

## GROUP B STREP (GBS) – Informed Choice Agreement

Group B Strep (GBS) is a type of bacteria that can be found in the genitals and/or lower intestines of 10-35% of all healthy adults. GBS is not the same bacteria as Group A Strep, which causes strep throat and other diseases. A person whose body carries GBS but who does not show signs of infection is said to be "colonized". GBS colonization is not contagious, and normally does not cause any problems. In fact, GBS are considered "normal" organisms in the human body. However, sometimes GBS can invade the body and cause serious infection, referred to as Group B Strep Disease.

GBS in Pregnancy. Among pregnant women, 5-35% are colonized, with higher rates found among white women under age 20. Most colonized women have no problems from the GBS, but in some cases the GBS can cause infections in pregnant women - in the uterus, in the amniotic fluid, in the urinary tract, and following a Cesarean Section. Such infections can make the woman sick, and can put her unborn baby at risk. For instance, a GBS infection of the urinary tract can increase the risk of premature birth. And an infection of the uterus or amniotic fluid can expose her baby to GBS. Exposure from their mothers causes 15% of newborns to be colonized with GBS, but **the vast majority of them have no problems from GBS.** Only 0.6 out of 1000 live births (.06-.4%) result in a baby with Group B Strep Disease, or approximately 8,000 babies each year in the U.S.

How Do Babies Get Sick from GBS? Typically, babies are exposed to GBS during labor and delivery. They may also be exposed after the mother's membranes rupture ("water breaks"). Babies can come in contact with Group B Strep if the bacteria travel upward from the mother's vagina into the uterus; they may also be exposed to it while passing through the birth canal. These babies can become infected when they swallow or inhale the bacteria. There is also evidence that GBS may cross intact membranes to expose the baby while it is still in the uterus. It is unclear why some babies get sick from GBS while the majority, while colonized, remain healthy. We do know that certain babies are clearly at more risk for GBS Disease than others, including premature babies, and babies with compromised immune systems.

Types of Group B Strep Disease. The majority (80%) of cases of GBS Disease among newborns occur in the first week of life. This is called **early onset disease.** Most of these babies are ill within a few hours after birth; most cases can be linked to a mother who is colonized with GBS. Babies who develop early onset disease may have one or more of the following: unstable temperature, breathing problems, grunting, fever, seizures, unusual change in behavior, stiffness, or extreme limpness. GBS Disease may also develop in infants one week to several months after birth. This is called **late onset disease.** About half of the cases of late onset disease can be linked to a mother colonized with GBS; in the remainder of cases, the source of infection is unknown, but may include poor hygiene practices in hospital or home. Meningitis is more common with late onset disease; the baby may develop the following signs: stiffness, limpness, inconsolable screaming, fever, refusal to eat.

GBS Disease is very serious for newborns. If a baby has symptoms of infection, they need to be evaluated immediately. Blood tests, cultures, and x-rays may help determine if a baby has GBS Disease. Despite antibiotic treatment after birth, GBS Disease is fatal in 5-15% of cases, and can cause permanent neurological damage such as hearing or vision loss, varying degrees of physical or mental disabilities, and cerebral palsy, in some of those who survive. The number of deaths are small - in the highest risk group, the chance of a baby dying of GBS disease is about 1 in 3,400. But for the families who are affected, the outcome is devastating. This is why it is important for you to have enough information about GBS to make a good decision for your own care.

Assessing Risk of GBS. Certain clinical risk factors, if found, put a baby at higher risk of developing GBS Disease. They are:

<i>Prenatal Risks:</i>	<i>Previous baby with GBS Disease</i>
	<i>Urinary tract infection from GBS at any time during the pregnancy</i>
<i>Labor Risks:</i>	<i>Onset of labor before 37 weeks pregnancy</i>
	<i>Rupture of membranes before 37 weeks pregnancy</i>
	<i>Rupture of membranes-more than 18 hours before birth</i>
	<i>Fever in mother over 100.4F during labor</i>

Certain combinations of factors seem to increase the likelihood of a baby developing GBS Disease. It is most likely to develop in babies whose mothers are carriers of GBS and who have one or more of the clinical risk factors listed above. Among these babies at highest risk, about **or 50 out of 1000 (5%)** will develop GBS Disease. Babies whose mothers are GBS carriers but have no clinical risk factors are less likely to develop GBS Disease - **or 5 out of 1000. (0.5%).**

Babies whose mothers have clinical risk factors but test negative for GBS are even less likely to develop GBS Disease - **about 1 in 1000 (0.1%).**

Babies whose mothers have neither risk factors nor a positive GBS culture have a very small chance of getting GBS Disease - **about 1 in 3000 (0.033%).**

Screening and treatment for Group B Strep in Pregnancy

The American College of Obstetricians and Gynecologists Protocol & Centers for Disease Control protocol is as follows: Perform vaginal/rectal cultures on all women at 35-37 weeks pregnant and treat with IV penicillin antibiotics every four hours during labor (if culture is positive). This protocol is **not** 100% effective in eliminating GBS disease, nor has it been adequately clinically tested (BIRTH 23:1. March 1998)

The most serious risk of antibiotic treatment is the possibility that you could have an allergic reaction to the medication. **Penicillin** is the most effective treatment, and is definitely the preferred antibiotic to use. However, even in people with no known allergy to penicillin, for every 10,000 people who receive the drug, one will have a fatal allergic reaction and another 70-1,000 will have a reaction that is less serious (fever, hives, itching, vomiting, coughing and/or mild respiratory difficulty). **Severe complications resulting in permanent disability can occur in the baby even when the reaction in the mother is not life threatening.**

Another risk of antibiotic treatment arises from the fact that widespread use of antibiotics increases that chance that drug-resistant strains of a particular organism will develop. From a public health perspective, it is important to avoid overuse of antibiotics. In the case of GBS, only a few cases of drug-resistant infection have been reported so far. Check out <http://evidencebasedbirth.com/groupbstrep/> for more information about GBS treatment options.

Alternative ways of handling risk of GBS Disease include:

- Using herbal antibiotics such as propolis and immune boosters such as Echinacea prophylactically during the last four weeks of pregnancy.
- Cleansing the intestines with 2 tbsp. of Chlorophyll per day along with 1500mg of Propolis capsules 3 times per day starting at 36 weeks.
- Using antibiotic herbal vaginal suppositories.
- Douching with hibiclens at the end of pregnancy and/or a vaginal wash of hibiclens in labor.

**YOUR CHOICES.** It is your right, and responsibility as a pregnant woman to choose how to handle the issue of GBS. Rather than imposing a particular protocol on every client, Rosehip Midwifery creates a unique management plan for each woman based on her wishes. Please select from the options listed below (and discussed above) as your preferred management of GBS:

\_\_\_ I choose to be screened for GBS by my midwife between week 35 and 37 of my pregnancy.

\_\_\_ I choose to decline the screening for GBS during my pregnancy.

**If I choose to be screened for GBS and my culture is positive I understand that no treatment is 100% effective at preventing GBS disease in my baby. My decision for treatment is:**

\_\_\_ I decline any treatment for GBS at this time.

\_\_\_ I desire antibiotic treatment during labor only if I present with risk factors (rupture of membranes for longer than 18 hours, fever greater than 100.4°F in labor, known GBS urinary tract infection, and/or preterm labor).

\_\_\_ I desire antibiotic treatment during labor regardless of my risk status.

\_\_\_ I choose the following alternative management (check all that apply):

- \_\_\_ Herbal vaginal suppositories
- \_\_\_ Vaginal wash of Hibiclens in labor.
- \_\_\_ Cleansing the intestines with 2 tbs. of Chlorophyll 2 times per day.
- \_\_\_ Douching with Hibiclens in the last weeks of pregnancy
- \_\_\_ Prophylactic use of herbal antibiotics

**I have read and understand the information presented above regarding GBS screening and treatment and my questions/concerns have been addressed to my satisfaction.** I understand the benefits and risks associated with GBS screening and treatment. I take full responsibility for the health of myself and my child. I further understand that if I choose any treatment other than antibiotic therapy and transport becomes necessary, many hospitals will consider me to be untreated and initiate IV antibiotic therapy for me during labor and/or for my baby after he/she is born.

Client \_\_\_\_\_ date \_\_\_\_\_ Midwife \_\_\_\_\_ date \_\_\_\_\_