**ACOG Comimittee Opinion**

**Prevention of Group B Strep, Early-Onset Disease in Newborns**

GBS is the leading cause of newborn infection. The primary risk factor is \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The prevalence of vaginal or rectal colonization in pregnant women is between \_\_\_\_\_\_ and \_\_\_\_\_\_\_

Associated with preterm labor and stillbirth, stronger association of preterm birth with \_\_\_\_\_\_\_\_\_\_\_\_

GBS early onset disease is characterized by sepsis, pneumonia, and less frequently meningitis, manifest within\_\_\_\_\_\_\_\_\_\_\_\_after birth

What GA do you collect the GBS swabs, and how do you collect a GBS swab appropriately?

How long is the test good for?

Risk Factors of developing GBS EOD

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Treat or Not treat intrapartum antibiotics?

1. 36 4/7 GBS positive status
2. G2P1001 at 38 3/7 with unknown GBS status in this pregnancy but previous pregnancy was GBS positive
3. G3P1011 at 39 0/7, with scheduled repeat C section, GBS unknown. Intact membranes
4. G1P0 with GBS bacteruria of >105,000, but negative GBS status—would you treat this?
   1. If culture was <105,000 colony, what is the treatment for antepartum vs while in labor?
5. PPROM at 35 2/7, not likely in imminently deliver, GBS status unknown
6. G2P1001 at 36 6/7 initially with scheduled c section due to breech at 39 weeks. GBS positive, she comes in with ROM, and baby still found to be breech.
7. G4P2012 currently at 41 6/7, GBS swab collected at 35 6/7, previously GBS negative
8. G1P0 at 38 0/7, GBS unknown, laboring for 2 days, ruptured for 21 hours
9. History of previous child with GBS early onset disease
10. Laboring mom, GBS negative, develops fever of 100.6F

Of those newborns not treated with intrapartum antibiotic prophylaxis, \_\_\_\_\_\_\_\_\_\_\_\_\_\_ will develop GBS EOD.

It is considered adequate treatment after \_\_\_\_\_ hours with GBS prophylaxis antibiotics prior to delivery.

GBS positive mom with history of urticaria rash when given PCN. What are the treatment options?