

PROTOCOL #36 - Maternal Fetal Medicine, University of New Mexico

GROUP B STREPTOCOCCUS

General

Group B Streptococcal (GBS), infection is the leading cause of neonatal sepsis in the United States. It infects 12, 000 newborns annually, causing the death of 2,000, and leaves up to 50% of the survivors neurologically damaged. While 15 to 40% of women harbor this organism in their lower intestinal and genital tracts, only 1 to 3 per 1,000 infants become infected.

The five factors that put the neonate at risk are:

1. preterm labor
2. preterm premature rupture of membranes
3. prolonged (>18 hours) rupture of membranes at term
4. maternal fever in labor
5. history of actual GBS infection in a prior infant (*does not mean simply a +GBS culture in a prior pregnancy*)

Antenatal Care:

1. If Patient has a GBS+ urine culture – the patient needs to be treated for the UTI. She does not require vaginal culture at standard time since this patient is highly colonized and a negative vaginal culture may give a false sense of patient status. Label chart as to status.
2. Women with a prior affected infant from early GBS should not be cultured since they require antibiotic treatment in labor no matter what the GBS culture shows. This does not mean simply a prior positive GBS culture without sequelae.
3. GBS positive patients should NOT be treated with oral antibiotics prior to labor, as this will not eliminate carriage.
4. Patients who plan to have a cesarean delivery should still be cultured since they may experience very small however.
5. Procedure for GBS culture at 35-37 weeks:
 - A. A speculum exam is not necessary to obtain GBS cultures. The provider or the patient may obtain the specimens.
 - B. A swab is inserted into the lower vagina and the anal canal/perianal area to obtain GBS cultures. Sampling from both sites is essential, as over a third of carriers will be missed if the rectum is not sampled. The cervix is NOT an appropriate site to sample.
 - C. For patients with true PCN allergy (hives or wheezing not simply a rash) – obtain sensitivities – THIS CAN BE DONE AT TIME OF THE INITIAL REQUEST BY ADDING TO THE COMMENT SECTION – PCN ALLERGY DO SENSITIVITIES

Intrapartum Care:

1. Protocol for unscreened woman presenting at <37 wks in active labor
 - a. Get a regular GBS screen not a rapid screen and treat with antibiotics if in labor since has risk of <37 weeks. This is primarily for newborn issues.

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2. Protocol for unscreened woman presenting at 37+ weeks in active labor
 - a. Get rapid GBS screen
 - b. If has a risk factor or likely to deliver within 4 hours initiate antibiotic therapy
 - c. Risk factors include:
 - i. EGA <37 wks
 - ii. Prolonged rupture of membranes (≥ 18 hours) (consider initiating antibiotics at 14 hours unless delivery imminent.
 - iii. Intrapartum temperature > 38.0 degrees C
 - iv. GBS positive urine culture
 - v. Previously affected infant
 - d. If rapid culture comes back negative – stop antibiotics unless risk factor develops
 - e. If rapid culture comes back positive – continue (or initiate) antibiotics
3. Any GBS (+) screened woman should be started on antibiotics. If the woman had a positive test earlier in pregnancy and was treated at that time (e.g. threatened preterm labor) she should still be treated when she does go into labor. Women having a repeat c-section without labor or ROM do not require GBS treatment.
4. ANTIBIOTIC recommendations
 - a. Aqueous Penicillin 5 million units IV followed by 2.5 units every 4 hours when in labor. (Ampicillin 2g IV followed by 1g IV q4h is an alternative, but may foster overgrowth of resistant gram-negative organisms)\
 - b. If the patient is allergic to penicillins with a rash only she should be begun on:
Cefazolin 2g initially, followed by 1g IV q8h - until delivery.c.
 - c. If the patient has a penicillin allergy that includes anaphylaxis, angioedema, respiratory distress and/or urticaria she should be begun on:

Vancomycin 1 gm IV q12h (much more expensive) \
Or
Clindamycin 900 mg IV q 8hrs (be careful since this is associated with a 15-20% incidence of GBS resistance and are no longer the preferred agents unless sensitivities have been done.)
5. If the patient does not go on to deliver within 48 hours (eg. PPROM), antibiotics should be continued per PROM protocol (ampicillin and erythromycin-2 days IV and 5 days PO). When the patient then does go into active labor, antibiotics should be resumed as above.
6. Culture status and treatment during labor need to be documented in the chart and in MARS
7. Nursery needs to be advised as to patient GBS+ status and number of antibiotic doses received for fetal monitoring

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Reference:

MMWR Prevention of Perinatal Group B Streptococcal Disease Revised Guidelines from CDC, 2010 November 19, 2010; Vol 59; No RR-10.

ACOG Committee Opinion 485. Prevention of Early Onset GBS Disease in the Newborn. April 2011

CONSULTATION

Twenty-four hour consultation is available by calling the Maternal Fetal Medicine service at the University of New Mexico Hospital. 1-888-866-7257.

