Bwrdd Iechyd Prifysgol
Hywel Dda
University Health Board

PREVENTION OF EARLY – ONSET NEONATAL GROUP STREPTOCOCCAL DISEASE GUIDELINE

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LOCSSIP Reference:	N/A	NATSSIP Standard:	List standard (NATSSIPS Standards)		

Version No:	Date of EqIA:	Approved by:	Date Approved:	Date made active:	Review Date:
2		Obstetric Written Control Documentation Group	23.4.2019	29.4.2019	23.4.2022
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Brief Summary of Document:	Management of Group B haemolytic streptococcus in pregnancy and labour
Scope	The purpose of this guideline is to provide guidance for obstetricians, midwives, paediatricians and neonatologists on the prevention of early-onset neonatal group B streptococcal (EOGBS) disease and the information to be provided to women, their partners and family.

To be read in conjunction with:	645 – PreTerm Pre-Labour Spontaneous Rupture of Membranes Guideline
Patient Information:	https://www.rcog.org.uk/globalassets/documents/patients/patient-information-leaflets/pregnancy/pi-gbs-pregnancy-newborn.pdfInclude links to Patient Information Library

Owning committee/ group	Obstetric & Maternity Written Control Documentation Group

Reviews and updates		
Version no:	Summary of Amendments:	Date Approved:
1	New guideline	21.9.2017
2	Revised	23.4.2019

Glossary of terms

Term	Definition
IAP	Intrapartum Antibiotic Prophylaxis
GBS	Group B Streptococcus
CLC	Consultant Led Care
CLU	Consultant Led Unit

Keywords	Group B Streptococcus

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1. Aim

The aim of this guideline is to ensure that babies do not come to avoidable harm as a result of being born to mother's who may be affected by Group B Streptococcus.

2. Objectives

The aim of the guideline will be achieved by:

- Achieving high placental transfer of appropriate antibiotic during active labour.
- Following recommended erythromycin guideline, if preterm rupture of membranes occur

3. Scope

The purpose of this guideline is to provide guidance for obstetricians, midwives, paediatricians and neonatologists on the prevention of early-onset neonatal group B streptococcal (EOGBS) disease and the information to be provided to women, their partners and family.

'The term "woman/women" in the context of this document is used as a biologically based term and is not intended to exclude trans and non-binary people who do not identify as women

4. Guideline

For the RCOG guideline on the prevention of early – onset neonatal group streptococcal disease follow the link below

https://obgyn.onlinelibrary.wiley.com/doi/full/10.1111/1471-0528.14821

Refer to Appendix 1 for an overview of the guideline to be followed.

5. Monitoring

A clinical audit programme will consider the following:

- Use of the Sepsis Risk Calculator
- The proportion of babies who receive antibiotics in relation to this guideline

PREVENTION OF EARLY – ONSET NEONATAL GROUP STRETOCOCCAL DISEASE (EOGBS)

Universal bacteriological screening is not recommended

Clinical risk factors

Clinical risk factors
Previous infant with GBS disease
Preterm labour
GBS carriage (colonisation) identified in a previous pregnancy
Pre-labour rupture of membrane
Pyrexia (38*C) and higher in labour
Suspected maternal intrapartum infection, including suspected chorioamnionitis
Prolonged rupture of membranes
GBS carriage in current pregnancy

If GBS was detected in a previous pregnancy

If GBS was detected in a previous pregnancy
Likelihood of maternal GBS carriage in current pregnancy in 50%
May have an option of: 1) IAP or 2)Bacteriological testing at 35 – 37 weeks of gestation or 3 – 5weeks to the anticipated delivery date, and 32-34 weeks of gestation for women with twins
If positive for GBS in current pregnancy offer **intrapartum antibiotic prophylaxis** (IAP)

If previous baby with early onset or late onset GBS disease

If previous baby with early onset or late onset GBS disease
IAP should be offered

If a woman requests testing for carrier status?

Maternal request in not indication for bacteriological screening

GBS bacteriuria identified during the current pregnancy

At the time of diagnosis appropriate treatment should be given

Antenatal treatment is not recommended for GBS cultured from a vaginal or rectal swab. Neither incidental nor intentional testing.

Induction of labour and elective caesarean section to GBS carrier

GBS does not influence the method of induction
Membrane sweeping is not contraindicated
IAP not indicated for women undergoing planned caesarean section in the absence of labour with intact membranes

Place of birth

If confirmed GBS positive in current pregnancy women should be booked under CLC and give birth in a CLU.
Any further discussions should take place with a Consultant Midwife and an individualised plan of care made.

Labour management

Women who are known GBS carriers should be offered immediate IAP and induction of labour as soon as reasonably possible
Women who are pyrexia (38*C or greater) in labour should be offered a broad-spectrum antibiotic regimen which should cover GBS in line with local microbiology sensitivities
IAP is recommended for women in confirmed preterm labour
IAP is not recommended for women not in labour and having a preterm planned caesarean section with intact membranes
Polymerase chain reaction or other near-patient testing at the onset of labour in not recommended
Birth in a pool is not contraindicated if the woman is a known GBS carrier
Woman with pre-term rupture of membranes: IAP should be given once labour is confirmed or induced irrespective of GBS status
Those with evidence of colonisation of GBS in the current pregnancy or in previous pregnancies and with a history of pre-term rupture of membranes may benefit from an expedited delivery at or more than 34 weeks of gestation

Bacteriological considerations

Swabs should be taken from the lower vagina and the anorectum. A single swab (vagina then anorectum) or two different swabs can be used
Specimens should be transported and processed as soon as possible, if processing is delayed, specimens should be refrigerated
Clinician should indicate that the swab is being taken for GBS on the request form. This is because Enriched culture medium tests are recommended for GBS

Antibiotics

Benzylpenicillin is the drug of choice: 3g iv stat. and 1.5mg every 4 hourly until delivery should be given
Woman has not had severe allergy to penicillin, a cephalosporin should be used. If there is evidence of severe allergy to penicillin, vancomycin should be used

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Who decline IAP

The baby should be very closely monitored for 12 hours after birth, discouraged from seeking very early discharge from the hospital

Adverse effects of IAP

Adverse effects of IAP
Anaphylaxis
Altered neonatal bowel flora
Abnormal child development

Vaginal cleansing

There is no evidence vaginal cleansing will reduce the risk of neonatal GBS disease

Management of baby if any concerns about early onset of neonatal infection

Management of baby if any concerns about early onset of neonatal infection
Abnormal behaviour (inconsolable crying or listlessness)
Unusually floppy
Difficulties with feeding or tolerating feeds
Abnormal temperature (lower than 36* C or higher than 38* C
Rapid breathing
Has change in skin colour

Remember to use the Sepsis Risk Calculator

Observation of the babies – who are at risk of EOGBS

Observation of the babies – who are at risk of EOGBS
Term babies who are clinically well at birth and whose mothers have received IAP for prevention of EOGBS disease more than 4 hours before delivery do not require special observation
The babies of women who have received broad spectrum antibiotics during labour for indications other than GBS prophylaxis may require investigation and treatment as per the NICE clinical guideline on early onset neonatal infection
Babies who are at risk of EOGBS disease whose mothers have not received adequate IAP need monitoring vital signs at 0, 1and 2 hours, and then 2 hourly until 12 hours

Babies with clinical signs of EOGBS disease

Babies with clinical signs of EOGBS disease should be treated with penicillin and gentamicin within an hour of the decision to treat

Previous baby with GBS disease

Babies of the mother who has had previous baby with GBS disease should be evaluated at birth for clinical indications of neonatal infection and have their vital signs checked at 0, 1 and 2 hours, and then 2 hourly until 12 hours

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Breast feeding

Breast feeding should be encouraged irrespective of GBS status

References: RCOG.ORG.UK, NICE.ORG.UK, BJOG.ORG.UK

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