SOGC Position Statement: The Prevention and Management of Oropouche Virus in Pregnancy

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Scope and Purpose

This position statement summarizes evidence on the prevention and management of Oropouche Virus (OROV) in pregnancy and provides clinical recommendations for health care providers.

Target Audience

Health care providers caring for individuals who are pregnant or planning a pregnancy and have travelled to or are preparing to travel to regions where OROV is endemic or emerging.

Methods

This position statement was developed by a working group of volunteer experts from the Society of Obstetricians and Gynaecologists of Canada's Clinical Obstetrics and Clinical Gynaecology Committees, the Canadian Paediatric Society's Infectious Diseases and Immunization Committee, the Association of Medical Microbiology and Infectious Diseases Canada, and the Public Health Agency of Canada's Committee to Advise on Tropical Medicine and Travel. No conflicts of interest relevant to the content of this statement were declared by the working group members.

A literature search, (Appendix A) was conducted to identify scientific evidence on OROV disease and pregnancy and evidence was supplemented with information from other credible sources to develop the recommendations.

Key Messages

- Oropouche Virus (OROV) is an arbovirus (arthropod-borne) that can cause a range of illnesses in infected individuals.
- OROV is expanding geographically in tropical areas, causing sizeable outbreaks, confirmed travel-associated illnesses and growing recognition of its potential for severe illness.
- There are a few case reports of fetal harm associated with vertical transmission of OROV from mother to fetus. However, the frequency of transmission, the likelihood of associated harm and the impact of factors such as timing of infection during pregnancy have not been established.
- Clinicians should adopt a precautionary approach and counsel pregnant patients to avoid nonessential travel to areas currently experiencing an OROV outbreak. Outbreak areas are listed on the Government of Canada Travel Health Page.
- If travel is unavoidable, measures to prevent insect bites should be emphasized, such as using approved skin repellents, wearing protective clothing, and staying in insect-protected living areas.

Consensus Statements/Recommendations

Recommendations

1. Obstetrical care providers should discuss travel plans with all pregnant patients. This should include discussion of safe travel practices, recommended vaccination and other pharmacologic prophylaxis related to travel, as well as infectious disease and other risks, based on the specific area of travel *(low, strong).*
2. Health care providers should advise pregnant patients to avoid travel to areas known to be suffering an OROV outbreak, and/or significant transmission of other arthropod-associated diseases (e.g., malaria, Zika) that present an increased risk of adverse maternal/fetal outcomes. Outbreak areas are available on the Government of Canada Travel Health Page *(low, strong).*
3. If travel is unavoidable, obstetrical care providers should discuss travel plans with the patient, with the aim of helping the patient to understand and take steps to manage pregnancy-related and other health hazards associated with travel. Dependent on travel complexity, potential exposures, and location(s), pregnant patients may be advised to seek advice from a travel-medicine expert *(low, strong)*
4. For all pregnant travellers to areas where OROV and other vector-borne diseases (e.g., malaria, dengue, Zika) are of concern, patients should be advised to take steps to prevent

the bites of blood-feeding mosquitos and other blood-feeding arthropods (e.g. ticks) *(good practice point)*.

Bite prevention strategies:

- Use a Health Canada approved insect repellent on exposed skin. Follow the instructions that accompany the repellent.
    - Midges that transmit OROV and for some mosquitoes, biting can occur inside living areas (as well as outside) and during the daytime or nighttime. If insects cannot be otherwise excluded, consider wearing repellent when indoors.
- Wear long-sleeved and loose-fitting clothing to minimize the areas of skin exposed to biting insects.
- Stay in living areas that are protected against insect entry, for example with air-conditioning and closed windows. Midges that transmit OROV are tiny and can pass through most window screens.
- Sleep under insecticide-treated bed nets

5. Pregnant patients should be counselled on the symptoms of OROV-associated illness (e.g., fever, headache, myalgia, rash) and advised to seek medical attention if symptoms develop during or within two weeks after travel to endemic or outbreak areas *(low, strong)*.
6. Pregnant patients with compatible symptoms should be evaluated for all arthropod-associated diseases, such as OROV, malaria, dengue, chikungunya and Zika as well as more common infections in pregnancy *(low, conditional).*
7. As per local protocol, testing for OROV should be considered. Management of OROV infections during pregnancy should focus on supportive care, including hydration, fever management with acetaminophen, and maternal-fetal monitoring, since there is no specific anti-viral or other medication for OROV currently available *(low, strong).*
8. Pregnant patients with confirmed or suspected OROV infection should undergo evaluation for the risk of congenital infection. This should include serial enhanced detailed ultrasound for ongoing fetal impact (e.g., microcephaly) and growth. The placenta should be sent for OROV PCR and histopathology after delivery *(very low, strong).*
9. Infants with possible or confirmed prenatal exposure to OROV infection should be clinically evaluated by a paediatric infectious disease specialist. Testing for OROV may be indicated after specialist evaluation. Follow-up care should include monitoring for potential congenital complications, including neurodevelopmental delays *(very low, conditional).*

Background, Context and Evidence

Oropouche Virus (OROV) is an arbovirus primarily transmitted by midges (*Culicoides paraensis*) and, less commonly, by mosquitoes (*Culex quinquefasciatus*). OROV is endemic to certain tropical

regions of South America. Historically, transmission was largely restricted to areas of the Amazon. In 2023–2024, a large outbreak affected these traditional areas but also affected new areas including: Bolivia, Brazil, Colombia, Cuba, Dominican Republic, Panama, Peru, and Venezuela (outbreak areas are available on the Government of Canada Travel Health Page).[1, 2] There is some evidence to suggest that the outbreak was associated with, and perhaps enhanced by, an OROV strain characterized by a higher viral replication rate, enhanced virulence, and reduced neutralization by pre-existing antibodies.[3]

There have been reports of travel-associated cases of OROV in Canada, Europe, the Caribbean, and the United States.[1]

In non-pregnant individuals, OROV infection is usually self-limited, although severe disease can occur.[4] Emerging evidence suggests OROV infection may pose risks during pregnancy, including potential vertical transmission and adverse fetal outcomes.[5]

Unlike the well-characterized link between Zika virus and congenital anomalies, the relationship between maternal OROV infection and adverse fetal outcomes is less clear.[6] A small case series from Brazil reported microcephaly in newborns following maternal OROV infection, and OROV antibodies have been detected in the cerebrospinal fluid and serum of neonates with microcephaly.[5, 7] Another case series reports one case of dysgenesis of the corpus callosum following maternal OROV infection, and OROV RNA detected in the neonate's serum.[8] However, the absence of robust and validated epidemiologic evidence means that much remains unknown, including: the impact of OROV infection on the pregnant person, the risk of vertical transmission, the risk of fetal harm if transmission occurs, the specific impact on the developing fetus, the timing of infection and risk and impact on pregnancy and the fetus, and the appropriate monitoring subsequent to infection.

Three cases of spontaneous abortion were reported in pregnant patients with confirmed OROV at seven-weeks gestation, eight-weeks gestation, and another case of infection at 30-weeks gestation.[8, 9]

Subsequently, the Pan American Health Organization (PAHO) and the World Health Organization (WHO) documented two confirmed cases of OROV at 29-weeks and 34-weeks gestation.[6] Both pregnancies progressed without incident and infants were born without complications or evidence of anomalies, neurological syndromes, or neurodevelopmental disorders.[6] Further, a recent case series reported 13 cases of maternal OROV infections in the third trimester of pregnancy, which resulted in healthy term deliveries.[8] To date, there have been no reports indicating an increased risk of severe maternal illness or pregnancy complications associated with OROV infection during pregnancy.

Observational data and case reports do highlight the potential for vertical transmission and adverse fetal outcomes. A case series reported the incidence of vertical transmission of OROV in

six neonates born with microcephaly of unknown cause, detecting OROV RNA and antigens in several tissues, including the brain.[7] OROV genetic material was identified in umbilical cord blood and organ tissues from a spontaneous abortion, including the brain, liver, kidneys, lungs, heart, and spleen, confirming the possibility of vertical transmission.[9]

Relevance to Obstetrical Clinical Practice in Canada: Symptoms, Treatment, and Management

The potential for travel-related cases of OROV presents new challenges for obstetrical care providers. Patients should be asked about all travel, particularly to regions where OROV is endemic, or experiencing an outbreak. Additionally, they should be advised to avoid non-essential travel to regions experiencing OROV outbreaks.[6, 10]

While OROV is the focus of this position statement, it is crucial to address other travel-related considerations. These include safe travel practices, appropriate travel vaccinations and other pharmacologic prophylaxis related to travel, and awareness of infectious disease hazards and vector-associated infections such as malaria and Zika.

Most OROV infections present as a self-limited febrile illness, with symptoms resembling those of other arboviral infections, such as dengue and chikungunya, and other non-arboviral infections such as influenza. The incubation period is approximately four to eight days, followed by sudden-onset symptoms, including: fever, headache, myalgia, nausea, vomiting, and rash.[11, 12] Most cases resolve within five to seven days, but in rare cases, neurological complications such as viral encephalitis, meningitis, and myelitis have been reported, requiring hospitalization and supportive care.[13] Current evidence does not suggest that symptoms are more severe during pregnancy[5] or that OROV infection causes adverse pregnancy outcomes, but data are too limited to make definitive conclusions.

Currently, there are no specific vaccines or antiviral treatments for OROV infection, although ongoing characterization of OROV isolates from current outbreaks may aid in the future development of pharmacological tools to mitigate the effects of the virus.[14, 15] Due to the potential for vertical transmission, congenital infection, and adverse fetal outcomes, pregnant patients presenting with febrile illness and relevant travel history should be evaluated for compatible travel-related illnesses including OROV infection along with more routine illnesses.[13]

Pregnant patients with suspected or confirmed OROV infection should receive symptom-based care, including analgesia for fever (with avoidance of NSAIDs) and myalgia, hydration, and rest.[16, 17] Molecular testing (RT-PCR) or serology for OROV should be considered in febrile pregnant patients with relevant travel history, as this will impact follow up care for the pregnant person, fetus, and neonate moving forward. [3, 18] At this time, testing for OROV in Canada is available through the National Microbiology Laboratory. Testing of other arboviruses should also be considered. The testing algorithm may vary by province; health care providers should discuss testing pathways with local microbiology and/or infectious disease experts.

Given the limited evidence on the effects of OROV on pregnancy outcomes, pregnant patients should be monitored by a multidisciplinary team, including obstetricians, reproductive infectious disease or infectious disease specialists, and maternal-fetal medicine experts, depending on the region, to ensure comprehensive monitoring.

Enhanced fetal surveillance is recommended for pregnant patients with suspected or confirmed OROV infection. This includes a detailed assessment for the risk of vertical transmission with ultrasound, then, consideration should be made for ultrasounds every four weeks to assess for microcephaly and brain abnormalities, as well as other impacts on growth and the fetus which have yet to be characterized.[5, 7] Currently, there is no clear indication for induction of labour due to OROV infection, unless ultrasound findings suggest otherwise. Concerns about OROV infection in pregnancy should be documented in the pregnancy and this information should be available at the time of delivery for neonatal and placental assessment. Following delivery, neonates born to OROV-infected mothers should undergo clinical evaluation and laboratory testing (RT-PCR, serology) directed by a paediatric infectious disease specialist, with follow-up to monitor for potential congenital complications, including neurodevelopmental delays.[6, 18] Developmental paediatricians or general paediatricians may assist with developmental monitoring and approaches to therapy for those affected. Placentas of OROV-infected mothers should also be sent to microbiology and pathology for OROV PCR and histopathology respectively.

Conclusion

While Canada is not facing local transmission, there is a potential for travel-related cases in Canada, creating a need for clinical awareness on prevention and management strategies. Clinicians should take a preventative approach to managing OROV infection in pregnancy, by recommending that nonessential travel to areas with known outbreaks of OROV or other vertically-transmitted infections should be avoided. If travel to these areas is unavoidable, clinicians should counsel patients on vector avoidance strategies to minimize exposure.

In cases of confirmed or suspected OROV infection during pregnancy, clinicians should provide standard supportive care for febrile illnesses and testing for OROV, as per local protocol, in combination with enhanced fetal surveillance for signs of congenital infection. Infants born to OROV-exposed mothers should undergo specialized follow-up to assess potential health impacts. Future research is required to further characterize the potential risks of vertical transmission and adverse fetal outcomes associated with OROV infection.

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Appendix A: Search Strategy

a) Search terms

Search title	PubMed	
	Search Date	Search terms
1. Oropouche and pregnancy	January 15, 2025	(("oropouche"[Title/Abstract] OR "OROV"[Title/Abstract] OR "oro"[Title/Abstract]) AND ("preg*"[Title/Abstract] OR "vertical transmission*"[Title/Abstract]))
	Grey Literature	
2. Oropouche and pregnancy (grey literature)	January 17, 2025	((“oropouche” OR “OROV” OR “oro”) AND (“preg*” OR “vertical transmission”) AND (“CDC” OR “WHO” OR “Health Canada” OR “ACOG” OR “RCOG” OR “RANZCOG”)

b) Inclusion/exclusion criteria and additional filters

	PubMed
Include	Articles published in English Articles published between January 2020 and March 2025 Articles with human subjects Grey literature from trusted sources: CDC, WHO, Health Canada, ACOG Reviews*, meta-analyses, case-reports, in-vivo studies, case series, reports, statements, guidelines, brief communications
Exclude	Articles not published in English Articles published before January 2020 Letters to the editor, news articles, commentaries

Appendix B: Quality of Evidence and Strength of Recommendations

Table 1. Strength of evidence and recommendations for Oropouche Viral Disease and pregnancy

References used	Type of evidence	Rationale (risk of bias, inconsistency, directness)	Key considerations	Quality of evidence	Strength of recommendation
1. Obstetrical care providers should discuss travel plans with all pregnant patients. This should include discussion of safe travel practices, recommended vaccination and other pharmacologic prophylaxis related to travel, as well as infectious disease and other risks, based on the specific area of travel.					
5, 10, 16, 17, 18	Review article*, clinical guidance, government reports (Health Canada, CDC)	Evidence consistently recommends counselling patients on travel-associated infection risks. Obstetrical care providers must discuss travel plans with pregnant patients in order to discuss region-specific infection risks. Evidence primarily focuses on regions with active OROV transmission, with limited data specific to North American populations. Limited sample sizes and case reports make it difficult to quantify the true risk of vertical transmission and adverse fetal outcomes. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No	WG places a high value on prevention of congenital infection and potential hazards to the fetus.	Low	Strong**

		randomized controlled trials (RCTs) directly address this recommendation.			
2. Health care providers should advise pregnant patients to avoid travel to areas known to be suffering an OROV outbreak, and/or significant transmission of other arthropod-associated diseases (e.g., malaria, Zika) that present an increased risk of adverse maternal/fetal outcomes.					
5, 6, 8, 9, 10, 13, 16, 17	Review articles*, case series, clinical guidance, government reports (Health Canada, CDC), international health organization reports (PAHO, WHO)	The evidence consistently recommends advising pregnant patients to avoid travels to areas known to be suffering OROV outbreaks. Observational findings and reports have linked OROV infection with adverse pregnancy outcomes. However, data are limited and inconsistent. A definitive causal relationship cannot be established. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.	WG places a high value on prevention of congenital infection and potential hazards to the fetus.	Low	Strong**
3. If travel is unavoidable, obstetrical care providers should discuss travel plans with the patient, with the aim of helping the patient to understand and take steps to manage pregnancy-related and other health hazards associated with travel. Dependent on travel complexity, potential exposures, and location(s), pregnant patients may be advised to seek advice from a travel-medicine expert.					
5, 10, 16, 18	Review article*, clinical guidance, government reports	The evidence consistently emphasizes the importance of managing travel-related risks during pregnancy.	WG places a high value on prevention of	Low	Strong**

	(Health Canada, CDC)	While the specific impact of travel counseling on reducing adverse outcomes is not quantified, the reported risks of vertical transmission support proactive intervention. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.	congenital infection and potential hazards to the fetus.

4. For all pregnant travellers to areas where OROV and other vector-borne diseases (e.g., malaria, dengue, Zika) are of concern, patients should be advised to take steps to prevent the bites of blood-feeding mosquitos and other blood-feeding arthropods (e.g. ticks).

[5, 6, 10, 16, 17, 18]	Review article*, clinical guidance, government reports (Health Canada, CDC), international health organization reports (PAHO, WHO)	The evidence consistently recommends bite prevention measures. No evidence specifically measures the reduction of OROV transmission through bite prevention and insect avoidance. No randomized controlled trials (RCTs) directly evaluate the effectiveness of these specific prevention methods against OROV.	Good practice point

5. Pregnant patients should be counselled on the symptoms of OROV-associated illness (e.g., fever, headache, myalgia, rash) and advised to seek medical attention if symptoms develop during or within two weeks after travel to endemic or outbreak areas.

5, 16, 18	Review article*, clinical guidance	Evidence consistently emphasizes the need for symptom monitoring and comprehensive evaluation for pregnant patients exposed to OROV-endemic or outbreak regions. There are limited data on the specific sensitivity of clinical evaluations for OROV during pregnancy; however, common symptoms of OROV are well documented. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.	WG places a high value on monitoring for vertical transmission and potential hazards to the fetus.	Low	Strong**
6. Pregnant patients with compatible symptoms should be evaluated for all arthropod-associated diseases, such as OROV, malaria, dengue, chikungunya and Zika as well as more common infections in pregnancy.					
5, 16, 18	Review article*, clinical guidance, government report (Health Canada)	Evidence consistently recommends evaluation of pregnant patients with OROV symptoms and travel exposure. OROV symptoms and travel history are consistent with symptoms of other arthropod-associated diseases. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.		Low	Conditional

7. As per local protocol, testing for OROV should be considered. Management of OROV infections during pregnancy should focus on supportive care, including hydration, fever management with acetaminophen, and maternal-fetal monitoring, since there is no specific anti-viral or other medication for OROV currently available.					
5, 10, 16, 18	Review article*, clinical guidance, government report (Health Canada, CDC)	Evidence consistently emphasizes the need for OROV detection in pregnant patients with travel exposure. There are limited data on the specific sensitivity of clinical evaluations for OROV during pregnancy, but clinical guidance and expert consensus supports the screening for multiple infections with overlapping symptoms. Evidence consistently recommends supportive care as the primary management approach for OROV infection during pregnancy. Evidence is supported to by recommendations for the management of similar illnesses in pregnancy, where there are no antiviral medications or treatment options available. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.	WG places a high value on monitoring for vertical transmission and potential hazards to the fetus.	Low	Strong**

8. Pregnant patients with confirmed or suspected OROV infection should undergo evaluation for the risk of congenital infection. This should include serial enhanced detailed ultrasound for ongoing fetal impact (e.g., microcephaly) and growth. The placenta should be sent for OROV PCR and histopathology after delivery.					
[5, 6, 7, 8, 18]	Review article*, clinical guidance, international health organization reports (PAHO and WHO), observational study	Evidence identifies potential risk for congenital infection and emphasizes a need for ongoing fetal monitoring. There are limited data on congenital infection and fetal outcomes; however, ongoing monitoring is required to assess fetal risk, impact, and growth. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.	WG places a high value on monitoring for vertical transmission, congenital infection, and potential hazards to the fetus.	Very low	Strong**
9. Infants with possible or confirmed prenatal exposure to OROV infection should be clinically evaluated by a paediatric infectious disease specialist. Testing for OROV may be indicated after specialist evaluation. Follow-up care should include monitoring for potential congenital complications, including neurodevelopmental delays.					
[5, 6, 7, 18]	Review article*, clinical guidance, international health organization reports (PAHO and WHO), observational study	Evidence identifies potential risk for congenital infection and potential risks to the infant following infection. Evidence is derived from observational studies, case reports/series, epidemiological reports, clinical guidance, and expert consensus. No randomized controlled trials (RCTs) directly address this recommendation.		Very low	Conditional

*Due to limited evidence, peer-reviewed narrative reviews were included as supporting documentation for recommendations. Recommendations were not made based on information from narrative reviews alone.

****Strength of recommendation**

Strong recommendation may be made despite very low, low, or moderate strength of evidence, based on a judgement of the potential for large patient benefit or strength of recommendation from other organizations. Strong recommendations were assigned for recommendations related to patient safety, shared decision-making, and ethical practices received strong endorsements based on well-established standards.