What is Group Beta Strep (GBS) Disease and how common is it?
The GBS bacterium is the most common cause of blood infection and meningitis in newborns. GBS infection also causes newborn pneumonia and is more common than other, better known, newborn problems such as rubella, congenital syphilis, and spina bifida. The CDC states that on average, about 1,200 babies in the U.S. less than one week old get early onset GBS disease each year. Care for these sick babies have improved in the U.S., and currently 4-6% of babies with GBS infections die (48-72 babies per year). GBS can also cause miscarriage, stillbirth, and preterm delivery. About 4 million babies are born in the U.S. each year, so the statistical chance of a baby having a fatal infection is less than 1 out of 250,000 births. Death from GBS infection is significantly less than the rate for maternal mortality associated with birth, which is 1 out of 4,800. Because of the use of antibiotics in labor for GBS positive women, the rate of GBS infection and death in newborns has been reduced by 86%-89%. Babies that survive a serious GBS infection, particularly those who have meningitis, may have long-term problems, such as hearing or vision loss or learning disabilities. In pregnant women, GBS can cause urinary tract infections, uterine infections, and stillbirth. Approximately 15% of the clients we serve will test positive for GBS. Most of the information in this Group Beta Strep Informed Choice document was written referencing research cited in the CDC’s Prevention of Perinatal Group B Streptococcal Disease 2010 Revised Guidelines, which may be found online on the CDC’s website at www.cdc.gov. I encourage you to read the CDC’s 2010 Guidelines in its entirety, as well as do your own research.

Who is screened for GBS and when?
GBS testing during pregnancy is the standard of care in the United States. The CDC recommends testing between 35-37 weeks of pregnancy. At this time, a swab is used to culture the vagina and rectum (performing the test is simple, and you can easily obtain this culture yourself during our 36 week home visit). These cultures are approximately 90% accurate in predicting who will be GBS + at delivery. A positive result will detect who has an active GBS colonization, not who will become ill. GBS can also come and go, so being positive at 36 weeks does not guarantee a colonization at delivery. Likewise, being negative at 36 weeks does not guarantee GBS negative status at delivery and screening will not catch 100% if colonization. More than 60% of early onset GBS cases have occurred among infants born to women who had a negative GBS culture.

I have tested positive for GBS. What are my options?
The CDC states: “Currently available GBS prevention strategies will not prevent all cases of early onset GBS disease”.

It is important to understand that there is no treatment that will give a 100% guarantee that your baby will not develop GBS disease. Any option is merely meant to help minimize risks.

What if I have GBS in my urine?
GBS can be found in the urine of 2%-7% of pregnant women. This signifies a heavy genital tract colonization and is associated with increased risk for early onset GBS disease in the newborn. Antibiotics to treat GBS during pregnancy will not eliminate GBS completely from the genitourinary and gastrointestinal tracts and recolonization afterward is typical. Studies have found that some women with GBS bacteriuria during the first trimester might not have vaginal-rectal colonization at 35-37 weeks or at the time of delivery. However, anytime GBS is found in the urine, there is an increased risk for early onset GBS.

What about prevention?
As the saying goes “An ounce of prevention is worth a pound of cure”. GBS starts in the gastrointestinal tract and a healthy GI can help to reduce colonization of the streptococcal bacteria. We recommend avoiding processed foods (this being one of many reasons), adding probiotics to increase healthy gut flora, and making fresh garlic a staple in the kitchen. It is also proactive to incorporate coconut oil, organic plain yogurts and Kefir, and foods naturally high in Vitamin C into your diet.
Who is at increased risk for GBS disease?
Pregnant women with the following conditions are at higher risk of having a baby with GBS disease:
- Previous baby with GBS disease
- Urinary Tract infection due to GBS
- Miscarriage late in pregnancy
- Fever during labor
- Rupture of membranes 18 hours or more before delivery
- Labor or rupture of membranes before 37 weeks

GBS COLONIZED women at high risk are those with the following conditions:
- Fever >100.4 during labor
- Rupture of membranes 18 hours or more before delivery
- Labor or rupture of membranes before 37 weeks

COLONIZED women who do NOT develop ANY of the above complications have a relatively low risk of delivering an infant with GBS disease. Therefore, the decision to take antibiotics during labor should balance risks and benefits. Antibiotics are very effective at preventing GBS disease in the newborn and are considered generally safe. To summarize risks:
- 1-2 in 100 chance of delivering a baby with GBS disease if no antibiotics are given.
- 86%-89% reduction in risk of delivering a baby with serious GBS infection if antibiotics are given.
- 4 in 100 chance of experiencing a mild allergic reaction to antibiotics.
- 1 in 2,500 to 1 in 25,000 chance of developing a severe allergic reaction to antibiotics.
- Antibiotics in labor double risk of postpartum yeast infections.

Warning Signs of GBS infection in the newborn:
The typical signs of GBS infection in a newborn baby include grunting, poor feeding and/or vomiting, lethargy, low blood pressure, irritability, abnormally high or low temperature, higher breathing and heart rates, and/or impaired consciousness. Warning signs of meningitis may also include: shrill or moaning cry or whimpering, dislike of being handled, fretful, tense or bulging soft spot, involuntary body stiffening or jerking movements, floppy body, blank staring or trance-like expression, turning from light, and/or pale or blotchy skin. A baby presenting with any of these symptoms should be seen immediately by a pediatrician. GBS infection is rare after one month of age and virtually unknown after three months.

Informed Choice:
The advantage of testing is that we can then know to do preventative treatment. My midwife, Rachel Chandler CPM-TN, can test for GBS colonization and offer methods to reduce newborn exposure before delivery, including giving antibiotics in labor. I understand that there is no “perfect” answer for GBS testing and treatment and that no screening or prophylactic treatment is 100% effective in preventing all GBS disease. I have read this informed choice document and have had the opportunity to ask questions and research for myself. I feel as though I am making an informed decision regarding GBS testing.

GBS SCREENING:
O I would like to be screened for GBS.
O I DO NOT wish to be screened for GBS.

If GBS POSITIVE:
O I decline the CDC recommended treatment of IV antibiotics in labor if I am GBS positive. I understand that in the absence of any intervention, the risk for GBS infection for my baby is 1-2%.
O I choose to follow the CDC recommendation of antibiotics in labor if I am GBS positive.

Client Signature:________________________________________________________ Date:____________
Partner Signature:_______________________________________________________ Date:____________
Midwife Signature:_______________________________________________________ Date:____________