University of Michigan
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GBS Intrapartum Antimicrobial Prophylaxis & Newborn Management Algorithm

Perinatal Joint Practice

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Table 1. Indications for Intrapartum Prophylaxis
(see table 3) **[A] [B] [G]**

1. Positive maternal GBS culture AT ANY POINT during THIS pregnancy
2. GBS bacteriuria during current pregnancy
3. Prior infant with GBS disease
4. GBS status unknown within 5 weeks of delivery AND either:
   -- <37 wks GA with onset of labor OR
   -- ROM >18 hours

Table 2. Intrapartum Prophylaxis Not Indicated [F]

1. Negative vaginal/rectal GBS ≤ 5 weeks in the current pregnancy, regardless of intrapartum risk factors (except maternal GBS bacteriuria)
2. Planned cesarean delivery performed in the absence of labor or ruptured membranes, regardless of maternal GBS status and regardless of gestational age.
3. Previous pregnancy w/ positive vaginal/rectal GBS but current pregnancy negative vaginal/rectal GBS ≤ 5 weeks.
4. In those cases where vaginal/rectal GBS was negative and IT IS > 5 weeks SINCE TEST, and >37 wks GA, and onset of labor
5. If GBS unknown, no prophylaxis, refer to Early Onset Sepsis calculator

Table 3. Recommended Regimens for Perinatal Disease Prevention

Regimens	Antimicrobial
Recommended	**Penicillin G** 5 million units IV initial dose, then 2.5 million units IV every 4 hours until delivery
Alternative	**Ampicillin** 2 grams IV initial dose, then 1 gram IV every 4 hours until delivery
If penicillin allergic:	
Low Risk or Medium Risk **[D]**	**Cefazolin** 2 grams IV initial dose; 3 grams if > 120kg, then 1 gram IV every 8 hours until delivery
High Risk **[E]**	**Clindamycin** 900 mg IV every 8 hours until delivery (if susceptible)**[C]** or **Vancomycin** 20 mg/kg every 8 hours until delivery MAX 2 grams per dose; Goal trough: 10-15 mcg/mL **[C]**

Footnotes

[A] When the diagnosis of **chorio-amnionitis** is made, the appropriate antibiotic coverage should be initiated

[B] If **culture expires** prior to labor admission, repeat culture upon admission for labor.

[C] Infants of mothers treated with **Clindamycin or Vancomycin** IAP may need to remain longer than 24 hours

[D] **Low to Medium risk** include patients who have previously tolerated a cephalosporin OR who do not meet high risk criteria (pruritis w/o rash, remote (> 10 years) unknown reaction, mild rash, severe rash or urticaria/hives with no other symptoms)

[E] **High risk** includes patients who have a history suggestive of an IgE-mediated event (anaphylaxis, angioedema, respiratory distress, cardiovascular symptoms), recurrent PCN reactions, reactions to multiple beta-lactams, or positive penicillin allergy test Severe rare delayed-onset cutaneous or systemic reactions, such aseosinophilia and systemic symptoms /drug induced hypersensitivity syndrome, Stevens-Johnson syndrome, or toxic epidermal necrolysis

[F] For example, GBS unknown within 5 weeks of delivery and no risk factors

[G] To properly obtain culture, do not use speculum. Swab lower half of vagina circumferentially, then insert into rectum 2cm and rotate 360°. Place in selective media for transport.

[H] Infants of mothers treated with **Clindamycin or Vancomycin** IAP should have "no antibiotics" selected in the Kaiser-Early Onset Sepsis calculator

Black = Obstetrical management

Blue = Newborn management

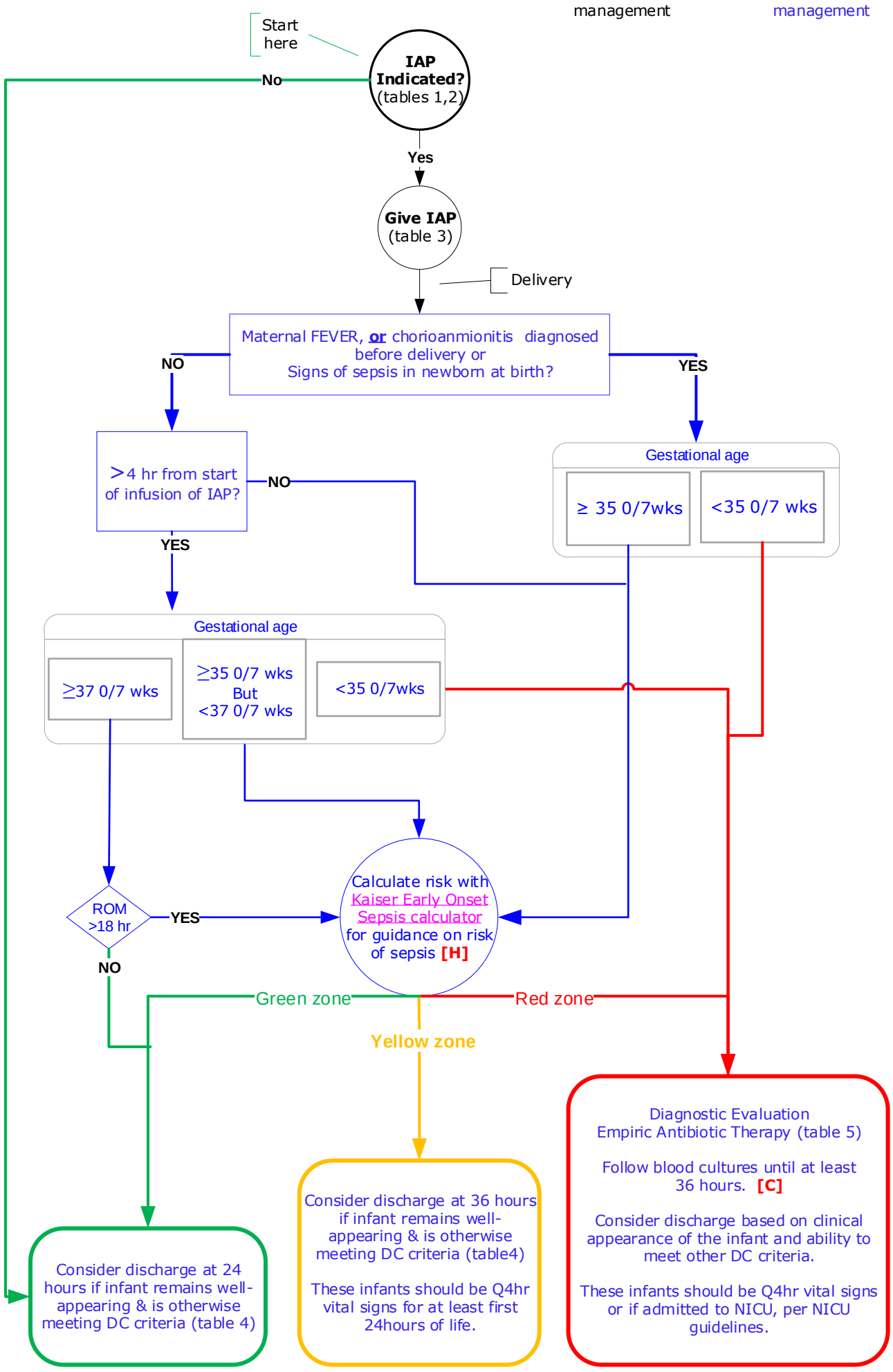

Table 4. Newborn Discharge Criteria

1. D/C criteria in PJPC Newborn Readiness for Discharge guideline are met
   http://www.med.umich.edu/i/obgyn/guidelines/nbn_d-c_criteria.pdf
2. For GBS + mom, ready access to medical care & an adult able to comply fully with instructions for home observation will be present

Table 5. Evaluation and Therapy of the Newborn

Blood culture and
-CXR if cardiopulmonary signs
-LP if signs of sepsis

May D/C if infant well and if cultures are negative

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