

**Group B Streptococcus (GBS)**

**What is Group B Strep?** 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 respiratory distress syndrome, hearing or vision loss, sepsis, pneumonia, meningitis, and brain damage. Some babies do die from GBS infection.

**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 swab.

**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. Ampicillin is recommended for treatment and is 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

• 1 in 20,000 chance of neonatal GBS disease with two doses 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 “superbugs,” 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 midwife can discuss these options with you. Please be aware that these treatments are not the standard of care and are not medically accepted treatments for GBS infection.

**GBS Pre Screen Treatment**

The neonate contracting Group Beta Strep (GBS) from the mother is rare but concerning. If a client is positive, there should be limited internal vaginal exams during labor, no artificial rupturing of the membranes (AROM) without good reason such as imminent delivery, and especially no intrauterine pressure catheter (IUPC) or internal fetal monitoring (IFM). Logic dictates that if GBS is at the introitus then we shouldn't be pushing it up to the cervix.

This protocol is not designed to mask or skew the results of the test. It is designed to reduce the population of GBS in the mother’s body – it is preventive supplementation to avoid GBS and also works as a treatment for GBS.

Protocol for women who want to avoid colonization with GBS before the screen or who want to treat GBS if they do test positive:

**Take twice a day** (breakfast and dinner)

* Acidophilus - 4 billion cells per dose
* Echinacea - 350 mg capsules x2 caps
* Garlic - 580 mg capsules x2 caps
* Vitamin C - 500 mg w/200mg bioflavonoids
* Grapefruit seed extract - 15 drops or one capsule
* Zinc & Vitamin B-6 can also be added w/beneficial results

**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>



**Group B Streptococcus (GBS)**

**Informed Consent**

**Consent:**

Screening for GBS is controversial. Evidence is clear that GBS can impose risks to the baby. However, the GBS test itself imposes minimal risk and can assist you in receiving the best care possible. Based upon the information contained in this document, please indicate your decision regarding GBS testing below:

I have read and understand the information provided and have had an opportunity to ask questions. I have been provided resources for further education regarding Group B Streptococcus. I am fully aware of the risks of GBS and I understand why GBS screening is recommended. Growing Families is in no way liable for my decision and I have freely chosen to take the following action:

Initial next to the decision you have chosen:

\_\_\_\_\_\_\_I consent to GBS screening between 35 and 37 weeks of pregnancy

\_\_\_\_\_\_\_I REFUSE to do GBS screening

**Consent:** I have been advised that the standard of care for GBS treatment is IV antibiotics during labor every 4 hours. Other treatments for GBS are not medically accepted. Growing Families will in no way be liable for my decision of treatment. If my culture is positive for GBS, my decision regarding treatment is:

\_\_\_\_\_\_\_I would like to receive IV antibiotic treatment during labor per the standard of care

\_\_\_\_\_\_\_I REFUSE treatment

\_\_\_\_\_\_\_I request the use of chlorhexidine as a vaginal lubricant during labor and birth even though this method of treatment is not the standard of care and may not prevent my newborn from contracting GBS Infection.

Date of Consent: \_\_\_\_\_\_/\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_

Client’s Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Midwife’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_