

How should we greet the news that some UK trusts have chosen to follow the lead taken by our American colleagues in screening all women for Group B Streptococcus (GBS) in late pregnancy, and then offering antibiotics in labour if they test positive? Should we celebrate the fact that we can use the might of preventative medicine to attack an infective agent that can occasionally be fatal to babies, or should we lament the additional stress that this test puts on women - on top of the many other decisions they need to make?

As most midwives know, there are two ways we can screen women in order to try to determine which babies are at highest risk of contracting GBS. As is the case with all screening (as opposed to diagnostic) tests, neither provides a definitive answer. One - the "risk-based approach" - seeks to identify the babies who may be at increased risk because of clinical risk factors such as premature rupture of membranes, so that their mothers can be offered intravenous antibiotics in labour. Of course, many of the mothers of babies with clinical risk factors will not be carriers of GBS, and will therefore have unnecessary antibiotics. It is estimated that this approach means giving antibiotics to 16 per cent of labouring women and would offer protection to 78 per cent of the babies who would have become infected with GBS (Oddie and Embleton 2002). I have estimated from the data that around 1116 women need to be given antibiotics in labour to save one baby from GBS (Wickham 2004).

Having used this approach in the UK for a while, many areas are now moving towards the second option of "culture-based screening", where women are screened for GBS in late pregnancy, and intrapartum antibiotics are offered to all women who are found to have GBS in their vagina or rectum. Although in theory (and, again, no screening test is 100 per cent accurate) this would identify even more of the babies who were potentially at risk, with this option up to 30 per cent of labouring women would be offered antibiotics. At a conservative estimate, around 2000 women would need to receive antibiotics in order to save one baby from GBS (Wickham 2004).

Some of the issues which women need to consider in relation to this issue are easily overlooked in our haste to make being born as safe as we possibly can. One concerns the potential to increase the problem of antibiotic-resistant bacteria by giving antibiotics even more freely than we do already. Secondly, although routine antibiotic cover appears to reduce the number of babies with GBS, there is no evidence to support the suggestion that this reduces the number of babies who die from GBS (Smaill 2003). Then there are the massive implications of restricting the movement of up to a third of labouring women, and the implications

this would have on their birth experiences and outcomes. Have we really thought through the effect that giving all of these antibiotics to all of these women might have on perinatal mortality and morbidity rates?

Surely women have a right to be helped to think about these issues, and about the potentially serious implications of choosing whether or not to have GBS screening? As with a number of similar situations where women face difficult decisions around screening for rare but potentially fatal conditions, midwives may need to look more closely at where women can go for unbiased advice. In some cases, the advice and support available may come from companies who have technologies, tests or vaccines to sell, or from parents who have tragically lost a baby to the condition; both of whom may be potentially, and understandably, biased. There are few support or information services run by people who are against screening, perhaps because the weight of opinion in our society tends to be in favour of all the tests we can find time for. Yet both sides of this picture are important facets of informed choice.

I wouldn't want to have to explain to parents who had lost a baby to GBS (or anything else) that there was a test available that could have prevented the death of their baby, but which they weren't offered. But I also wouldn't want to explain to a woman that her cesarean section might have been caused by her being less able to move around because she was on a drip and monitor because of the results of a routine screening test about which she didn't have all the facts. Yet it takes time to explain all of these issues to women before they make their choices, and time is a precious resource for most midwives. As our society's passion for public health increases, so does the complexity of the issues, the potential decision-related stress for pregnant women and the pressure on midwives who seek to enable women to choose for themselves. It's a wonder to me not that so many midwives have left the profession, but that so many remain.

Oddie S Embleton ND. Risk factors for early onset neonatal group B streptococcal sepsis: case-control study *British Medical Journal* 2002; 325: 308

Smaill F. Intrapartum antibiotics for Group B streptococcal colonisation (Cochrane Review). In: *The Cochrane Library*, Issue 4, 2003. Chichester, UK: John Wiley & Sons, Ltd

Wickham S (2004). The War on Group B Strep. *AIMS Journal*, Vol 15, No 4, pp 7-9.