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Both groups agreed to support universal maternal screening and, if necessary, the use of antibiotics to prevent the transmission of GBS bacteria from mother to baby before or during childbirth. Since the GSS prevention recommendations were first introduced in 1990, the national incidence of GBS at the beginning of the year has fallen from 1.8 per 1,000 live births to 0.23 per 1,000 live births in 2015, the release said. Updated Recommendations/Group Findings Updated GBS recommendations/conclusions are broad and include the following: Targeted intranatal antibiotic prophylaxis protector has demonstrated efficacy in preventing GBS early onset of disease in newborns born in women with positive antepartum GBS cultures and those who have other risk factors for intraparto-party colonization of GBS. When assessing the risk of GBS infection in newborns, children born at 35-0/7 weeks or older, as well as children born at 34-6/7 weeks or younger, should be taken into account separately. Babies born at 34-6/7 weeks of pregnancy are premature and at greatest risk of early sepsis, including GBS disease. Regardless of the planned mode of birth, all pregnant women must undergo prenatal screening for GBS at 36-0/7 to 37-6/7 weeks of pregnancy, if intranatal antibiotic prophylaxis prevention of GBS is not shown due to GBS bacteriology during pregnancy or based on the history of the newborn's previous GBS infection. This new recommended time for screening provides a five-week window for valid crop results, which includes births that occur before gestational age for at least 41-0/7 weeks. Early onset of GBS infection should be diagnosed with blood or cerebrospinal fluid culture. Assessment of late onset of GBS associated with preterm birth should be based on clinical signs of the disease. In the updated recommendations for dosing for the treatment of neonatal and infant GBS disease, the preferred antibiotic for confirmed GBS disease in infants is penicillin G, followed by ampicillin. About 20% to 30% of pregnant women in the United States carry GBS bacteria in the gastrointestinal tract or genital tract, which can lead to transmission to the baby shortly before or during childbirth. About half of babies born to women with GBS bacteria who have not been treated with antibiotics will pick up the bacteria, leading to invasive infection in about 1% to 2% of them. According to the release, experts acknowledge that questions remain about the long-term health effects of antibiotics when taken during childbirth, because the treatment affects the microbiota of the newborn's gut, which develops and diversifies in early childhood. We hope to identify more ways these infections, such as a vaccine that can be used worldwide, said Puopolo in a release. These guidelines are the most effective tool we have right now to protect babies babies save lives. Family Physician Perspectives expert Sarah Coles, M.D., Phoenix, member of the AAFP Public Health and Science Commission, reviewed the updated GBS recommendations in April. She told AAFP News that the CDC's 2010 recommendation initially called for universal screening of women for GBS between 35 and 37 weeks of pregnancy. The new screening window recommended by ACOG allows physicians to have valid crop results up to 41-0/7 weeks of pregnancy. This would reduce the number of times a patient should be re-screened, Coles said. As with previous guidelines, women who have GBS bacteriuria at any point in pregnancy will need intranatal prevention and should not be re-screened. Another big change in these ACOG recommendations, she said, is that women who are present in work with unknown GBS status but who knew about the colonization of GBS during a previous pregnancy are now candidates for intra-native GBS prevention. This is in direct disagreement with the 2010 CDC guidelines, Coles said. The rationale behind this change was that women who were GBS colonized during a previous pregnancy have a 50% chance of transporting GBS in their current pregnancy. However, specific patient-centered data on reducing early GBS disease are not available in this guide. It is prudent to make joint decision-making with these women when considering intranatal antibiotic prophylaxis prevention. Coles added that there are specific criteria that need to be met for women with unknown GBS status to require intranatal GBS prevention, including birth at less than 37-0/7 weeks of gestation, membrane rupture within 18 hours or more in time, intranatal fever (100.4 degrees Fahrenheit or higher) and positive results of intra-birth nucleic acid testing for UGB testing. Colleen C. Canyo, M.D., of Tucson, Arizona, who wrote about preventing GBS disease in July 1, 2012, a U.S. family physician issue, told AAFP News it is important that family doctors note the condition of a patient's penicillin allergy in laboratory requisitions for GBS culture and, if the patient is allergic, request that the sample be tested for clindain susceptibility. When determining the antibiotic prevention regimen, consider penicillin skin allergy testing if a woman is at low risk or an unknown risk of anaphylactic reaction, Saido said. Coles agreed: I think this is a very important point. Up to 10% of adults report penicillin allergies, but about 90% are not really allergic. It may be that they lost the sensitization of penicillin over time or the initial reaction was not due to penicillin. Also Said doctors should evaluate patients who report penicillin allergies for high-risk reactions such as anaphylaxis, angioedema and respiratory failure. Low-risk reactions to penicillin allergies can be tested on the skin, or first-generation cephalosporins (cucasolin) can be used. Stories of high-risk anaphylaxis should receive clindamycin for intranatal prevention, she said. However, doctors should remember to ask for a test of the susceptibility of GBS culture to clindamycin. The resilience rate of clindamycin exceeds 20%. If isolate is not sensitive to clindamycin, vancomycin is used. According to Canyo, the shorter duration of recommended intranatal antibiotics is less effective than four or more hours of prevention. However, two hours of exposure to antibiotics has been shown to reduce the number of vaginal COLONIEs of GBS and reduce the incidence of clinical diagnosis of neonatal sepsis, she added. Therefore, obstetric interventions, when necessary, should not be postponed solely to ensure four hours of antibiotic administration before birth. Cagno said when screened for a GBS infection, it is important that the sample is collected correctly. A sample of the vaginal rectal bowel is recommended, she said. The most common mistake of doctors when screening for GBS is to collect vaginal culture only without the accompanying rectal sampling. Behind the CDC, a tampon should be inserted two centimeters into the vagina and the same tampon inserted one centimeter into the anus during screening for GBS. It should be noted that the CDC mobile app on this topic has not yet been updated with these latest recommendations at the time of publication, but the agency said it was in the works. Cagno concluded that advising for women who are currently pregnant about the timing of GBS screening and the decision regarding intranatal antibiotics when THE results of THE GBS culture are unknown will be important to develop now. Read more from AAFP Familydoctor.org: Group B Strep Infection Schrag SJ, Verani JR. Intranatal antibiotic prophylaxis prevention for perinatal group B streptococcal infection: experience in the United States and implications for potential group B streptococcal vaccine. Vaccine 2013;31 (suppl 4):D 20-6.Article Places:Boyer KM, Gadzala CA, Burd LI, Fisher DE, Paton JB, Gotoff SP. Selective intragenital chemoprophylaxis of neonatal group B streptococcal early onset disease. I. Epidemiological justification. J Infect Dis 1983;148:795-801.Article Places:Nanduri SA, Petit S, Smelser C, Apostle M, Alden NB, Harrison LH, et al. 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