sepsis in a large international population.

Conclusion: The operationalization of the new maternal sepsis definition requires generation of a set of practical criteria to identify women with sepsis. These criteria should enable clinicians to focus on the timely initiation of actionable elements of care (administration of antimicrobials and fluids, support of vital organ functions, referral) and improve maternal outcomes.

Key-words: sepsis, maternal sepsis, consensus, definition

Plain English summary

Sepsis occurs when the body's response to infection damage its own organs and tissues. If not recognised early and treated timely, sepsis can progress to shock and death. Physiological, immunological and mechanical changes in pregnancy make pregnant women more susceptible to infections compared with non-pregnant women. Furthermore, physiological adaptations to pregnancy may obscure signs and symptoms of infection and sepsis.

Efforts have been made in the last 20 years to standardize definitions of sepsis for the general adult population, but the validity and applicability of the proposed definition and identification criteria to pregnant women are uncertain.

We reviewed articles and WHO documents, as well as clinical guidelines providing definitions and/or identification criteria of maternal sepsis. We also surveyed a multidisciplinary international panel of experts on their opinion on the existing sepsis definitions and importance of different criteria for identification of maternal sepsis. The literature review and expert consultation resulted in a new WHO consensus definition. These identification criteria should enable clinicians to focus on the timely initiation of actionable elements of care (administration of antimicrobials and fluids, support of vital organ functions, referral) and improve maternal outcomes. Plans are in progress to validate the new WHO definition of maternal sepsis in a large international population.

79 **Introduction**

80 Sepsis is a major public health concern[1]. Sepsis includes three essential components:
81 infection, host response to infection and organ dysfunction. A wide range of pathogens could
82 cause life threatening responses in many organs; consequently sepsis has a broad spectrum of
83 clinical presentations. Pregnant women are particularly predisposed to develop infections and
84 sepsis for several reasons. Physiological, immunological and mechanical changes in pregnancy
85 make pregnant women more susceptible to infections compared with non-pregnant women,
86 particularly during the postpartum period[2]. Furthermore, physiological adaptations to
87 pregnancy (e.g. hyperdynamic circulation, tachycardia, diminished oxygen reserve,
88 hypercoagulability), blood loss, maternal efforts during second stage of labour, or
89 interventions during labour, may obscure signs and symptoms of infection and sepsis[3],[4].
90 This may result in delays in the recognition and treatment of sepsis[5]. Another factor to be
91 considered is that a substantial proportion of early onset neonatal sepsis originates from intra-
92 uterine infections and antepartum maternal infections.

93
94 Globally, important achievements in healthcare (for example, hand washing, antibiotics)[6]
95 had a great impact on the reduction of infection-related maternal deaths; however sepsis is
96 still an important contributor to preventable maternal mortality. Infections are considered the
97 underlying cause in about 11% of maternal deaths[7] and are a significant contributor to many
98 deaths attributed to other conditions. However, the true frequency of maternal infections and
99 its complications are not well known. Imprecise and varying definitions may have led to
100 discrepancies in reported incidence and observed mortality[1, 2, 8]. Available data on
101 pregnancy associated sepsis from high-income countries report an incidence of 9 to 49 per
102 100,000 deliveries-years, depending on the definition and population used[9]. Lack of data
103 from low-income countries makes the incidence difficult to determine in those countries[10].
104 Compared to other pregnancy complications the case fatality rate of maternal sepsis is very

high. Sepsis with acute organ dysfunction has a mortality of 20–40% in high-income countries[11]. Estimates of case fatality rates after puerperal infection vary from 4 to 50% in Africa and Asia[12].

Efforts have been made in the last 20 years to standardize definitions of sepsis for the general adult population[13, 14]. In 2016, definitions and clinical criteria for identifying sepsis and septic shock were updated[1] and the Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score was proposed to classify organ dysfunction and thus identify sepsis in the adult population[1]. However, the validity and applicability of the proposed definition and identification criteria to pregnant women are uncertain.

The objective of this paper is to report the development of a standard definition for maternal sepsis based on a systematic review of literature and a technical consultation.

Materials and Methods

The development of a consensus definition of maternal sepsis was based on two components, a systematic review of literature and a technical consultation.

Systematic review

The systematic review of literature focused on definitions and identification criteria of maternal sepsis. Prognostic literature, including articles on prediction scores used to identify obstetric patients at risk of developing complications, were not included in this review.

Search Strategy

We conducted an electronic search to identify review articles on maternal sepsis and original articles reporting on the development and testing of maternal sepsis definitions or

identification criteria for maternal sepsis. Clinical guidelines and WHO documents related to
 the prevention, identification and management of maternal sepsis were also reviewed. The
 literature search in PubMed/MEDLINE and EMBASE databases was carried out on 15/02/2016
 and included papers published from 01/01/2010 and 15/02/2016. The search strategy used a
 combination of the following terms, expanded and adapted for each database: “sepsis”,
 “septicemia”, “septic shock”, “maternal”, “mother”, “pregnancy”, “childbirth”, “postpartum”,
 “death”, “mortality”, “severe morbidity”, “critical illness”, “near-miss”, “intensive care”,
 “critical care”, “emergency”, “definition”, “identification criteria”, and “diagnostic criteria”.
 Additional details of the search strategy are provided in the Supplementary Table S1.
 Guidelines and WHO documents related to the prevention, identification and treatment of
 maternal sepsis were searched using the terms “maternal sepsis” and “guideline” in the
 following databases: National Guideline Clearinghouse, WHO guidelines repository, Guidelines
 International Network (G-I-N), Institute for Health and Care Excellence (NICE) and Google. Only
 the first ten pages of results provided by the Google search engine were screened.

Review Process

All citations identified through PubMed/MEDLINE and EMBASE were downloaded into
 reference management software and duplicates were removed. All titles and abstract were
 screened by two independent reviewers (VNP, MJR), using the following standardized inclusion
 criteria: (a) all review articles related to maternal sepsis; (b) all articles that report on the
 development/testing of identification criteria for maternal sepsis cases; (c) all guidelines
 reporting a definition or identification criteria for maternal sepsis; (d) published in the period
 2010-2016.
 Full-texts of the reviews with potentially relevant information on maternal sepsis, or when
 title/abstract was deemed insufficient for decision on inclusion/exclusion, were obtained. Full

157 texts of potential eligible articles were assessed independently by two reviewers (VNP, MJR).
158 WHO documents and guidelines were assessed by one reviewer (MB). Data were extracted
159 using a standardized spreadsheet specifically developed for this review and including the
160 following domains: 'first author's name'; 'year of publication'; 'study design'; 'definition of
161 maternal sepsis provided'; 'list of identification criteria of maternal sepsis provided'. Data was
162 extracted once and extraction forms were double checked by a second reviewer. Discrepancies
163 on inclusions and/or data extraction were resolved through discussion or, if required, by a
164 third reviewer.

166 *Data Collection and Synthesis*

167 The definitions of maternal sepsis reported by the included studies, WHO documents and
168 guidelines were extracted. Identification criteria were organized based on organ system
169 involved (circulatory, respiratory, central nervous, renal, coagulation, digestive, skin, genital,
170 and inflammatory). Information concerning specific clinical values or general symptoms and
171 signs was also extracted. No meta-analysis was performed due to the non-numerical nature of
172 the data and heterogeneity.

174 Expert consultation

175 Based on the systematic review presented in this paper and the recently published Sepsis-3
176 consensus definition[1], a technical group developed draft definitions of maternal sepsis and
177 proposed a two-stage approach to identify women with possible severe maternal infection
178 who may benefit from prompt clinical action (e.g. further clinical or laboratory investigation,
179 initiation of therapy, and referral), and a second set of criteria to confirm diagnosis of maternal
180 sepsis.

182 An online survey was carried out to assess expert opinion on the new definition of sepsis
183 proposed for the adult population (SEPSIS-3) and the alternatives developed by the technical

group, the applicability for the obstetric population and the merits of various criteria for the identification of maternal sepsis.

The survey was sent in March 2016 to 231 experts selected from professional societies of obstetrics, midwifery, nursing and intensive care, research groups working on maternal morbidity and authors of reviews identified in the systematic review describe above. Two reminders were sent to all participants. The survey was anonymous and structured with multiple choice and open-ended questions. Participants were asked to choose a preferred definition of maternal sepsis among various different alternatives drafted by the technical group. The respondents were also asked to provide their level of agreement with the definition of organ dysfunction in adults and its application to maternal sepsis (in a five-point Likert scale ranging from strongly disagree to strongly agree with the statement, , and to rank variables to be used as identification criteria . Combined percentages were calculated for the responses “Strongly agree” and “Agree”, “Strongly disagree” and “Disagree”, “Important” and “Very important”, “Not important” and “Slightly important”.

In April 2016, WHO’s Department of Reproductive Health Research and Jhpiego convened a face-to-face expert consultation, including some of the experts who participated in the online survey, to review results of this systematic review and online consultation, and to agree on a consensus definition for maternal sepsis.

Results

Systematic review

The search yielded to 245 citations after exclusion of duplicates. A total of 78 were selected for full-text evaluation. After screening, 26 studies[2, 4-6, 8, 10, 15-35], 9 guidelines[11, 36-43] and 3 WHO documents[44-46] matched the inclusion criteria (Figure 1).

<Figure 1 HERE> Figure 1 Flow chart

This review found several definitions and sets of criteria being used to identify maternal sepsis cases (Table 1 and 2). However, a substantial proportion of studies (11/26) and guidelines (7/9) referred to the First (1991) or Second (2001) International Consensus on Sepsis developed by a joint task force of American and European societies of intensive care medicine (Table 1). These international consensus published in 1992[47] and 2003[48], proposed definitions and criteria for the identification of sepsis cases in the general population and were based on the previous understanding of sepsis as an infection with a systemic inflammatory response (SIRS).

<TABLE 1 HERE> Table 1. Summary of definitions used to refer to maternal sepsis in studies, guidelines and WHO documents included in the systematic review

Nine studies (9) referred to a previous WHO definition of “puerperal sepsis” as an infection of the genital tract occurring at any time between the onset of rupture of membranes or labour and the 42nd day postpartum, without any reference to complicated infections and systemic response. Another WHO document[45] gives a slightly different definition of puerperal sepsis as any bacterial infection of the genital tract which occurs after the birth of a baby. The most recent WHO documents[45] also provides a definition of septic abortion as an abortion complicated with infection of the genital-tract. However these two documents also included shock or septicemia as one of the clinical presentations that may also occur with infection during the puerperium or after an abortion.

TABLE 2 HERE> Table 2. List of criteria used to identify maternal sepsis in studies and guidelines included in the systematic review

238

239 Coverage of the different stages of pregnancy and the postpartum/post-abortion periods is not
240 consistent. The majority of reviews and guidelines cover all stages of pregnancy, intrapartum,
241 postpartum and post-abortion periods. However some studies[2, 4, 6, 15, 17, 25, 35] and
242 guidelines [36] were limited to certain stages (e.g. postpartum) or conditions (abortion) [2, 15,
243 19, 27]. Furthermore, time limits for the postpartum period varied to up to the end of the 10th
244 day after childbirth or abortion in ICD-10, to the 42nd day postpartum.

245

246 There is also variation regarding the type of infection considered. Nine of the reviews referred
247 to any pregnancy or non-pregnancy-related infection, including incidental infections. Other
248 preferred to differentiate those infections from nosocomial infections, or to classify infections
249 into those related to the genital-tract infections and non-genital-tract infections. Furthermore,
250 four documents (2 reviews[4, 25], 2 WHO documents[44, 45]) limited to postpartum genital
251 tract infections. Three reviews focused on Group A *Streptococcus* (GAS) infections [6, 23, 49].

252

253 Criteria proposed to identify maternal sepsis also vary widely. The most common variables
254 were temperature, heart rate, blood pressure, respiratory rate and leukocytosis. Reviews and
255 guidelines considering laboratory findings for identification of septic women include several
256 testing of liver (enzymes, bilirubin), kidney (creatinine) and clotting (INR, aPPT) function. Five
257 reviews [6, 8, 19, 28, 49] recommended use of cultures to identify causative microorganism,
258 including two reviews specific on GAS infection[6, 49] and requiring isolation of the pathogen
259 for confirmation of diagnosis. Most of the guidelines also referred to the use of glucose, CRP
260 and plasma procalcitonin. These variables were less frequently proposed in the included
261 reviews. The full set of results of the online survey is presented in Supplementary tables S2A,
262 S2B and S3A, S3B.

263

Expert consultation

The online survey of experts elicited 48 responses. The full set of results of the online survey is presented in Supplementary S4. The background of the participants was obstetrics (n=23), midwifery (3), adult or obstetric critical care (10), infectious disease (3), researchers (17) and public health specialists (1), from both public (43) and private (5) sector, and representing all regions (Africa (9), Americas (14), Asia (7), Europe (11), Middle East (2)).

The majority of experts stated that the definition of organ dysfunction used in maternal sepsis should be adapted from the SEPSIS-3 consensus for adults (33/46), and should be based on specific criteria for the obstetric population (35/46). Most of the respondents stated that the assessment of organ dysfunction should include respiratory, cardiovascular, renal and neurologic variables (43, 44, 41 and 38 respondents respectively out of 46 respondents to the questions). Less than half considered important to include fetal variables (22/46). Regarding specific variables, experts tended to prefer thresholds adapted to the obstetric population over those of the qSOFA. Experts also preferred the use of clinical signs over laboratory investigations necessary to calculate the SOFA score. However, two-thirds of the respondents considered serum creatinine (31/44), serum lactate (29/44) and arterial pH (30/44) as important markers of clinical severity. Fourteen of these experts also participated in the face-to-face meeting, where all findings were reviewed and discussed.

Consensus Definition of Maternal Sepsis

As a result of this systematic review and international expert consultation, a standard definition of maternal sepsis was proposed as: “Maternal Sepsis is a life-threatening condition defined as organ dysfunction resulting from infection during pregnancy, childbirth, post-abortion, or post-partum period”.^[50]

It is proposed that the identification of organ dysfunction takes place in two steps, one for identification of women with possible severe maternal infections, and presenting with early signs of infection with systemic repercussion (to allow initiation of timely treatment) and another for “confirmed” cases of maternal sepsis (to enable comparative studies). The attributes of these identification criteria were also agreed by the experts. These criteria should be actionable, simple to obtain, able to predict early signs of sepsis, based on clinical signs at bedside, allow for additional tests where available, and suited to high- and low-resource settings. They have to be useful in clinical practice to identify women who may benefit from early intervention. They also have to be compatible with the current classification of disease ICD-10 and contribute to the ongoing revision of the classification to allow comparability of data.

Discussion

This paper describes the process towards a consensus definition of maternal sepsis, based on a systematic review and international expert consultation. This new WHO definition of maternal sepsis may facilitate a better understanding of the burden of this condition and allow comparisons across different settings. Ultimately this will provide the basis for effective prevention, identification and management of maternal sepsis.

The systematic review showed a wide range of definitions and criteria being used to describe maternal sepsis. Most of the reviews and guidelines identified align with the previous definitions of sepsis, severe sepsis and septic shock, and criteria used to identify adult septic patients. However, in obstetrics, the term sepsis is often used interchangeably to refer to puerperal infectious morbidity. There are also differences in the type of infections considered. Some definitions included only infections from the genital tract (chorioamnionitis, endometritis [22]), while others have a broader definition and include infections from other

organ systems, such as pneumonia, or incidental infections (malaria). In addition, few studies report maternal sepsis across all the spectrum of pregnancy, including antenatal, postpartum, and abortion related sepsis. All these variations may have important implications for clinical care and potentially lead to misdiagnosis, inadequate treatment or delays in care. They also have epidemiological implications, making it difficult to assess the real burden of maternal sepsis and allow comparisons across different settings (hospitals, countries).

In February 2016 the Third International Consensus on Sepsis was published and included a substantial change in the understanding of sepsis[1]. This Sepsis-3 consensus definition defined sepsis as a life-threatening organ dysfunction caused by a dysregulated host response to infection. The significance of the systemic inflammatory response was de-emphasized compared to the previous definition based on the SIRS criteria. The SOFA score was also introduced to better describe severity of organ dysfunction and to predict in-hospital mortality^[1]. This scoring includes the evaluation for the following organ systems: Respiration (PaO₂), Coagulation (platelets), Liver (bilirubin), Cardiovascular (mean arterial blood pressure, MAP), Central Nervous System (Glasgow Coma Scale), Renal (serum creatinine and urine output).

The proposed new WHO definition of maternal sepsis aligns with the current understanding of sepsis in adults, and considers sepsis as a consequence of a dysregulated, life-threatening response to infection. This is supported by the results of the expert consultation, but also previous guidelines which already were recommending the use of definitions and criteria developed for the general population. However, many of the variables used to calculate the SOFA score were not mentioned in the included reviews or supported by results of the expert consultation. This is despite the fact that the SOFA score variables and its clinical proxies have been previously proposed by WHO as gold-standard for severity markers to be used to identify

women with life-threatening conditions[51]. For example PaO₂ was mentioned in two reviews only [15, 17]. Glasgow Coma scale was not mentioned in any of the included reviews and in one guideline only[42]. Results of the online survey showed similar results, as most of the experts preferred to use clinical markers of severity over laboratory investigation necessary to compute the SOFA score. The exception was the use of serum creatinine and lactate. These results may be in part influence by the criteria set in the survey, such as ensuring applicability in low resource settings, in a wide range of clinical settings and by different cadres of health care providers. The results also suggest that the list of identification criteria used for maternal sepsis must accommodate different resources available to clinicians, whilst allowing them to incorporate into the diagnosis laboratory findings when available.

The new definition also aligns with the WHO definition of maternal morbidity defined as “any health condition attributed to and/or complicating pregnancy and childbirth that has a negative impact on the woman’s wellbeing and/or functioning”[52]. Regarding infectious morbidities, the definition of pregnancy related infections includes genital tract infections (e.g. chorioamnionitis and endometritis), extra-genital infections (e.g. mastitis, breast abscess, pyelonephritis, tetanus), as well as other maternal infections complicating pregnancy, childbirth and the puerperium (e.g. HIV, malaria, STIs, other fungal and viral infections).

A clear problem for using clinical criteria for pregnant women is that physiological changes in pregnancy may affect many organ systems: blood pressure, PaO₂, bilirubin or creatinine measurements [3]. Furthermore, experts report that clinical criteria must be applied with great care in the obstetric patient where, sometimes, only one or even none of the above findings are present despite a severe infection [4]. For this reason modified obstetric early warning scoring systems (MOEWS) have been developed for pregnant women[53]. MOEWS systems vary widely in terms of alert thresholds, format, and accuracy. However, none of the current

existing tools have shown good performance in predicting the development of severe sepsis [53] [54]. A limitation of this review is that we did not include these MOEWS or SOS (Sepsis in Obstetrics) scores as potential sources of criteria for identification of septic women. However, these scores have not been prospectively validated in a large obstetric population across different settings, particularly in low- and middle-income countries where their impact could be the largest.

Conclusion

The new maternal definition and set of identification criteria will be tested and validated in a large global study[55]. A global one-week cross-sectional study will be carried out in 2017 in a large network of health facilities, the *Ending Maternal Sepsis Week* study. This study aims to cover existing knowledge gaps. It will assess the frequency of maternal sepsis using the proposed definition and identification criteria in all settings, particularly in low- and middle-income countries, and across the spectrum of pregnancy including the antenatal, peripartum, postpartum and post-abortion periods. Information on prevention and management strategies will be collected to inform the development of a strategy for reducing maternal infections and sepsis.

Table 1. Summary of definitions used to refer to maternal sepsis in studies, guidelines and WHO documents included in the systematic review

Name of organization proposing the definition, (year)	Definition	Studies referring to the definition	Guidelines referring to the definition
American College of Chest Physicians and the Society of Critical Care Medicine (1992)	<p><i>Systemic inflammatory response syndrome (SIRS)</i>: Widespread inflammatory response to severe clinical insult defined by the presence of two or more of the following symptoms:</p> <ul style="list-style-type: none"> ► Temperature >38°C or <36°C ► Heart rate >90/min ► Respiratory rate >20/min or PaCO₂ <32 mm Hg ► White blood cells >12×10⁹/dL or <4×10⁹/dL or >10% immature forms <p><i>Sepsis</i>: SIRS plus definitive evidence of infection</p> <p><i>Severe sepsis</i>: Sepsis with signs of organ dysfunction, hypoperfusion or hypotension</p> <p><i>Septic shock</i>: Sepsis with hypotension despite adequate fluid resuscitation</p>	Barton, 2012[8]; Buddeberg, 2015[4]; Chebbo, 2016[17]; Cordioli, 2013; Frise, 2015[21]; Morgan, 2013[5]; Oud[33] Pacheco, 2014[34]; van Dillen, 2010[10]	FLASOG 2013[43]
International Classification of Diseases, Revision 10 (ICD-10) (1994)	A temperature rise above 100.4 F (38 °C) maintained over 24 h or recurring during the period from the end of the first to the end of the 10th day after childbirth or abortion.	Acosta, 2013[2]; Bamfo, 2013[16]; Dillen, 2010[10]; Hashmi, 2014[24]; Sung, 2011[56]	-
SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference (2001)	Refers to American College of Chest Physicians and the Society of Critical Care Medicine (1992) with expanded list of criteria.	Arulkumaran, 2013[15]; Hashmi, 2014[24]	CEC 2015[41]; HSE 2014[39]; NICE 2016[38]; South Australian Perinatal Practice Guidelines 2014[40]; RCOG 2011[37]; RCOG 2012[11]
The prevention and management of puerperal infections World Health Organization (WHO) (1992)	<i>Puerperal sepsis</i> is an infection of the genital tract occurring at any time between the rupture of membranes or labour and the 42nd day postpartum, in which, two or more of the following are present: pelvic pain, fever, abnormal vaginal discharge and delay in the reduction of the size of the uterus	Acosta, 2013[2]; Buddeberg, 2015[4]; Bamfo, 2013[16]; Karsnitz, 2013[25]; Lamy[27] Lucas, 2011[29]; Dillen, 2010[10]; Hashmi, 2014[24]; Sung, 2011[56]	-
Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors WHO (2003)	Infection can result in failure of the circulatory system to maintain adequate perfusion of the vital organs (shock). Suspect or anticipate shock if at least one	-	WHO 2003[46]

	<p>of the following is present: fast weak pulse (110 per minute or more), low blood pressure (systolic less than 90 mmHg), sweatiness or cold clammy skin, rapid breathing (rate of 30 breaths or more), anxiousness, confusion or unconsciousness, scanty urine output (less than 30 ml per hour), other symptoms and signs of shock include: pallor (specially of inner eyelid, palms or around mouth).</p> <p>Septic abortion: an abortion complicated with infection. Sepsis may result from infection if organisms rise from the lower genital tract following either spontaneous or unsafe abortion. Symptoms and signs are: lower abdominal pain, rebound tenderness, tender uterus, prolonged bleeding, malaise, fever, foul-smelling vaginal discharge, purulent cervical discharge, cervical motion tenderness</p>		
Midwifery education modules – Managing puerperal sepsis (WHO) (2008)	<p><i>Puerperal sepsis</i> is any bacterial infection of the genital tract which occurs after the birth of a baby. The following symptoms and signs occur in puerperal sepsis: fever (temperature of 38°C or more), chills and general malaise, lower abdominal pain, tender uterus, subinvolution of the uterus, purulent, foul-smelling lochia. Symptoms and signs that may also be present: light vaginal bleeding, shock</p> <p><i>Septic abortion</i>: An abortion (loss of pregnancy during the first 22 weeks) that is followed by infection of the uterus and may spread throughout the genital tract causing fever and chills, foul-smelling vaginal discharge, pelvic pain and septicaemia</p>	-	WHO 2008[45]

ACCP = American College of Chest Physicians, ATS = American Thoracic Society, ESICM = European Society of Intensive Care Medicine, SCCM = Society of Critical Care Medicine, SIS = Surgical Infection Society

Table 2. List of criteria used to identify maternal sepsis in studies and guidelines included in the systematic review

System	Variable	Values or ranges (min - max)	References studies	References guidelines	Other signs	Other symptoms
Circulatory	Heart rate	> 90 /min (90-120/min) or > 2 SD above the normal value for age	[2, 4, 5, 8, 10, 15- 18, 21, 23-25, 27, 29, 30, 32-34]	[11, 14, 36, 38-42]	Vasoplegia[31]	-
	Blood pressure	SBP <100 mm Hg MAP <70 (65-70) mm Hg Decrease SBP >40 mm Hg	[4, 10, 15, 17, 18, 23, 25, 27, 33, 34]	[11, 14, 36, 38, 40- 42]	Hypotension[23], significant oedema / positive fluid balance[10, 15, 18, 33, 34, 39, 43]	-
Respiratory	Respiratory rate	>20 / min (≤ 10 or ≥ 25 / min)	[2, 4, 5, 8, 10, 16, 21, 24, 27, 30, 32- 35]	[11, 14, 36, 38, 40- 42]	Marked tachypnea, Acute lung injury in the absence of pneumonia as infection source, Arterial hypoxaemia [10, 17, 24, 34, 49]	Cough, sore throat[4, 20], chest pain[37]
	Arterial hypoxaemia	PaO2 (arterial oxygen partial pressure) /FIO2 (fraction of inspired oxygen) <40kPa	-	[39]		
Central Nervous System	Altered mental status	Glasgow Coma scale <14/15	-	[42]	Confusion, decreased alertness, prostration, unduly anxious, distressed or panicky[4, 11, 19, 20, 36-43]	Headache, pain, lethargy, body pain, arthralgia, myalgia[4, 19, 20, 25]
	Hyperthermia	> 38 °C (37.8-38.5°C)	[2, 4, 5, 8, 10, 15- 18, 21, 23-25, 27, 29-34]	[11, 14, 36, 39-42, 45]	-	Fever, Chills[23, 25, 29]
	Hypothermia	< 36 °C (35.5°C - 36 °C)	[2, 4, 5, 8, 10, 15- 18, 21, 24, 25, 27, 29, 31-34]	[11, 36, 39-41]	-	-
Renal	Lactate (mmol/L)	>1 (>1-4)	[6, 10, 15, 17, 18, 20, 33]	[11, 14, 36, 38, 39, 41]	Acute oliguria, anuria[8, 10, 15, 17, 19, 20, 24, 33, 34]	Urinary symptoms[4, 20, 22], renal angle pain and tenderness [37]
	Kidney (Creat mg/dL)	> 2 mg/dL or Raise > 0.5 mg/dL	[6, 10, 15, 17, 18, 20, 24, 33]	[34,37,40,42]		
Coagulation	Platelets (/ml)	<100,000	[6, 10, 15, 17, 18, 33]	[11, 36, 37, 39, 42]	-	Coagulopathy, Disseminated intravascular coagulation[6, 31, 35, 49]
		INR >1.5 or aPTT >60 s	[10, 15, 17, 18, 20, 24, 33]	[11, 36-40, 42, 43]		
Digestive	Glucose (mmol/L)	> 7.7 in the absence of DM	[10, 15, 17]	[11, 14, 36, 39, 40]	Mild intestinal tenderness without rebound tenderness	Reduced appetite, Nausea, Vomiting,
	Liver: total	> 2 mg/dL	[6, 10, 15, 17, 18,	[11, 36-40, 43]		

	bilirubin (mmol/L)	> 70mmol/L	20, 24, 33]		Peritonitis[4, 20, 22, 25] Ileus[10, 15, 17, 18, 33, 34]	diarrhea, abdominal pain[4, 8, 20, 22, 27]
Skin	-	-	-	-	Decreased capillary refill, clammed or mottled skin Generalized erythematous macular rash, Rash, erythema[4, 23, 49] Necrotizing fasciitis or myositis Gangrene[6, 8, 10, 15, 17, 18, 22, 33-35, 49]	-
Genital	-	-	-	-	Pus or foul-smelling fluid from the cervix, pyometra, cervicitis, metrorrhagia, delay in the rate of reduction of size of uterus [8, 16, 19, 22, 23, 25, 27]	Purulent vaginal discharge[25, 27] pelvic pain, [8, 16, 19, 22, 23, 25]
Inflammatory	WBC(cells/μl)	>12000 (11000-16000) or <4000 or >10% immature forms	[2, 4, 5, 8, 10, 15-18, 20, 21, 23-25, 29, 31-34]	[11, 36-43]	Preterm labour[20]	Breast redness, Pain of site of infection[4, 8, 17, 20]
	CRP	> 7mg/L > 2SD	[10, 15, 17, 18, 24, 33]	[11, 36-40, 43]		
	Procalcitonin	> 2SD	[15, 17, 18, 33]	[39, 43]		
Other	Culture	Positive	[6, 8, 19, 28, 49]	-	-	-
	Fetal distress	-	-	-	Fetal distress secondary to maternal acidosis[41]	Reduced or absent fetal movements[41]

CRP: C-reactive protein; MAP: Mean Arterial Blood Pressure; SBP: Systolic Blood Pressure; WBC: White Blood Cell Count.

List of abbreviations

ACCP	American College of Chest Physicians
aPPT	Activated Partial Thromboplastin Time
ATS	American Thoracic Society
CRP	C-reactive protein
ESICM	European Society of Intensive Care Medicine
GAS	Group A Streptococcus
G-I-N	Guidelines International Network
ICD-10	International Classification of Disease, version 10
INR	International Normalized Ratio
MAP	Mean Arterial Blood Pressure
MOEWS	Modified Obstetric Early Warning Scoring Systems
NICE	Institute for Health and Care Excellence
PaO ₂	Oxygen Partial Pressure
qSOFA	quick SOFA
SBP	Systolic Blood Pressure
SCCM	Society of Critical Care Medicine,
SIS	Surgical Infection Society
SOFA	Sequential [Sepsis-related] Organ Failure Assessment (SOFA) score
SOS	Sepsis in Obstetrics
WBC	White Blood Cell Count
WHO	World Health Organization

Declarations

Ethics approval and consent to participate

The completion of the online survey implied participant consent to participate

Consent for publication

Not applicable

Availability of data and materials

All data generated or analysed during this study are included in this published article [and its supplementary information files.

Competing interests

The authors declare that they have no competing interests

Funding

MB, VNP and JPS were funded by the UNDP-UNFPA-UNICEF-WHO-World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), the Department of Reproductive Health and Research (RHR), World Health Organization, Geneva, Switzerland. MJR was supported by the Utrecht University Medical Centre – Department of Obstetrics and Gynaecology and Julius Global Health, Julius Center for Health Sciences and Primary Care, Utrecht, The Netherlands. DL and AC were supported by the University of Birmingham.

Author Contributions

MB, VNP, JPS and AMG conceptualized the study; VNP and MJR carried out screening, data extraction and analyzed results of the systematic review. MB and JPS contributed to the analysis of the systematic review and coordinated and reviewed results of the expert consultation. AC and DL contributed to the conceptualisation of the international consultation and analysis of the result. MB, VNP, MJR, drafted the paper. All authors commented on and approved the final manuscript.

Acknowledgments

We gratefully acknowledge contributions of participants to the in-person technical consultation (in alphabetical order): Edgardo Abalos (Rosarinian Center for Perinatal Studies, Argentina), Aniekian Abasiattai (University of Uyo Teaching Hospital, Nigeria), Linda Bartlett (John Hopkins University, USA), Fernando Bellissimo Rodrigues (University of São Paulo, Brazil),

1 Maria Fernanda Escobar Vidarte (Fundación Valle del Lili, Colombia), Carlos Füchtner (FIGO,
2 President Elect), Asmae Khattabi (National School of Public Health, Morocco), Zahida Qureshi
3 (Kenyatta University, Kenya), Sadia Shakoor (The Aga Khan University, Pakistan), Claudio G.
4 Sosa (Latin American Center for Perinatology, Women and Reproductive Health (CLAP),
5 Uruguay), Jos van Roosmalen (VU University Amsterdam, The Netherlands). Special thanks are
6 also due to all of the respondents who anonymously participated in our online survey.
7

8 **Supporting information**

9
10 Supplementary table 1. Search strategy.

11
12
13 Supplementary tables 2A and 2B. Summary of studies included in the systematic review:
14 definitions and identification criteria for maternal sepsis.
15

16
17 Supplementary tables 3A and 3B. Summary of guidelines included in the systematic review:
18 additional symptoms and signs.
19

20 Supplementary file S4. Results of the online survey.
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65

References

1. Singer M, Deutschman CS, Seymour CW, Shankar-Hari M, Annane D, Bauer M, Bellomo R, Bernard GR, Chiche JD, Coopersmith CM *et al*: The Third International Consensus Definitions for Sepsis and Septic Shock (Sepsis-3). *JAMA* 2016, 315(8):801-810.
2. Acosta CD, Knight M: Sepsis and maternal mortality. *Curr Opin Obstet Gynecol* 2013, 25(2):109-116.
3. Bauer ME, Bauer ST, Rajala B, MacEachern MP, Polley LS, Childers D, Aronoff DM: Maternal physiologic parameters in relationship to systemic inflammatory response syndrome criteria: a systematic review and meta-analysis. *Obstet Gynecol* 2014, 124(3):535-541.
4. Buddeberg BS, Aveling W: Puerperal sepsis in the 21st century: progress, new challenges and the situation worldwide. *Postgrad Med J* 2015, 91(1080):572-578.
5. Morgan J, Roberts S: Maternal sepsis. *Obstet Gynecol Clin North Am* 2013, 40(1):69-87.
6. Anderson BL: Puerperal group A streptococcal infection: beyond Semmelweis. *Obstet Gynecol* 2014, 123(4):874-882.
7. Say L, Chou D, Gemmill A, Tuncalp O, Moller AB, Daniels J, Gulmezoglu AM, Temmerman M, Alkema L: Global causes of maternal death: a WHO systematic analysis. *Lancet Glob Health* 2014, 2(6):e323-333.
8. Barton JR, Sibai BM: Severe sepsis and septic shock in pregnancy. *Obstet Gynecol* 2012, 120(3):689-706.
9. Oud L: Pregnancy-Associated Severe Sepsis: Contemporary State and Future Challenges. *Infect Dis Ther* 2014, 3(2):175-189.
10. van Dillen J, Zwart J, Schutte J, van Roosmalen J: Maternal sepsis: epidemiology, etiology and outcome. *Curr Opin Infect Dis* 2010, 23(3):249-254.
11. Royal College of Obstetricians and Gynaecologists. Sepsis in Pregnancy, Bacterial (Green-top Guideline No. 64a); 2012. [<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg64a/>] Accessed 10 February 2017
12. Dolea, C, Stein, C. Global burden of maternal sepsis in the year 2000. World Health Organization: 2003. [http://www.who.int/healthinfo/statistics/bod_maternalsepsis.pdf] Accessed 10 February 2017
13. Levy MM, Fink MP, Marshall JC, Abraham E, Angus D, Cook D, Cohen J, Opal SM, Vincent JL, Ramsay G: 2001 SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference. *Crit Care Med* 2003, 31(4):1250-1256.
14. Dellinger RP, Levy MM, Rhodes A, Annane D, Gerlach H, Opal SM, Sevransky JE, Sprung CL, Douglas IS, Jaeschke R *et al*: Surviving sepsis campaign: international guidelines for management of severe sepsis and septic shock: 2012. *Crit Care Med* 2012, 41(2):580-637.
15. Arulkumaran N, Singer M: Puerperal sepsis. *Best Pract Res Clin Obstet Gynaecol* 2013, 27(6):893-902.
16. Bamfo JE: Managing the risks of sepsis in pregnancy. *Best Pract Res Clin Obstet Gynaecol* 2013, 27(4):583-595.
17. Chebbo A, Tan S, Kassis C, Tamura L, Carlson RW: Maternal Sepsis and Septic Shock. *Crit Care Clin* 2016, 32(1):119-135.
18. Cordioli RL, Cordioli E, Negrini R, Silva E: Sepsis and pregnancy: do we know how to treat this situation? *Rev Bras Ter Intensiva* 2013, 25(4):334-344.
19. Eschenbach DA: Treating spontaneous and induced septic abortions. *Obstet Gynecol* 2015, 125(5):1042-1048.
20. Ford JM, Scholefield H: Sepsis in obstetrics: cause, prevention, and treatment. *Curr Opin Anaesthesiol* 2014, 27(3):253-258.

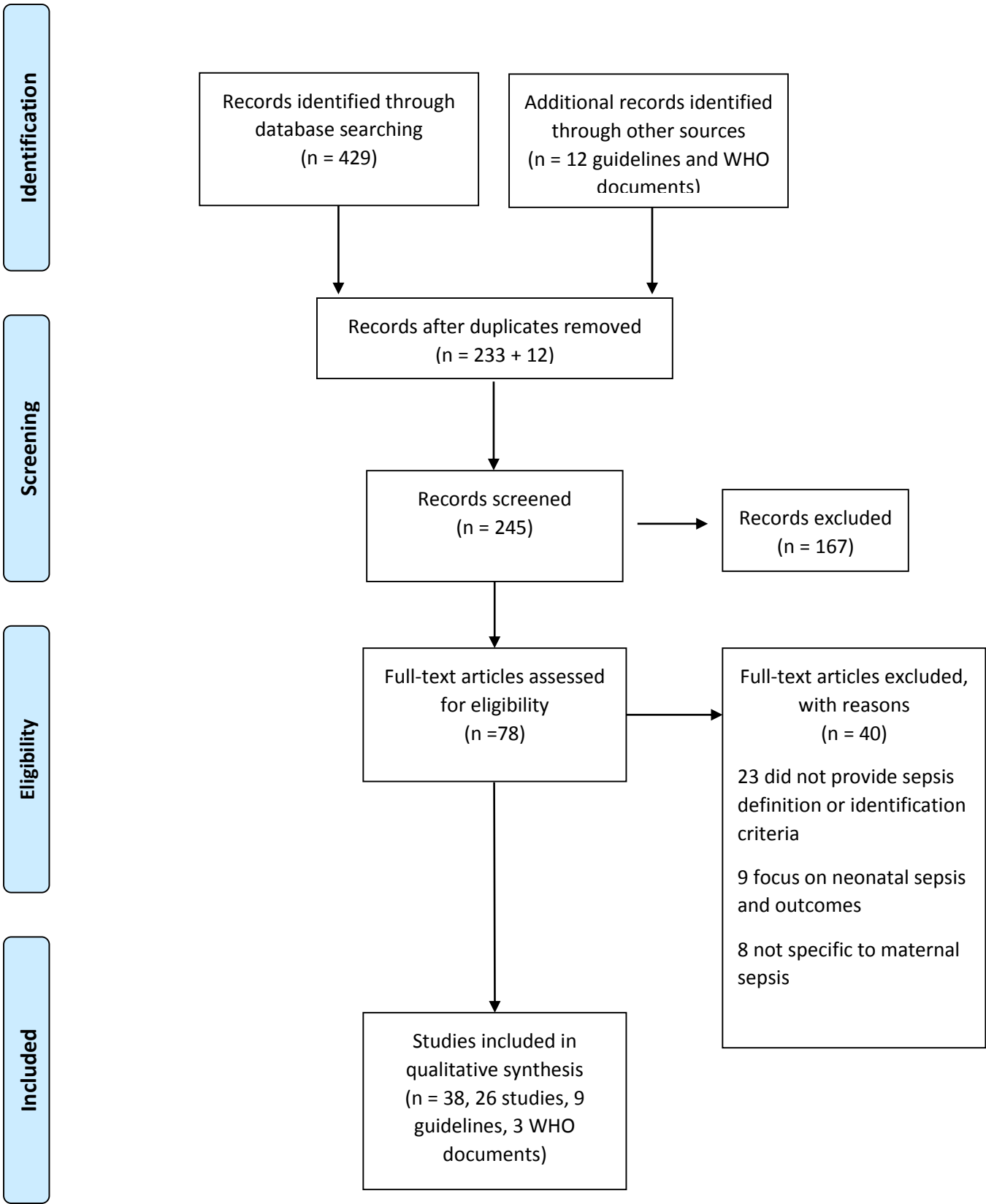
21. Frise CJ, Frise MC, Nelson-Piercy C: Management of the critically-ill obstetric patient. *Obstetrics, Gynaecology and Reproductive Medicine* 2015, 25(7):188-194.
22. Guntupalli KK, Karnad DR, Bandi V, Hall N, Belfort M: Critical illness in pregnancy part II: Common medical conditions complicating pregnancy and puerperium. *Chest* 2015, 148(5):1333-1345.
23. Hamilton SM, Stevens DL, Bryant AE: Pregnancy-related group a streptococcal infections: temporal relationships between bacterial acquisition, infection onset, clinical findings, and outcome. *Clin Infect Dis* 2013, 57(6):870-876.
24. Hashmi M, Khan FH: A review of critical care management of maternal sepsis. *Anaesthesia, Pain and Intensive Care* 2014, 18(4):436-442.
25. Karsnitz DB: Puerperal infections of the genital tract: a clinical review. *J Midwifery Womens Health* 2013, 58(6):632-642.
26. Knowles SJ, O'Sullivan NP, Meenan AM, Hanniffy R, Robson M: Maternal sepsis incidence, aetiology and outcome for mother and fetus: a prospective study. *BJOG* 2015, 122(5):663-671.
27. Lamy C, Mezan de Malartic C, Perdriolle E, Gauchotte E, Villeroy-de-Galhau S, Delaporte MO, Morel O, Judlin P: [Management of post-abortion infections]. *J Gynecol Obstet Biol Reprod (Paris)* 2012, 41(8):904-912.
28. Lapinsky SE: Obstetric infections. *Crit Care Clin* 2013, 29(3):509-520.
29. Lucas DN, Robinson PN, Nel MR: Sepsis in obstetrics and the role of the anaesthetist. *Int J Obstet Anesth* 2012, 21(1):56-67.
30. McClure JH, Cooper GM, Clutton-Brock TH: Saving mothers' lives: reviewing maternal deaths to make motherhood safer: 2006-8: a review. *Br J Anaesth* 2011, 107(2):127-132.
31. Neligan PJ, Laffey JG: Clinical review: Special populations - critical illness and pregnancy. *Critical Care* 2011, 15(4).
32. O'Gorman N, Penna L: Maternal collapse. *Obstetrics, Gynaecology and Reproductive Medicine* 2015, 25(5):115-122.
33. Oud L: Pregnancy-associated severe sepsis. *Current Opinion in Obstetrics and Gynecology* 2016, 28(2):73-78.
34. Pacheco LD, Saade GR, Hankins GD: Severe sepsis during pregnancy. *Clin Obstet Gynecol* 2014, 57(4):827-834.
35. Sriskandan S: Severe peripartum sepsis. *Journal of the Royal College of Physicians of Edinburgh* 2011, 41(4):339-346.
36. Royal College of Obstetricians and Gynaecologists. Sepsis following Pregnancy, Bacterial (Green-top Guideline No. 64b); 2012. [<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg64b/>] Accessed 10 February 2017
37. Royal College of Obstetricians and Gynaecologists. Maternal Collapse in Pregnancy and the Puerperium (Green-top Guideline No. 56); 2011. Accessed 10 February 2017 [<https://www.rcog.org.uk/en/guidelines-research-services/guidelines/gtg56/>]
38. Institute for Health and Care Excellence. Sepsis: recognition, diagnosis and early management; 2016. [<https://www.nice.org.uk/guidance/ng51>] Accessed 10 February 2017
39. HSE National Clinical Programmes in Obstetrics and Gynaecology, Anaesthesia and Critical Care. Guidelines for the Critically Ill Woman in Obstetrics; 2014. [<http://hse.ie/eng/about/Who/clinical/natclinprog/criticalcareprogramme/publications/guidelines.pdf>] Accessed 10 February 2017
40. South Australian Perinatal Practice Guidelines workgroup. Clinical practice guideline on sepsis in pregnancy; 2014. [<http://www.sahealth.sa.gov.au/wps/wcm/connect/31b0af004eeddd9eb4c6b76a7ac0>]

[d6e4/Sepsis+in+pregnancy_Feb2015.pdf?MOD=AJPERES&CACHEID=31b0af004eeddd9eb4c6b76a7ac0d6e4](http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/292193/Maternal-Sepsis-Pathway-December-2016.pdf)] Accessed 10 February 2017

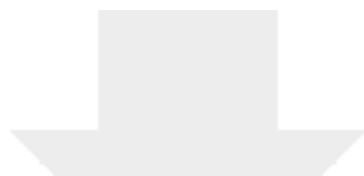
41. Clinical Excellence Commission. Maternal Sepsis Pathway. SEPSIS KILLS program. [http://www.cec.health.nsw.gov.au/__data/assets/pdf_file/0008/292193/Maternal-Sepsis-Pathway-December-2016.pdf] Accessed 10 February 2017
42. National Department of Health South Africa. Essential steps in the management of common conditions associated with maternal mortality; 2007. [<http://www.sasog.co.za/images/essentialsteps.pdf>] Accessed 10 February 2017
43. Federación Latino Americana de Sociedades de Ginecología y Obstetricia. Guía Clínica de Sepsis y Embarazo. FLASOG: 2013, GUÍA Nº 1. [<http://www.sogvzla.org/sogvzlawebold/pdfs/flasog/guias/SEPSISENOBSTETRICIA.pdf>] Accessed 10 February 2017
44. WHO. The Prevention and Management of Puerperal Infections. Report of a technical group. Geneva: 1992. [https://extranet.who.int/iris/restricted/bitstream/10665/59429/1/WHO_FHE_MSM_95.4.pdf] Accessed 10 February 2017
45. WHO. Managing Puerperal Infections. Education material for teachers of midwifery Midwifery education modules - second edition. Geneva: 2008. [http://www.who.int/maternal_child_adolescent/documents/4_9241546662/en/] Accessed 10 February 2017
46. WHO. Managing Complications in Pregnancy and Childbirth: A guide for midwives and doctors. Integrated Management of Pregnancy and Childbirth. Geneva: 2007 [http://www.who.int/maternal_child_adolescent/documents/9241545879/en/] Accessed 10 February 2017
47. Bone RC, Balk RA, Cerra FB, Dellinger RP, Fein AM, Knaus WA, Schein RM, Sibbald WJ: Definitions for sepsis and organ failure and guidelines for the use of innovative therapies in sepsis. The ACCP/SCCM Consensus Conference Committee. American College of Chest Physicians/Society of Critical Care Medicine. *Chest* 1992, 101(6):1644-1655.
48. Levy MM, Fink MP, Marshall JC, Abraham E, Angus D, Cook D, Cohen J, Opal SM, Vincent JL, Ramsay G: 2001 SCCM/ESICM/ACCP/ATS/SIS International Sepsis Definitions Conference. *Intensive Care Med* 2003, 29(4):530-538.
49. Yamada T, Yamada T, Yamamura MK, Katabami K, Hayakawa M, Tomaru U, Shimada S, Morikawa M, Seki T, Ariga S *et al*: Invasive group A streptococcal infection in pregnancy. *J Infect* 2010, 60(6):417-424.
50. WHO. Statement on Maternal Sepsis. Geneva; 2017. [http://www.who.int/reproductivehealth/publications/maternal_perinatal_health/maternalsepsis-statement/en/] Accessed 17 February 2017
51. Say L, Souza JP, Pattinson RC: Maternal near miss--towards a standard tool for monitoring quality of maternal health care. *Best Pract Res Clin Obstet Gynaecol* 2009, 23(3):287-296.
52. Chou D, Tuncalp O, Firoz T, Barreix M, Filippi V, von Dadelszen P, van den Broek N, Cecatti JG, Say L: Constructing maternal morbidity - towards a standard tool to measure and monitor maternal health beyond mortality. *BMC pregnancy and childbirth* 2016, 16:45.
53. Edwards SE, Grobman WA, Lappen JR, Winter C, Fox R, Lenguerrand E, Draycott T: Modified obstetric early warning scoring systems (MOEWS): validating the diagnostic performance for severe sepsis in women with chorioamnionitis. *Am J Obstet Gynecol* 2015, 212(4):536 e531-538.

- 1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
21
22
23
24
25
26
27
28
29
30
31
32
33
34
35
36
37
38
39
40
41
42
43
44
45
46
47
48
49
50
51
52
53
54
55
56
57
58
59
60
61
62
63
64
65
54. Aarvold AB, Ryan HM, Magee LA, von Dadelszen P, Fjell C, Walley KR: Multiple Organ Dysfunction Score Is Superior to the Obstetric-Specific Sepsis in Obstetrics Score in Predicting Mortality in Septic Obstetric Patients. *Crit Care Med* 2016.
 55. The Global Maternal and Neonatal Sepsis Initiative Working Group: The Global Maternal and Neonatal Sepsis Initiative: a call for collaboration and action by 2030. *Lancet Glob Health* 2017. doi: 10.1016/S2214-109X(17)30020-7
 56. Sung E, George J, Porter M: Sepsis in pregnancy. *Fetal and Maternal Medicine Review* 2011, 22(4):287-305.

Figure 1 Flow chart



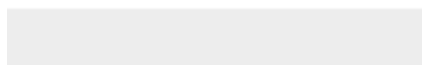
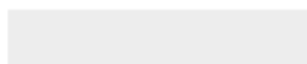




[Click here to access/download](#)

Supplementary Material

Supplemetary file S2 and S3.docx





Click here to access/download
Supplementary Material
Supplemetary file S4.docx