ment is not effective in eliminating carriage or preventing neonatal disease and can cause adverse consequences (DI). • Intrapartum antibiotic prophylaxis to prevent early-onset GBS disease is not recommended as a routine practice for cesarean deliveries performed before labor onset on women with intact amniotic membranes, regardless of the GBS colonization status of the woman or the gestational age of the pregnancy (CIII). The use of perioperative prophylactic antibiotics to prevent infectious complications of cesarean delivery should not be altered or affected by GBS status. Women expected to undergo cesarean deliveries should undergo routine vaginal and rectal screening for GBS at 35–37 weeks’ gestation because onset of labor or rupture of membranes can occur before the planned cesarean delivery, and under those circumstances GBS-colonized women should receive intrapartum antibiotic prophylaxis (AII). • Health-care providers should inform women of their GBS screening test result and the recommended interventions (BIII).

The following key changes were made from the 2002 guidelines:

• Guidance regarding cesarean deliveries performed before onset of labor on a woman with intact amniotic membranes is clarified as applying to cesarean deliveries performed at any gestational age (CIII).

• In settings in which NAAT for GBS is available, obstetric providers can choose to perform intrapartum testing of vaginal-rectal samples from women with unknown GBS colonization status and no intrapartum risk factors (temperature of ≥100.4º F [≥38.0ºC] or rupture of amniotic membranes ≥18 hours) at the time of testing and who are delivering at term (CII). If an intrapartum risk factor subsequently develops, antibiotic prophylaxis should be administered regardless of the intrapartum testing results (AIII).

• Women with positive intrapartum NAAT results for GBS should receive antibiotic prophylaxis (AII). NAAT testing is optional and might not be available in all settings.

Threatened Preterm Delivery

Women admitted with signs and symptoms of preterm labor (before 37 weeks and 0 days’ gestation) should be managed according to the algorithm provided (Figure 5). Women with rupture of membranes at <37 weeks and 0 days’ gestation should be managed according to the algorithm provided (Figure 6).

The following are key components of threatened preterm delivery GBS management:

• Women admitted with signs and symptoms of labor or with rupture of membranes at <37 weeks and 0 days’ gestation should be screened for GBS colonization at hospital admission unless a vaginal-rectal GBS screen was performed within the preceding 5 weeks (AII).

• Women admitted with signs and symptoms of preterm labor who have unknown GBS colonization status at admission or a positive GBS screen within the preceding 5 weeks should receive GBS prophylaxis at hospital admission (AII).

• Antibiotics given for GBS prophylaxis to a woman with preterm labor should be discontinued immediately if at any time the patient is considered not to be in true labor, discontinue GBS prophylaxis.** If GBS culture results become available prior to delivery and are negative, then discontinue GBS prophylaxis.†† Unless subsequent GBS culture prior to delivery is positive. §§ A negative GBS screen is considered valid for 5 weeks. If a patient with a history of PTL is re-admitted with signs and symptoms of PTL and had a negative GBS screen >5 weeks prior, she should be rescreened and managed according to this algorithm at that time.

FIGURE 5. Algorithm for screening for group B streptococcal (GBS) colonization and use of intrapartum prophylaxis for women with preterm* labor (PTL)

* At <37 weeks and 0 days’ gestation.

† If patient has undergone vaginal-rectal GBS culture within the preceding 5 weeks, the results of that culture should guide management. GBS-colonized women should receive intrapartum antibiotic prophylaxis. No antibiotics are indicated for GBS prophylaxis if a vaginal-rectal screen within 5 weeks was negative.

§ See Figure 8 for recommended antibiotic regimens.

‡ Patient should be regularly assessed for progression to true labor; if the patient is considered not to be in true labor, discontinue GBS prophylaxis.

** If GBS culture results become available prior to delivery and are negative, then discontinue GBS prophylaxis.

†† Unless subsequent GBS culture prior to delivery is positive.

§§ A negative GBS screen is considered valid for 5 weeks. If a patient with a history of PTL is re-admitted with signs and symptoms of PTL and had a negative GBS screen >5 weeks prior, she should be rescreened and managed according to this algorithm at that time.

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