Poole Hospital NHS
NHS Foundation Trust

Neonatal Group B streptococcal disease – prevention of early onset

SUMMARY POINTS

This controlled document (Procedure, Guideline etc) details:
• Screening for GBS
• Management of GBS
• Antibiotics

DOCUMENT DETAILS

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Job Title:	SpR Obstetrics
Signed:	
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DOCUMENT HISTORY

Date of Issue	Version No.	Next Review Date	Date Approved	Director Responsible for Change	Nature of Change
Sep 2018	1.1	Jan 2019			Under review

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1. RELEVANT TO

1.1 All staff within the maternity service including Ostetricians, Neonatologists and Midwives

2. PURPOSE

2.1 The purpose of this guideline is to prevent early onset neonatal Group B streptococcal disease. (EOGBS)

3. DEFINITIONS

3.1 This guideline will describe the detection and management of EOGBS

4. DOCUMENT DEVELOPMENT

4.1 GBS commonly colonises the gut but may occur in the vagina with no ill effects for the carrier. Colonisation may be intermittent and duration unpredictable.

The incidence of EOGBS in the UK in the absence of screening or widespread intra-partum antibiotic prophylaxis is 0.5/1000 births. A risk of 2.3/1000 is assumed if GBS is present on a vaginal swab. GBS Bacteruria is associated with a higher risk of chorioamnionitis and neonatal disease although it is not possible to accurately quantify these risks. Intrapartum Antibiotic Prophylaxis (IAP) has been shown to significantly reduce the risk of culture positive EOGBS but not late onset GBS (occurring 7 or more days after birth). It has not been shown to reduce all causes of mortality or GBS-related mortality. There have been no studies addressing whether routine screening has had any impact on all-cause mortality.

Antenatal screening and treatment carry disadvantages for the mother, which include anaphylaxis, possible infection with antibiotic resistant organisms and increased medicalisation of labour and the intra-partum period.

5 ANTENATAL

Screening

5.1 Routine bacteriological screening for all pregnant women for antenatal GBS carriage is not recommended.
(This includes women in whom GBS carriage was detected in a previous pregnancy)

Vaginal swabs should not be taken during pregnancy unless there is a clinical indication to do so
(If the woman is Penicillin Allergic please state this on Microbiology request form)

TREATMENT
If GBS is detected on swabs antenatally, treatment before the onset of labour is not recommended

Women with GBS urinary tract infection (growth of greater than 10^5 cfu/ml) should receive treatment at the time of diagnosis

5.2 INTRAPARTUM

Intrapartum Antibiotic Prophylaxis (IAP) IAP should be offered to women:

Who have GBS Bacteruria identified in the current pregnancy
Who have GBS detected on a vaginal swab in the current pregnancy
With a previous baby with neonatal GBS disease
Who are pyrexial in labour (>38°)

(For Antibiotic choice see final section)

IAP should not be offered if GBS carriage was detected in a previous pregnancy

GBS is not an indication for continuous fetal monitoring in Labour

Please tell the couple that receiving IAP is not a guarantee against the baby needing either a period of observation in hospital OR a course of antibiotics lasting at least 48 hours.

5.3 SPONTANEOUS RUPTURE OF MEMBRANES AT TERM (at or over 37 weeks gestation)

Women who are known to be colonised with GBS should be offered immediate induction of labour and IAP

Women who are not known to be colonised with GBS should be offered immediate induction of labour or induction after 24 hours (in line with NICE guidelines) and IAP should not be given unless there are other risk factors

If chorioamnionitis is suspected, broad-spectrum antibiotic therapy including an agent active against GBS should replace GBS-specific IAP and induction of labour should be considered.

5.4 Preterm labour

Women presenting in established pre-term labour with intact membranes and no other risk factors for GBS should not routinely be offered IAP, unless they are known to be colonised with GBS

5.5 Preterm prelabour rupture of membranes (pPROM)

Administration of antibiotics specific to GBS are not necessary prior to labour. When in labour, IAP should be offered.

5.6 Antibiotics

For women that have accepted IAP, Benzylpenicillin should be administered as soon as possible after the onset of labour and given regularly until delivery
(3g intravenous Benzylpenicillin should be given as soon as possible after the onset of labour and 1.5g 4-hourly until delivery)

Clindamycin should be administered to women allergic to Benzylpenicillin
(Clindamycin 900mg should be given intravenously 8-hourly)

Women who have pyrexia in labour should be treated with Cefuroxime 1.5g iv 8-hourly and Metronidazole 500mg iv 6-hourly

5.7 Incidence

Incidence of EOGBS in UK = 0.5/10000
Incidence of EOGBS in women with GBS in current pregnancy 2.3/1000
Incidence of EOGBS in women with GBS in previous pregnancy

6. APPROVAL PROCESS

6.1 To be approved by East Dorset Maternity Documentation Group and the trust Drugs and Therapeutics group.

7. REVIEW AND REVISION ARRANGEMENTS INCLUDING VERSION CONTROL

7.1 This document is due for review in 2016, or earlier if required.

8. MONITORING COMPLIANCE AND EFFECTIVENESS

8.1 Compliance will be monitored through the Medway clinical information system