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Body Wise Birth Services
Childbirth Education & Doula Training

Group B Streptococcus testing...

What Does The Research Really Say?

Most pregnant women have heard of Group B Streptococcus, but unfortunately know little true information about the condition and the real risks involved. All pregnant women are screened between weeks 35 and 37 of their pregnancies to determine if they are carriers of GBS by taking a swab of the vaginal and rectal areas. About 30% of pregnant women are found to be colonized with GBS in one of both areas.

The recommended treatment is intravenous antibiotics during birthing because GBS can be passed from you to the baby during delivery and cause sepsis (a blood infection), pneumonia, and/or meningitis (an infection of the fluid and lining of the brain).

WHY WOULDN'T A MOTHER CHOOSE ANTIBIOTICS?

To answer this question, we need to look at what GBS truly is and why it might not be such a good idea to recommend that a third of all pregnant women expose themselves and their babies to antibiotics from birth.

GBS is a bacterium that normally lives in the intestinal tracts of many healthy people. In truth, you should never be termed "GBS infected" but rather "GBS colonized". Remember that the intestinal tract is composed of normal healthy bacteria, including GBS. It is usually a transient condition that will come and go through your pregnancy. You may swab positive at 36 weeks, only to be negative again at 38 weeks.

GBS can cause problems only when it is present in the genital area during birthing and delivery. When this happens, there is a very small risk that the bacteria will be passed on to the baby and become sick. Approximately 0.0225% of women found to be GBS+ at 35 to 37 weeks who aren't treated with antibiotics will have a baby who becomes ill. That's 1 in 4444 babies who will become ill.

But here's the most important point: in women who do receive antibiotics, 0.0225% of babies will go on to become ill from GBS. That's also 1 in 4444 babies who will become ill.

Antibiotics make absolutely no difference in the number of babies who will die from GBS.

There are many reasons you may choose antibiotics for Group B Streptococcus. these include:

• Increasing occurrence of antibiotic-resistant infections ("superbugs" - think MRSA)
• Use of antibiotics has increased risk of developing other infections (sepsis & E. Coli included)
• Colonization of GBS is a poor indicator of which babies will become ill
• Antibiotics fail to prevent infection in 30% of cases

The most-commonly used antibiotic for treating Group B Streptococcus during birthing is penicillin. Fewer bacteria currently show a resistance to penicillin than to other antibiotics used to treat GBS. Ampicillin and amoxicillin are virtually worthless for treating GBS due to overuse that has now made Group B Streptococcus resistant to them. It's only a matter of time until penicillin is also ineffective against GBS. The superbug is on its way.

If you are allergic to penicillin, your options decrease. 29% of Group B Streptococcus strains are resistant to non-penicillin antibiotics. If you don't know if you're allergic or even if you've had it in the past, there's a 1/10 chance of a mild reaction such as a rash, and a 1/10,000 chance of anaphylaxis, a life-threatening allergic reaction.

Two in 10,000 babies may be saved by antibiotics during birth, but this comes at the cost of giving 1/3 of all pregnant women antibiotics. The risks of developing a superbug are greater than the chances of saving your baby with antibiotics. This also doesn't take into account how many other infections babies given antibiotics may develop other than Group B Streptococcus.

WHAT ARE THE RISK FACTORS FOR MOTHERS WITH GBS?

There are three significant factors that place your baby at increased risk of infection: fever during birthing, water breaking 18 hours or more before birthing (prolonged rupture of membranes, or PROM), and/or birthing or broken water before 37 weeks. Other factors that can contribute to a newborn's risk of contracting Group B Streptococcus infection include age, ethnicity, and medical criteria, such as the following: being born to a mother who is less than 20 years old, large amounts of GBS bacteria in the vaginal tract, and having a previous baby with GBS disease.

WHAT ARE THE SYMPTOMS OF GBS INFECTION IN A BABY?

There are two forms of Group B Streptococcus infection: early and late onset. In early-onset GBS disease, your baby will become ill within seven days of birth. In severe early-onset GBS infection, about 6 percent of babies will die from complications of the infection. Full-term babies are less likely to die; 2-8% suffer fatal complications. Premature babies have mortality rates of 25-30%. Late-onset GBS infection is more complicated and may not have anything to do with whether you had GBS during birthing. It occurs between seven days and three months of age.

Symptoms of early-onset Group B Streptococcus infection include any of the following: fever or abnormally low body temperature, jaundice (yellowing of the skin and whites of the eyes), poor feeding, vomiting, seizures, difficulty in breathing, swelling of the abdomen, and bloody stools. The most common symptom is difficulty breathing, which is also the most common complication in babies whose mothers choose drugs during birthing. Since these symptoms can occur in so many circumstances not related to GBS, a C-Reactive protein test can be given to a symptomatic baby to reveal the presence of an active infection.

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ARE THERE ALTERNATIVES TO ANTIBIOTICS?

Even though Group B Streptococcus is a transient (it comes and goes) infection, without an active effort to eradicate the GBS colonisation, it is likely that you will still be colonized after 37 weeks. We will see better outcomes by simply focusing on reducing colonization rather than treating it after the fact.

There are many pro-biotic, natural remedies that focus on restoring a healthy vaginal flora balance, reducing bacterial overgrowth, and directly reducing the bacterial concentration. These treatments can begin at 32 weeks rather than waiting for a positive culture.

Another option is to NOT screen for beta strep during pregnancy, but to follow a strict protocol during birthing if you have the following risk factors: 1) fever over 38 degrees Celsius, 2) pre-term birthing < 37 weeks, 3) prolonged rupture of membranes > 18 hours, 4) multiple births, and 5) previously-infected baby. In these cases antibiotics may be indicated. Those infants who are symptomatic (fever, fast breathing, poor feeding, high pitched cry) can be evaluated for sepsis and given antibiotics for 48-72 hours. Alternately, you can request a C-reactive protein test to determine the presence of an active infection before giving antibiotics to the baby.

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