

Group Beta Streptococcus

What is GBS?

GBS (also known as “Group B Strep,” “Strep B,” or “Beta Strep”) is a bacteria that lives in the intestines of normal, healthy people without causing disease. About 25% of women will also carry GBS in the vagina. GBS is transient – that is, it can come and go. GBS does not pose a health risk to the pregnant woman.

Why are we concerned?

While GBS is not dangerous for the pregnant woman, a small percentage of babies will pick up the bacteria during labor or birth and can become ill. Early-onset infection (within the first week of life) is a very serious condition. Of the babies who develop this infection, approximately 5% die and approximately 25% have lifelong injuries such as hearing loss, vision loss, or learning disabilities.

How do we test for GBS?

Because GBS can come and go, the Centers for Disease Control (CDC) recommends screening at 35-37 weeks, as close to delivery as possible while still allowing time to receive results. Of women who test positive, approximately 56% will still have GBS in the vagina at the time of delivery. Of the women who test negative, approximately 2% will have GBS in the vagina at the time of delivery. The closer the test is to the time of delivery, the more accurate the results are.

The test for GBS involves a swab which is first inserted into the vagina approximately 2cm and then inserted just past the anus. You can do this yourself, or you can ask the midwife to do it for you. This swab is then sent to the lab for culturing.

How is it treated?

Oral antibiotics are not effective in treating GBS. The recommendation from the CDC is that women who screen positive receive IV antibiotics in labor. Currently penicillin is the standard drug used for treatment; for women who are allergic to penicillin, other drugs are available. The goal is to administer at least 2 doses of penicillin by IV, 4 hours apart. This can be done without attaching a permanent IV line in labor, if you desire.

Rates of early-onset GBS infection without treatment (for infants born at or beyond 37 weeks):

For all mothers (this is your presumed risk if you choose to decline screening)	1:3000
In mothers who test positive and have no additional risk factors	1:770
In mothers who test positive and have >18 hours of ruptured membranes	1:150
In mothers who test positive and have a fever in labor	1:20

Rates of early-onset GBS infection with treatment (for infants born at or beyond 37 weeks):

In mothers who test positive and have no additional risk factors, after 2 doses of antibiotics	1:100000
In mothers who test positive and receive less than two doses of antibiotics in labor	1:80000
In mothers who test positive and have >18 hours of ruptured membranes	1:17000
In mothers who test positive and have fevers in labor	1:4000

Risks of following CDC guidelines

- 2% of women who screen negative will be positive at the time of birth. Practitioners often manage situations differently based on screening results, which may be risky for these women.
- 44% of women who screen positive will be negative at the time of birth. For these women, treatment would be unnecessary. Unfortunately, we have no better way to screen at this time.
- If more than 10 doses of antibiotics are required, the risk of antibiotic-resistant infection in the newborn rises.
- There is a risk of allergic reaction to the antibiotic, most often involving minor irritation but very rarely (approximately 1:100000) involving life-threatening anaphylaxis.