Table 1. Summary of expert screening guidelines for prevention of early-onset neonatal group B streptococcal (GBS) infections

Prevention strategy	Groups endorsing strategy
(A) No universal screening, but intrapartum chemoprophylaxis for all women with identified risk factors*	American College of Obstetricians and Gynecologists (in 1993)[15] Canadian consensus group† (in 1994)[13,14] Centers for Disease Control and Prevention, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics‡ (in 1996)[16,17]
(B) Universal antenatal screening at 26–28 weeks gestational age with a single combined vaginal–anorectal swab and selective intrapartum chemoprophylaxis for GBS culture-positive women with identified risk factors or women with risk factors and unknown colonization status	American Academy of Pediatrics (in 1992)[18] Canadian consensus group† (in 1994)[13,14]
(C) Universal antenatal screening at 35–37 weeks gestational age with a single combined vaginal–anorectal swab and intrapartum chemoprophylaxis for all GBS carriers, and all women with preterm delivery, a prior infant with GBS or GBS bacteriuria	Centers for Disease Control and Prevention, American College of Obstetricians and Gynecologists, and American Academy of Pediatrics‡ (in 1996)[16,17]

*Risk factors: preterm labour (< 37 weeks gestational age), term labour (≥ 37 weeks gestational age) with either prolonged rupture of membranes (> 18 hours) or maternal fever (temperature > 38.0°C), previous delivery of a newborn with GBS disease, and previously documented GBS bacteriuria.

†Either strategy A or B is acceptable. The antibiotic regimen of choice is ampicillin (2 g intravenously initially, followed by 1–2 g intravenously every 4–6 hours) or penicillin G (5 million units every 6 hours) until delivery or until labour is stopped. Women with allergy to penicillin may be given clindamycin (300–600 mg intravenously every 8 hours). The Canadian consensus group consisted of the Canadian Paediatric Society and the Society of Obstetricians and Gynaecologists of Canada.

‡Either strategy A or C is acceptable. Antibiotic regimen of choice is penicillin G (5 million units intravenous load, followed by 2.5 million units intravenously every 4 hours until delivery) or ampicillin (2 g initially, followed by 1 g every 4 hours) or until delivery or until labour is stopped. Women with allergy to penicillin may be given clindamycin (900 mg intravenously every 8 hours) or erythromycin (500 mg intravenously every 6 hours) until delivery.

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