Group B Strep (GBS) is a bacterium that lives very normally in the digestive and genital tracts of approximately ten to thirty percent of pregnant mothers. It may be transient, chronic, or intermittent. Rarely, mothers can become sick following the birth of their babies via an infection in their uterus or blood, if they are GBS carriers. Unborn babies can aspirate infected amniotic fluid which can lead to stillbirth, neonatal pneumonia, or sepsis. Mothers and unborn babies are rarely affected by GBS.

The primary concern is the risk GBS poses to your newborn. During birth, your baby can become exposed to the bacteria after the onset of labor or membrane rupture. Most babies do not become sick from GBS, but a small number (1-2%) do acquire a very serious GBS infection. The most common health problems associated with GBS infection in the newborn are hearing or vision loss, sepsis, pneumonia, meningitis, and brain damage. Some babies die.

**How do you test for GBS?**
The Center for Disease Control recommends that all pregnant women be screened near term, between their 35th and 37th week of pregnancy. Screening for GBS is a fast, simple procedure that women can do themselves. The test involved collecting vaginal and rectal secretions with a long cotton swab (similar to a Q-tip).

**What if my GBS screen is positive?**
This means you are a carrier of GBS. Your risk of having a baby with a GBS infection if not treated is 1 in 200. Of babies who become infected, some (15-30%) will suffer permanent neurological damage, and for some (5-22%) the infection is fatal.

It is not clearly understood why some babies become sick while others do not. We do know that several risk factors (listed below) are known to increase the risk of infection. However, 60% of all cases of GBS infection at birth occur in term babies with no risk factors:

- Preterm Birth (before 37 weeks)
- Prolonged rupture of membranes (more than 18 hours before birth)
- Fever during labor
- Baby who weighs less than 5 ½ pounds
- Prior baby with GBS infection
- GBS detected in the urine during pregnancy

**How is GBS treated?**
The Center for Disease Control (CDC) recommends treatment of all GBS-carriers in labor. The drug of choice is penicillin G, which would be administered through an IV every four hours until birth. The goal is to administer a minimum of two doses thirty minutes prior to birth. This practice will reduce, but not totally eliminate early GBS infection in all babies, reducing the incidence to 1/20,000.

**Without antibiotic treatment:**
- 1 in 200 chance of neonatal GBS disease
- 1 in 20 chance of neonatal GBS disease among GBS positive moms with a risk factor.

**With antibiotic treatment:**
- 1 in 4,000 chance of neonatal GBS disease with one dose of antibiotics
What risks are associated with antibiotic treatment?

Allergic reaction is always a risk when antibiotics are administered. Approximately one person in 10 will have a minor reaction, such as skin rash. About one in 10,000 will have a more serious reaction, which might include irritability, difficulty breathing, and convulsions. Another one in 100,000 will have a fatal reaction.

Some women develop a secondary yeast infection from the antibiotic and their newborns are then more susceptible to thrush from contact with the yeast. This can impact the breastfeeding relationship, although can be remedied through early detection, treatment and of course prevention through judicious use of probiotics during and following antibiotic treatment.

Widespread antibiotic use contributes to the increasing prevalence of antibiotic resistant “super-bugs,” which can potentially infect baby and of course, holds long-term consequences on a larger public health issue. Finally, there is a small risk of discomfort or bruising at the injection site.

Are there any alternative treatments?

Due to the growing concern over antibiotic resistant bacteria, many consumers, midwives, and researchers have begun to experiment with alternative GBS treatments. If you are interested in alternative GBS treatments your nurse-midwife can discuss these options with you. Please be aware that these treatments are not medically accepted treatments for GBS infection.

For more information:
http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5111a1.htm
http://www.aafp.org/afp/20030301/practice.html
http://www.gentlebirth.org/archives/gbs.html

I have read and understand the risks associated with Group B Streptococcus and the treatment modality/modalities I have chosen. I take full responsibility of the health of my child, and I will ensure that if my infant displays any symptoms of GBS infection, regardless of treatment modality, I will immediately have him/her evaluated by a local pediatric provider. I further understand that if I choose any treatment other than antibiotic therapy and transport becomes necessary, many hospitals will consider me untreated and initiate IV antibiotic therapy during labor and/or for my baby after s/he is born. This would likely include several days in the Neonatal Intensive Care Unit.

☐ I consent to screening and would like antibiotics administered during labor.
☐ I consent to screening, but if my culture is positive, I would like to discuss alternative options to treatment.
☐ I do not consent to GBS screening.

Mother’s signature  Date  RN or CNM  Date

up-dated August, 2011