

An Observational Study on the Fetomaternal Outcomes of Pyrexia in Pregnancy at a Tertiary Care Hospital

Preeti Saini¹, Vineeta Garg², Komal Tiwari³, Sangeeta Mehrada⁴, Preeti Agarwal⁵

¹Senior Resident, Department of Obstetrics and Gynaecology, RUHS College of Medical Sciences, Jaipur, Rajasthan, India.

²Senior Professor and Head, Department of Obstetrics and Gynaecology, Government RDBP Jaipuria Hospital, Attached to RUHS College of Medical Sciences, Jaipur, Rajasthan, India.

³Senior Resident, Department of Obstetrics and Gynaecology, Vyas Medical College and Hospital, Jodhpur, Rajasthan, India.

⁴Senior Resident, Department of Obstetrics and Gynaecology, RUHS College of Medical Sciences, Jaipur, Rajasthan, India.

⁵Senior Resident, Department of Obstetrics and Gynaecology, RUHS College of Medical Sciences, Jaipur, Rajasthan, India.

Abstract

Background: Fever in pregnancy is a common clinical scenario with high maternal and foetal morbidity. The body's physiological and immunological changes during pregnancy make them more susceptible to infections, which can have negative impacts on pregnancy outcomes. Prompt identification and treatment of febrile illnesses is key to reducing fetomaternal morbidity. The current study was designed to assess fetomaternal outcomes in pregnancies complicated by pyrexia in a tertiary care hospital focusing on etiological profile of fever and its maternal and fetal outcomes. **Material and Methods:** The study was a prospective observational study conducted in the Department of Obstetrics and Gynaecology, Government RDBP Jaipuria Hospital, Jaipur for 5–6 months following approval from the Institutional Ethics Committee. Sixty-nine pregnant women with a history of fever and/or complaints compatible with febrile illness were enrolled in labour. A predesigned proforma was used for demographic, clinical, laboratory and obstetric data collection. Maternal and neonatal outcomes were evaluated up to discharge. IBM SPSS Statistics version 20.0 was used to analyze the data. **Results:** Most of the women were in the age group 20–30 years (84.1%) and were primigravidae (89.9%). The most frequent cause of fever was upper respiratory tract infection (44.9%), urinary tract infection (20.3%), typhoid (20.3%) and dengue (14.5%). Sixty six and two thirds of the participants had low grade fever. The most common complications were fetal distress (34.8%) and intrauterine growth restriction (26.1%). 18.8% had preterm labour and 14.5% had premature rupture of membranes. 63.8% of women had a full-term vaginal delivery. Neonatal complications were intrauterine growth restriction (26.1%), low birth weight (21.7%), preterm birth (18.8%), and NICU admission (14.5%). No intrauterine death, no neonatal septicaemia and no neonatal mortality was reported. **Conclusion:** Pyrexia in pregnancy results in significant maternal and neonatal morbidity including fetal distress, intrauterine growth restriction, low birth weight and preterm labour. Early diagnosis, early treatment of underlying infections and careful antenatal monitoring may help to ensure good fetomaternal outcome.

Keywords: Pyrexia in pregnancy, maternal fever, fetomaternal outcome, pregnancy complications, neonatal outcome.

Received: 01 July 2026

Revised: 21 July 2026

Accepted: 05 August 2026

Published: 20 August 2026

INTRODUCTION

Fever is a frequent clinical condition that is seen during pregnancy and it is an important cause of maternal and fetal morbidity.^[1] Changes in physiology, hormones and the immune system during pregnancy may make them more vulnerable to infectious diseases and make them present differently.^[2] The most common causes of fever in pregnancy are urinary tract infection, respiratory tract infection, dengue, malaria, typhoid and other systemic infections.^[3] Particular concern is given to the occurrence of maternal pyrexia as this can have an impact on both the mother and developing foetus, and therefore prompt diagnosis and management is required.^[4]

Maternal fever has been linked to a variety of obstetric and neonatal complications.^[5] Possible adverse effects of fever during pregnancy include miscarriage, preterm labour, premature rupture of membranes, intrauterine growth restriction (IUGR), low birth weight, fetal distress, neonatal sepsis and perinatal death, depending on severity, duration

and timing of the fever. Intrapartum fever has also been associated with a higher incidence of operative delivery, postpartum complications, and neonatal intensive care unit (NICU) admissions.^[7–9] In addition, severe maternal infections can lead to substantial morbidity, and can have direct or indirect effects on neonatal outcomes due to their impact on fetal development.^[10]

Although the effects of maternal fever on pregnancy outcomes are known, information on its aetiology and fetomaternal

Address for correspondence: Dr. Preeti Saini,
Senior Resident, Department of Obstetrics and Gynaecology, RUHS College of
Medical Sciences, Jaipur, Rajasthan, India.
E-mail: preetisaini8824@gmail.com

DOI:
10.21276/amit.2026.v13.i2.968

How to cite this article: Saini P, Garg V, Tiwari K, Mehrada S, Agarwal P. An Observational Study on the Fetomaternal Outcomes of Pyrexia in Pregnancy at A Tertiary Care Hospital. Acta Med Int. 2026;13(2):1838-1843.

consequences is still limited, especially in low and middle income countries. Most of the studies available are on individual infectious diseases and not fever as a clinical entity, and evidence from Indian tertiary care facilities is limited. Considering the wide spectrum of infectious diseases in India and the risk of potential preventable maternal and neonatal complications, a thorough assessment of fever in pregnancy and its outcomes is needed. This kind of information can help identify high-risk cases early on and enhance clinical management strategies.

Hence, the aim of the present study was to assess fetomaternal outcomes in pregnancies complicated by pyrexia at a tertiary care hospital. The specific objectives were to identify the different causes of fever in pregnancy, the maternal and fetal outcome of febrile illness and to find out the prevalence of fever in women attending the study center.

MATERIALS AND METHODS

The study was an institution based prospective observational study conducted in the Department of Obstetrics and Gynaecology, Government RDBP Jaipuria Hospital, Jaipur for 5–6 months following approval from the Institutional Ethics Committee. The objective of the study was to assess the fetomaternal outcome in pyrexia in pregnancy. The study was approved by the Institutional Ethics Committee before it began and written informed consent was taken from all participants before their enrolment.

The study population consisted of pregnant women in labour with a history of fever (temperature $\geq 99.9^{\circ}\text{F}$ for more than two days) in any trimester of pregnancy or with a complaint suggestive of febrile illness at admission. The study included women over 18 years of age who gave written informed consent. Pregnant women with no history of febrile illness and with fever due to septicaemia, intrauterine fetal demise, blood transfusion reactions, drug reactions, diabetes mellitus, chronic hypertension, connective tissue disorders and severe anaemia were excluded. Those who did not want to participate were also excluded from the study. Consecutive cases were selected for all those eligible, resulting in a sample of 69 participants.

A predesigned semi-structured proforma was used to collect the data. Demographic data such as age, educational status, place of residence, family income and socioeconomic status as per modified Kuppuswamy classification were taken. A detailed febrile illness history, with associated symptoms and obstetric information, was acquired. General physical examination and obstetric assessment were performed for all participants. Body temperature was taken orally with a digital thermometer and recorded as a temperature in degrees Fahrenheit. Laboratory investigations were done which included complete blood count, peripheral blood smear, malaria antigen, dengue serology (IgM/IgG), C-reactive protein, erythrocyte sedimentation rate, random blood sugar, liver and renal function tests, urine routine examination, urine culture and sensitivity, blood culture, Widal test, COVID-19/swine flu RT-PCR, sputum examination, and high vaginal swab as and when clinically indicated. Ultrasonography was used to evaluate fetal status and chest radiographs with abdominal shielding were obtained as needed. Participants were monitored during labour and their hospital stay after birth. Maternal outcomes measured included anaemia, pre-term rupture of membranes, PPH and other systemic complications. Fetal and neonatal outcomes assessed included gestational age at delivery, birth weight, APGAR score, intrauterine growth restriction, admission to neonatal intensive care unit (NICU) and neonatal sepsis and perinatal mortality. Data was entered and analysed by IBM SPSS Statistics version 20.0 (IBM Corp., Armonk, NY, USA). Descriptive statistics were presented in the form of frequency, percentage, mean and standard deviation. Chi-square test was used to assess the associations between categorical variables and Student's t-test was used to compare continuous variables. A p-value of <0.05 was considered statistically significant.

RESULTS

Among the 69 pregnant women included in the study, the majority belonged to the age group of 20–30 years (58, 84.1%), followed by women aged >30 years (9, 13.0%) and <20 years (2, 2.9%). The majority of participants were primigravidae (62, 89.9%) and 7 (10.1%) were multigravida. As regards socioeconomic status, more than half of the participants (35, 50.7%) were of lower socioeconomic status, followed by lower middle (20, 29.0%) and upper middle (14, 20.3%). [Table 1]

Table 1: Baseline Maternal Characteristics of Study Population (n=69)

Variable	Category	n (%)
Age (years)	<20	2 (2.9%)
	20–30	58 (84.1%)
	>30	9 (13.0%)
Parity	Primigravida	62 (89.9%)
	Multigravida	7 (10.1%)
Socioeconomic status	Upper middle	14 (20.3%)
	Lower middle	20 (29.0%)
	Lower	35 (50.7%)

Upper respiratory tract infection (URTI) was the most common cause of maternal fever (31 (44.9%)). Urinary tract infection (UTI) and typhoid each had 14 (20.3%) cases, and dengue fever had 10 (14.5%) cases. In terms of pyrexia

severity, low grade pyrexia was the most common (46, 66.7%) and moderate grade pyrexia was seen in 20 (29.0%) women and high grade pyrexia was seen in 3 (4.3%) women. [Table 2]

Table 2: Etiology and Severity of Maternal Fever (n=69)

Variable	Category	n (%)
Etiology of fever	URTI	31 (44.9%)
	UTI	14 (20.3%)
	Typhoid	14 (20.3%)
	Dengue	10 (14.5%)
Grade of pyrexia	Low grade (100.4–102°F)	46 (66.7%)
	Moderate grade (102–104°F)	20 (29.0%)
	High grade (>104°F)	3 (4.3%)

Severity of fever was analysed based on etiology, all cases of URTI and typhoid were associated with low grade fever. In patients with dengue fever, 8 (40.0%) had moderate grade fever and 2 (66.7%) had high grade fever. Moderate grade fever was seen in 12 (60.0%) cases of UTI while one

case each had low and high grade fever. Overall, low grade fever accounted for 46 (100%), moderate grade fever accounted for 20 (100%) and high grade fever accounted for 3 (100%). [Table 3]

Table 3: Association Between Etiology and Grade of Pyrexia

Etiology	Low Grade n (%)	Moderate Grade n (%)	High Grade n (%)
URTI	31 (67.4%)	0 (0%)	0 (0%)
Typhoid	14 (30.4%)	0 (0%)	0 (0%)
Dengue	0 (0%)	8 (40.0%)	2 (66.7%)
UTI	1 (2.2%)	12 (60.0%)	1 (33.3%)
Total	46 (100%)	20 (100%)	3 (100%)

Maternal and fetal complications due to fever were common. The most frequent complication was fetal distress (24, 34.8%) followed by intrauterine growth restriction (IUGR) (18, 26.1%). Thirteen (18.8%) women were in preterm labour and 12 (17.4%) women had moderate anaemia. Ten (14.5%) had premature rupture of membranes

(PROM) and ten (14.5%) had diarrhoea. Other complications reported were oligohydramnios in 8 (11.6%) women, pregnancy induced hypertension (PIH) in 7 (10.1%) women, thrombocytopenia in 5 (7.2%) women and jaundice in 5 (7.2%) women. [Table 4]

Table 4: Maternal Complications Associated with Fever (n=69)

Complication	n (%)
Fetal distress	24 (34.8%)
IUGR	18 (26.1%)
Preterm labour	13 (18.8%)
Moderate anemia	12 (17.4%)
PROM	10 (14.5%)
Diarrhoea	10 (14.5%)
Oligohydramnios	8 (11.6%)
PIH	7 (10.1%)
Postdatism	7 (10.1%)
Thrombocytopenia	5 (7.2%)
Jaundice	5 (7.2%)

Maternal systemic complications were different depending on the cause of fever. Moderate anemia was the most frequent in women with URTI [5 (41.7%)] and UTI [4 (33.3%)] and also in three women with dengue [25.0%]

Thrombocytopenia was seen in all women with dengue fever [5 (100%)] and so was jaundice [5 (100%)] Typhoid fever was the only illness associated with diarrhea and all 10 (100%) affected cases had diarrhea. [Table 5]

Table 5: Maternal Systemic Complications According to Etiology

Complication	URTI n (%)	UTI n (%)	Typhoid n (%)	Dengue n (%)
Moderate anemia (n=12)	5 (41.7%)	4 (33.3%)	0 (0%)	3 (25.0%)
Thrombocytopenia (n=5)	0 (0%)	0 (0%)	0 (0%)	5 (100%)
Diarrheic (n=10)	0 (0%)	0 (0%)	10 (100%)	0 (0%)
Jaundice (n=5)	0 (0%)	0 (0%)	0 (0%)	5 (100%)

The fetomaternal outcome was evaluated based on the cause of fever and it was found that the highest number of IUGR cases were associated with UTI [8 (44.4%)] The majority of preterm delivery was among women with URTI [11 (84.6%)] PROM and oligohydramnios were mostly seen in

women with UTI (6 [60.0%] and 6 [75.0%]). The distribution of PIH between UTI and typhoid fever was equal with each contributing 3 (42.9%) cases. Fetal distress was seen in most women with URTI [8 (33.3%)] followed by typhoid [7 (29.2%)] and dengue fever [6 (25.0%)]

[Table 6]

Table 6: Fetomaternal Outcomes According to Etiology of Fever

Outcome	URTI n (%)	UTI n (%)	Typhoid n (%)	Dengue n (%)
IUGR (n=18)	4 (22.2%)	8 (44.4%)	2 (11.1%)	4 (22.2%)
Preterm birth (n=13)	11 (84.6%)	1 (7.7%)	1 (7.7%)	0 (0%)
PROM (n=10)	4 (40.0%)	6 (60.0%)	0 (0%)	0 (0%)
Oligohydramnios (n=8)	2 (25.0%)	6 (75.0%)	0 (0%)	0 (0%)
PIH (n=7)	1 (14.3%)	3 (42.9%)	3 (42.9%)	0 (0%)
Fetal distress (n=24)	8 (33.3%)	3 (12.5%)	7 (29.2%)	6 (25.0%)

Concerning the way of delivery, most women (44, 63.8%) had full-term vaginal delivery. Preterm vaginal delivery and full-term LSCS were each performed in 12 (17.4%) women, and preterm LSCS was performed in only 1 (1.4%) woman.

Of the 13 women who had LSCS, the most common indication was fetal distress (69.2%) followed by breech presentation (23.1%) and cephalopelvic disproportion (7.7%). [Table 7]

Table 7: Mode of Delivery (n=69)

Variable	Category	n (%)
Mode of Delivery	Full-term vaginal delivery	44 (63.8%)
	Preterm vaginal delivery	12 (17.4%)
	Full-term LSCS	12 (17.4%)
	Preterm LSCS	1 (1.4%)
Indications for LSCS (n=13)	Fetal distress	9 (69.2%)
	Breech presentation	3 (23.1%)
	Cephalopelvic disproportion	1 (7.7%)

Neonatal outcomes were generally good with 59 (85.5%) neonates having a normal APGAR score (>7). Ten (14.5%) neonates had low APGAR score (<7). Ten (14.5%) neonates needed NICU admission. Low birth weight was

noted in 15 (21.7%) neonates, preterm birth in 13 (18.8%) neonates and IUGR in 18 (26.1%) neonates. There were no cases of intrauterine deaths in the study population. [Table 8]

Table 8: Neonatal Outcomes (n=69)

Outcome	n (%)
Normal APGAR (>7)	59 (85.5%)
Low APGAR (<7)	10 (14.5%)
NICU admission	10 (14.5%)
Low birth weight	15 (21.7%)
Preterm birth	13 (18.8%)
IUGR	18 (26.1%)
Intrauterine death	0 (0%)

The most common indication was respiratory distress syndrome (RDS) and all 10 (100%) neonates admitted to the NICU had RDS. Seven (70.0%) of the NICU admissions were due to preterm birth, and six (60.0%) of the neonates

admitted were low birth weight. There were no cases of neonatal septicemia. 100% of all neonates admitted to NICU survived until discharge. [Table 9]

Table 9: Indications for NICU Admission (n=10)

Indication	n (%)
Respiratory distress syndrome	10 (100%)
Preterm birth	7 (70.0%)
Low birth weight	6 (60.0%)
Septicaemia	0 (0%)

DISCUSSION

The aim of the present study was to assess fetomaternal outcomes in pregnancies complicated by pyrexia in a tertiary care hospital. The most common cause of fever was upper respiratory tract infection (URTI) (44.9%), followed by urinary tract infection (UTI) (20.3%) and typhoid (20.3%) while dengue fever accounted for 14.5% of cases. Biswas et al. and Prajapati et al. reported respiratory tract infections to be the common cause of fever in pregnancy

and UTI as the common cause of fever respectively which is 31.3%.^[11,12] Rinnie Brar et al. found that the prevalence of dengue fever was higher (24.3%) than the present study.^[3] Low grade fever was present in most of the women in our study (66.7%) and high grade fever was present in only 4.3% of women, suggesting mild to moderate febrile illness during pregnancy. Such differences in etiological patterns could be due to the difference in epidemiology, seasonal availability of the disease and the healthcare seeking behaviour in different

regions.

The current study showed that there was a significant association between obstetric complications and maternal fever. The most frequent complications were fetal distress (34.8%), intrauterine growth restriction (IUGR) (26.1%), preterm labour (18.8%) and premature rupture of membranes (14.5%). Hcini et al. have shown that women with infectious illness during pregnancy are at higher risk for preterm delivery and fetal growth restriction (FGR).^[13] The rate of preterm delivery in our study was 18.8% while Prajapati et al. reported 23.7% and Shabana Sultan et al. reported 21.6% of febrile pregnancies leading to preterm delivery.^[12,14] Of note, the highest proportion of IUGR cases (44.4%) and oligohydramnios (75.0%) was associated with UTI, while the highest proportion of preterm births (84.6%) was associated with URTI. The results underscore the need for prompt detection and care of maternal infections to prevent poor outcomes of pregnancy.

Maternal infection and IUGR could be linked, through several mechanisms. Maternal infections can trigger systemic inflammatory responses, including increased levels of the cytokines IL-6 and TNF α , that can lead to impaired placental perfusion and nutrient transfer to the fetus. Furthermore, infection can also lead to endothelial dysfunction, placental insufficiency and chronic foetal hypoxia, which can limit foetal growth. Maternal febrile illnesses are also linked to higher metabolic needs and lower maternal nutritional intake, which could lead to further stunted fetal growth and development. All these pathophysiological mechanisms could account for the relatively high incidence of IUGR observed in the present study, especially in women with UTI and systemic infections.

Multiple physiologic changes in the mother during infection can also cause fetal distress due to fever. Fetal oxygen consumption may be increased by maternal hyperthermia, which raises body temperature and metabolic rate of the fetus. At the same time, maternal dehydration, tachycardia and decreased uteroplacental blood flow associated with the infection can impair fetal oxygen delivery. The inflammatory mediators and endotoxins produced as a result of the infection can also cause irritability of the uterus and dysfunction of the placenta, leading to fetal hypoxia and distress. These mechanisms may account for the fetal distress being the most common obstetric complication and indication for cesarean delivery in the current study.

Neonatal outcomes in the current study were mostly good with 85.5% neonates having normal APGAR score (>7). However, adverse outcomes were noted, such as IUGR (26.1%), low birth weight (21.7%), preterm birth (18.8%) and NICU admission (14.5%). Similarly, Manoj Kumar et al reported higher incidence of low weight and preterm delivery in neonates of mothers who had febrile illness [10] A study by Prajapati et al reported low birth weight (40.0%) and preterm birth (23.7%) which were higher than the present study.^[12] The most common indication for NICU admission was respiratory distress syndrome, reflecting the strong association between maternal infection, prematurity and neonatal respiratory morbidity among all neonates

admitted. Notably, there were no intrauterine deaths or neonatal septicaemia, indicating good surveillance at the ante-natal level and timely obstetric and neonatal care.

Talking about delivery outcomes, 63.8% of women had full term vaginal delivery and 18.8% had cesarean section. The most common reason for LSCS was fetal distress (69.2% of operative deliveries). This has been noted in other studies as well: fetal compromise was the most common reason for cesarean delivery in febrile pregnancies.^[1,14,15] The lack of maternal mortality, intrauterine death, and neonatal mortality in the current study is a reflection of the advantages of prompt diagnosis, multidisciplinary approach to care, and appropriate intrapartum monitoring. The overall results suggest that despite pyrexia in pregnancy being a cause of serious maternal and neonatal morbidity, good outcomes are possible with timely diagnosis, close monitoring and early therapeutic intervention.

There are some limitations in the present study that must be noted. The results of this single-center study might not be applicable to larger populations or other clinical environments. The relatively small sample size might have reduced the power to identify smaller associations and subgroup differences. Furthermore, multivariate analysis was not conducted, which could have limited the ability to adjust for possible confounding factors affecting the outcomes of the study. Also, follow-up was restricted to the hospitalisation/discharge period and long-term outcomes and implications could not be evaluated. Though the study has few limitations, it offers interesting information and forms the basis for future larger multicentric studies with longer follow-up.

CONCLUSION

Pyrexia in pregnancy is still an important clinical condition with high maternal and foetal morbidity. In the present study, upper respiratory tract infection was the most common cause of maternal fever followed by urinary tract infection, typhoid and dengue. Maternal fever was linked to poor outcomes such as fetal distress, intrauterine growth restriction (IUGR), low birth weight, preterm labour and NICU admission. However, in most instances, good maternal and neonatal results were obtained, with most women giving birth at term, a high rate of normal APGAR scores in neonates and no intrauterine or neonatal deaths. These findings emphasize the need for timely diagnosis, early treatment of underlying infection, routine prenatal monitoring and a multidisciplinary approach to reduce fetomaternal complications and enhance pregnancy outcomes in women with febrile illness.

REFERENCES

1. Egloff C, Sibiude J, Couffignal C, et al. Causes and consequences of fever during pregnancy: A retrospective study in a gynaecological emergency department. *J Gynecol Obstet Hum Reprod.* 2020;49(9):101899.
2. Robinson DP, Klein SL. Pregnancy and pregnancy-associated hormones alter immune responses and disease pathogenesis. *Horm Behav.* 2012;62(3):263-71.
3. Brar R, Suri V, Suri V, et al. Fever During Pregnancy: Etiology and Fetomaternal Outcomes. *J Obstet Gynaecol India.* 2022;72:102-108.
4. Shrestha A, Bhattarai S, Madhup SK. Pyrexia in Pregnancy and

- its Maternal and Fetal Outcome. Kathmandu Univ Med J (KUMJ). 2023;21(81):7-12.
5. Ainebyona H, Ayebare E, Nabisere A, et al. Prevalence of Maternal Fever and Associated Factors among Postnatal Women at Kawempe National Referral Hospital, Uganda: A Preliminary Study. *Int J Environ Res Public Health*. 2024;21(3):316.
6. Shaik T, Madhavi K, Sreelatha K. Evaluation of febrile pregnant women of term gestation and its effect on maternal and fetal outcome in tertiary care hospital. *Int J Curr Pharm Rev Res*. 2025;17(4):98-103.
7. An H, Zheng W, Zhu Q, et al. Retrospective study of intrapartum fever in term pregnancies and adverse obstetric and neonatal outcomes. *Peer J*. 2022;10:1-14.
8. Lin X, Xie Q, Xu Y, et al. Effects of epidural labor analgesia on intrapartum fever and obstetric outcomes in women with gestational diabetes mellitus: A retrospective cohort study. *Medicine (Baltimore)*. 2025;104(41):1-6.
9. Jothika KRK, Nath AG, Prem A. Risk Factors of Intrapartum Pyrexia in Term Pregnancies and Its Associated Fetomaternal Outcome. *J South Asian Feder Obst Gynae*. 2025; 17(3):288-92.
10. Kumar M, Saadaoui M, Al Khodor S. Infections and Pregnancy: Effects on Maternal and Child Health. *Front Cell Infect Microbiol*. 2022;12:873253.
11. Biswas J, Banerjee K, Sanyal P, et al. Fetomaternal outcome of pyrexia in pregnancy: a prospective study. *Int J Womens Health Rep Sci*. 2015;3(3):132-5.
12. Prajapati DD, Patel SV, Panchal NP, et al. Feto maternal outcome in pregnancy with fever. *Int J Reprod Contracept Obstet Gynecol*. 2024;13(6):1507-10.
13. Hcini N, Lambert V, Picone O, et al. Causes and consequences of fever in Amazonian pregnant women: A large retrospective study from French Guiana. *PLoS Negl Trop Dis*. 2023;17(10):1-16.
14. Sultan S, Parihar R, Badkur P. Study on pyrexia in pregnancy and labour with special emphasis on fetomaternal outcome. *Int J Reprod Contracept Obstet Gynecol*. 2020;9(11):4414-9.
15. More VS. Fever in pregnancy and its maternal and fetal outcomes. *Int J Reprod Contracept Obstet Gynecol*. 2017;6(12):5523-8.