

Tree of Life Midwifery Care  
Lisa Black – LM, CPM  
214-394-5687

## **Group B Streptococcus Informed Consent/Refusal**

### **What is it?**

Group B Streptococcus (GBS) is a bacterium that can be carried in the genital, urinary, digestive, and respiratory tracts. Up to one third of all adults carry GBS in their intestines, and one in four women carry it in their vaginas. Frequently, those who are carriers are asymptomatic (without symptoms) so often they do not realize that they are colonized. However, during pregnancy, birth and the postpartum period, GBS can cause serious problems for both mom and baby.

### **What effect does it have?**

Prenatally, women with GBS have a higher incidence of urinary tract infections, premature rupture of the amniotic membrane (bag of water) and chorioamnionitis (infection of the amniotic membrane). Although urinary tract infections can be treated with antibiotics or alternative therapies, infection or rupture of the amniotic sack can cause premature birth or even fetal death.

Although the overall GBS neonatal infection rate is only 0.18% (1.8/1000 live births), GBS is the most common cause of sepsis (blood infection), pneumonia and meningitis (infection of the fluid and lining surrounding the brain and central nervous system) in the newborn. The rate of infection increases to 0.5% (5/1000 live births) for babies born to mothers who are known to be colonized with GBS but who are without symptoms, and up to 4% (40/1000) for babies born to mothers who are colonized and have symptoms.

Most cases of neonatal GBS infections (75%) occur during the first week of life (early-onset), and most of these are apparent a few hours after birth. These occurrences can be directly attributed to exposure of the baby during birth to GBS colonization in the mother. The remaining 25% develop after the first week of life (late-onset), and frequently cause meningitis. Only about half of the late-onset infections can be attributed to exposure to colonization of the mother, leaving the source of the other half unknown. The mortality (death) rate for the infected newborns is 5-20%, and babies that survive, particularly those with meningitis, may have long-term problems such as hearing or vision loss or learning disabilities.

Postpartum, women with GBS have a higher incidence of endometritis (infection of the uterine lining) and puerperal sepsis (blood infection related to the birth).

### **How do I know if I have it?**

Testing policies vary, but if you have had a urinary tract infection caused by GBS, or if you have ever delivered a GBS-positive baby, you are considered to be positive for GBS. Otherwise, GBS colonization can be detected during pregnancy by a culture grown from a vaginal/rectal swab. To most accurately predict a woman's GBS status for delivery, the Centers for Disease Control recommend that the swab be taken between the 35<sup>th</sup> and 37<sup>th</sup> week of pregnancy. Being positive means you are colonized with GBS and at risk of transmitting the disease to your newborn, particularly if you have a fever during labor, if your membranes are ruptured for more than 18 hours before delivery, or if you have preterm (before 37 weeks) labor or rupture of membranes.

### **What can I do if I have it?**

Some care providers prescribe oral antibiotics for women with positive cultures, but studies show that prenatal oral antibiotics do not reliably prevent re-colonization of the mother once the treatment is finished, and therefore do not protect the newborn from GBS exposure. The administration of intravenous (or intramuscular) antibiotics such as Ampicillin, Amoxicillin or Erythromycin during labor has been found to be more effective (although not 100% effective) in preventing newborn GBS.

However, antibiotics also may pose a threat to mother or baby, and some reactions may be life threatening. Therefore, any decision to take antibiotics should include consideration of the risk factors associated with antibiotics, especially since women who are colonized with GBS but do not develop any symptoms are at a relatively low risk (0.5%) of delivering a baby with GBS disease. Statistically, 10% (100/1000) of people who receive antibiotics experience a mild allergic reaction (such as a rash), 0.01% (1/10,000) experience a mild anaphylactic reaction, and 0.001% (1/100,000) experience a severe anaphylactic reaction resulting in death. Although it is uncommon, an unborn baby can experience a severe reaction even if the mother's reaction is not life threatening.

**What other options do I have?**

Experiential data has shown several alternative treatments to be effective in combating GBS colonization thereby minimizing infant exposure. These include an oral garlic/echinacea herbal regimen, intra-vaginal use of garlic oil capsules, tea tree vaginal suppositories, and homeopathic treatment. However, because these are non-medical treatments, there is no statistical data to support their effectiveness.

In addition, there is a new protocol being tested that calls for the use of chlorohexidine (Hibicleanse) as a vaginal lubricant during labor. This surgical wash has proven effective against streptococcal bacteria in dental use, and has been used as a bactericide in obstetrics and surgery for many years. Some individuals experience a mild allergic reaction to chlorohexidine, usually in the form of a mild rash, but severe reactions are extremely rare, and no adverse effects to the newborn have been noted.

**Consent for GBS screening:**

- I have a history of GBS and will forego screening and assume that my GBS status remains positive
- I consent to GBS screening between 35 and 37 weeks of pregnancy
- I do not consent to GBS screening

**If my culture is positive for GBS, my decision regarding treatment is:**

- Refuse treatment
- Request the use of chlorohexidine as a vaginal lubricant during labor
- Oral herbal treatment beginning week 37 or as soon after as I am informed of my GBS-positive status
- Intravaginal herbal treatment beginning week 37 or as soon after as I am informed of my GBS-positive status
- Homeopathic treatment as recommended by my homeopathic healthcare provider
- Antibiotic treatment during labor
  - I have never had a reaction to antibiotic treatment.
  - I have previously had a reaction to antibiotic treatment.

Antibiotic(s)/Reaction(s): \_\_\_\_\_  
\_\_\_\_\_

I have read and understand the risks associated with Group B Streptococcus and the treatment modality/modalities I have chosen. I take full responsibility for the health of my child, and I will ensure that if my infant displays any symptoms of GBS infection, regardless of treatment modality, I will immediately have him/her checked by a healthcare provider with pediatric expertise. 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.

\_\_\_\_\_  
Signature of Client Date

\_\_\_\_\_  
Signature of Guardian (if Client is a minor) Date