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UPDATE: NJDOH ZIKA VIRUS TESTING RECOMMENDATIONS – August 2017

Background: On July 24, 2017 CDC released [Update: Interim Guidance for Health Care Providers Caring for Pregnant Women with Possible Zika Virus Exposure](https://www.cdc.gov/mmwr/volumes/66/wr/mm6629e1.htm?s_cid=mm6629e1_w) (https://www.cdc.gov/mmwr/volumes/66/wr/mm6629e1.htm?s_cid=mm6629e1_w). These recommendations update the prior CDC guidance in response to two developments in the Zika outbreak. First, the number of people with Zika infection in the Americas is declining and in a setting with reduced disease occurrence, the risk of false positive test results increases. Second, emerging data has shown that IgM antibodies can persist for months in some pregnant women, making it difficult to determine the timing of infection (prior to or during the current pregnancy). The limitations of currently available tests and the lack of a vaccine or an effective therapy to prevent congenital infection or mitigate sequelae of Zika virus infection during pregnancy, or in the neonate, underscore the importance of shared provider-patient decision-making for screening and testing pregnant women. False test results can cause stress and anxiety, and can also lead to more healthcare procedures than are necessary.

Summary of recommendations:

1. Pregnant women with recent possible Zika virus exposure who have a fetus with prenatal ultrasound findings consistent with congenital Zika virus syndrome should be tested concurrently with PCR (both serum and urine) and Zika virus IgM antibody regardless of symptoms. If amniocentesis is performed as part of clinical care, PCR testing for Zika should be considered.
2. Pregnant women with recent possible Zika virus exposure and symptoms of Zika virus disease (fever, rash, arthralgia, conjunctivitis) should be tested concurrently with PCR (both serum and urine) and Zika virus IgM antibody as soon as possible and through 12 weeks after symptom onset.
3. Asymptomatic pregnant women with recent possible Zika virus exposure (not ongoing exposure) are no longer recommended for routine testing. Providers and patients should discuss testing and care plans in the context of exposure risk prior to and during the current pregnancy, patient preferences, clinical judgment, and the limitations of available Zika tests. If Zika testing is ordered, women should be tested concurrently with PCR (both serum and urine) and Zika virus IgM antibody as soon as possible and through 12 weeks after last possible Zika exposure.

4. Asymptomatic pregnant women with ongoing exposure (daily or weekly travel to an area with Zika transmission) should be tested with PCR (serum and urine) three times during pregnancy unless a previous test confirmed Zika infection.
5. Testing placental tissue specimens can be considered in certain scenarios, to include symptomatic pregnant women and women with infants with possible Zika virus-associated birth defects without a definitive maternal Zika diagnosis. Testing should also be considered in instances of fetal loss and infant death.
6. Updated guidance for interpreting Zika virus laboratory test results is available at <https://www.cdc.gov/zika/pdfs/lab-table.pdf>

Evaluation and management of pregnant women: In New Jersey, women and their partners may routinely travel to areas with Zika transmission whether for work, business, family commitments, or leisure. Therefore, it is important that health care providers who care for pregnant and reproductive age women be vigilant in screening women for Zika exposure at each prenatal visit. It is important to advise pregnant women and women planning pregnancy to avoid travel to areas with Zika transmission. Women with unavoidable travel or sexual exposure to Zika should delay pregnancy by abstaining or using the most effective contraceptive method available; use male or female condoms or other barrier protections to prevent sexual transmission; and protect themselves against mosquito bites during travel. Travelers should also be advised to avoid mosquito bites for 3 weeks after their return, to prevent the virus from infecting mosquitoes in New Jersey.

For pregnant women with laboratory evidence of possible Zika virus infection, serial fetal ultrasounds (every 3-4 weeks) should be considered to assess fetal anatomy, particularly fetal neuroanatomy, and to monitor growth.

Evaluation and management of infants: For all newborns, pediatric healthcare providers should inquire about possible maternal and congenital Zika exposure. Apart from routine newborn care, depending on the level of possible Zika exposure, clinicians may consider if additional evaluation for congenital Zika syndrome is warranted. Further guidance is available in the [NJDOH Zika Delivery Packet \(http://www.nj.gov/health/cd/documents/topics/zika/njdoh_zika_delivery_packet.pdf\)](http://www.nj.gov/health/cd/documents/topics/zika/njdoh_zika_delivery_packet.pdf).

Shared Decision-Making Resources: Testing and care plan decisions should involve patients and providers working together to consider patient preferences and values, clinical judgment, a balanced assessment of risks and expected outcomes, and the jurisdiction's recommendations. Providers should consider potential exposure risk factors including symptoms, type and length of possible exposure, Zika virus transmission trends at location of possible exposure and the use of prevention measures (e.g., insect repellent, appropriate clothing, and condom use). CDC has issued [Screening Pregnant Women for Zika Testing \(https://www.cdc.gov/zika/pdfs/zikapreg_screeningtool.pdf\)](https://www.cdc.gov/zika/pdfs/zikapreg_screeningtool.pdf) to assist clinicians when considering Zika testing.

NJDOH will continue to monitor the prevalence of Zika virus infection during the current season for any further modifications in recommendations. Persons with questions about Zika can contact the Communicable Disease Service at 609-826-5964 or CDS.ZikaTeam@doh.nj.gov.