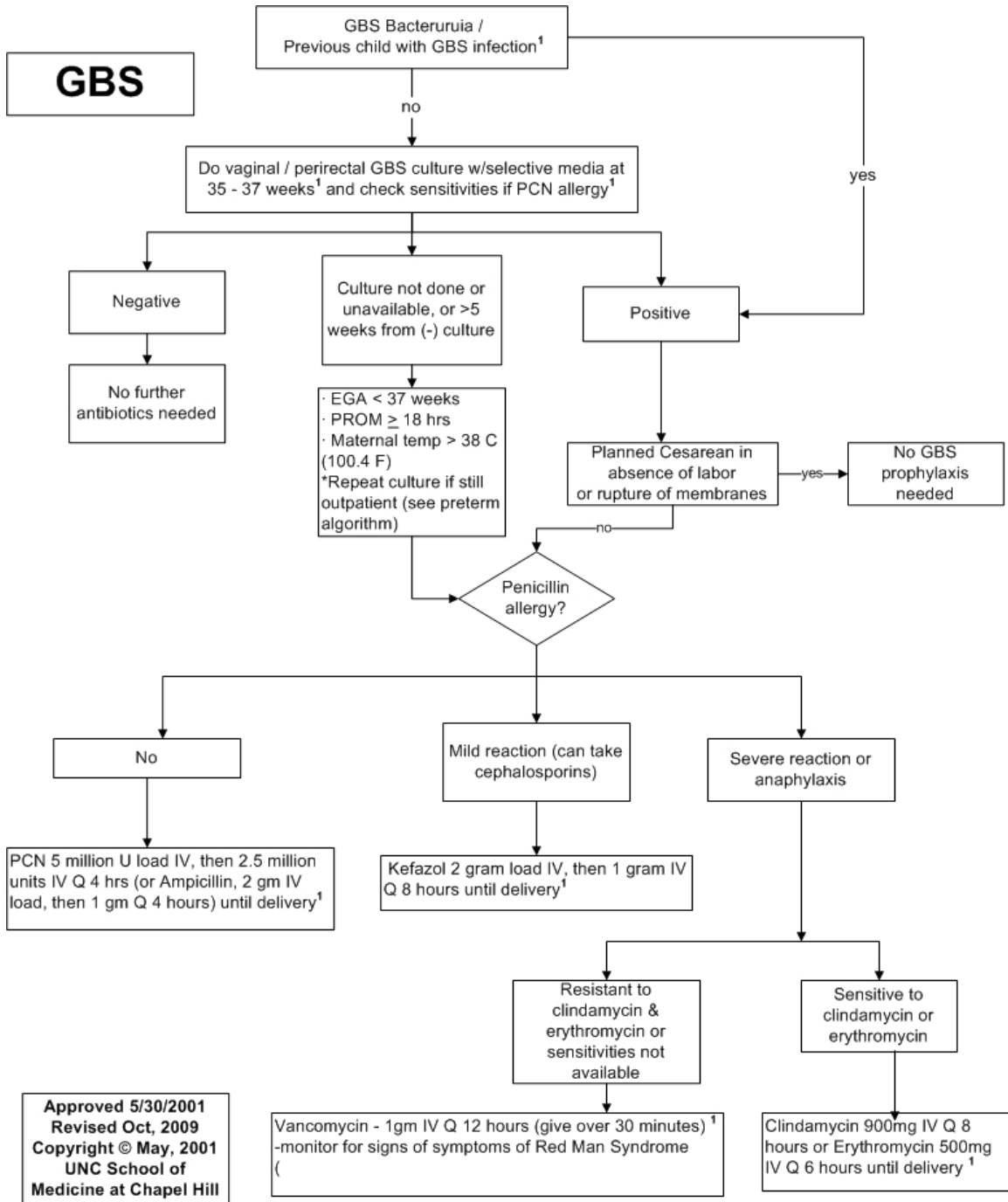


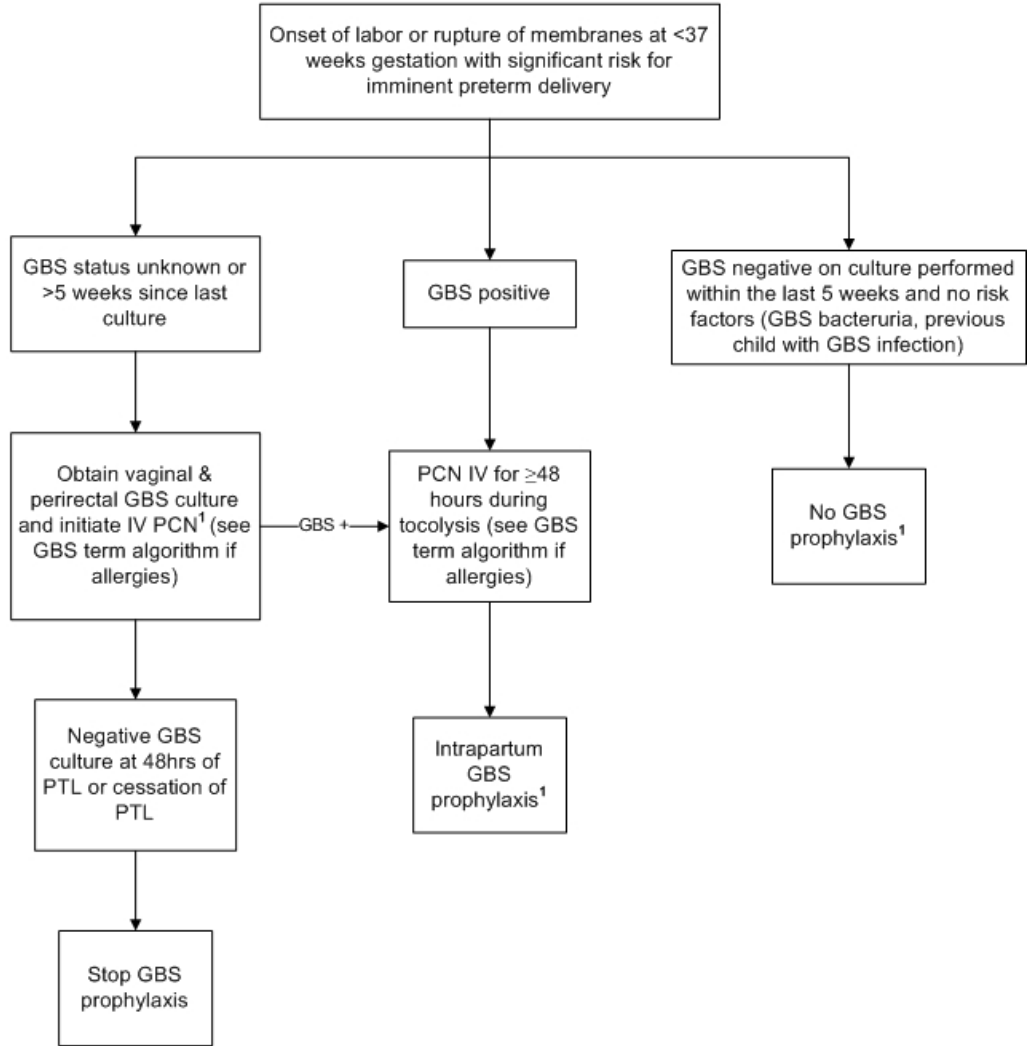
Group B Strep In Pregnancy

GBS Algorithm for Term Pregnancies



GBS Algorithm for Preterm Labor

GBS and Preterm Labor



**If a woman is screened early for GBS because of threatened preterm delivery but does not deliver within 4 weeks, she should be screened again for GBS colonization and managed according to the result of the repeated screening culture.¹

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References

- 1) **MMWR 2002;51:1-22.** Prevention of perinatal Group B streptococcal disease (revised guidelines from the CDC).

Women who have previously given birth to an infant with invasive GBS infection should receive intrapartum chemoprophylaxis; prenatal culture-based screening is not necessary for these women.

All pregnant women should be screened at 35 – 37 weeks' gestation for vaginal and rectal GBS colonization.

If the result of the GBS culture is not known at the onset of labor, intrapartum chemo prophylaxis should be administered to women with any of the following risk factors: gestation < 37 weeks, duration of membrane rupture \geq 18 hours, or a temperature of \geq 100.4 °F (\geq 38 °C).

Penicillin remains the agent of choice for intrapartum antibiotic prophylaxis. Ampicillin is an acceptable alternative, but penicillin is preferred because it has a narrower spectrum of antimicrobial activity and be less likely to select for resistant organisms.

Among penicillin-allergic women not at high risk for anaphylaxis, cefazolin, because of its narrow spectrum of activity and ability to achieve high intraamniotic concentrations, is the agent of choice for intrapartum prophylaxis.

For penicillin allergic women at high risk for anaphylaxis, testing of GBS isolates from prenatal screening for susceptibility to clindamycin and erythromycin is recommended if feasible.

Vancomycin should be reserved for penicillin-allergic women at high risk for beta-lactam anaphylaxis when clindamycin and erythromycin are not options because of in vitro resistance or unknown susceptibility of a prenatal isolate.

One of these agents (clindamycin or erythromycin) should be employed for intrapartum GBS prophylaxis if the screening isolate is susceptible.

For women not yet screened for GBS, a vaginal and rectal specimen for GBS culture should be obtained if time permits. If GBS screening culture results from the current pregnancy are not available and if onset of labor or rupture of membranes occurs before 37 weeks' gestation with a substantial risk for preterm delivery (as assessed by the woman's health-care provider), intrapartum antibiotic prophylaxis for GBS should be provided pending culture results.

If a negative culture result within the previous 4 weeks is on record, or if the clinician determines that labor can be successfully arrested and preterm delivery averted, antibiotics for GBS prophylaxis should not be initiated.

Regardless of management strategy chosen, these women should also receive intrapartum antibiotic chemoprophylaxis for GBS when labor likely to proceed to delivery occurs or recurs.

Previous data suggest that the accuracy of GBS screening cultures in predicting colonization status at delivery is greatest if the cultures are collected within 5 weeks of delivery. Therefore, if a woman is screened early for GBS because of threatened preterm delivery but does not deliver within 4 weeks, she should be screened again for GBS colonization and managed according to the result of the repeated screening culture

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Notification to Users

These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities.

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