Worcestershire Acute Hospitals NHS Trust

Obstetric Antimircobial Prophylaxis Guidelines

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Approved by:	Maternity Governance Meeting	
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Key Amendments

Date	Amendments	Approved by

Guideline Details

Caesarean Section - no history of MRSA colonisation

- Review previous Microbiology record for significant culture results
- Screen patient for MRSA antenatally, if high-risk, according to the WAHT MRSA policy. Begin decolonisation pre-operatively, if possible.
- For best efficacy, antibiotics should be given within 30-60 minutes **before** incision (ECCMID consensus 2014). It is accepted that, for practical reasons, doses should be given at induction of anaesthesia.

All aspects of antibiotic prophylaxis, for example where prophylaxis is not given when recommended, should be clearly recorded in the case records. Antibiotic prophylaxis should be prescribed in the once only section of the inpatient drug chart.

Organisms

S. aureus, beta-haemolytic Streptococci, anaerobes, coliforms

Pre Procedure First Line

Cefuroxime 1.5 g intravenous injection over 3 to 5 minutes at induction

AND

Metronidazole 500 mg intravenous infusion over 20 to 30 minutes at induction

Pre Procedure, if cephalosporin or severe penicillin allergy

Clindamycin# 600 mg intravenous infusion in 50 ml sodium chloride 0.9% or glucose 5% over 30 minutes at induction

AND

Gentamicin 120 mg intravenous injection over 3 to 5 minutes at induction

#if known resistance to clindamycin **add**

Teicoplanin: dose based on booking weight (see below) intravenous injection over 5 minutes

booking weight	dose
<50 kg	400 mg
50- 65 kg	600 mg

>65 kg	800 mg

Post Procedure

No further prophylactic antibiotics are required after the procedure.

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Group B *Streptococcus* Intrapartum Prophylaxis

Antibiotic prophylaxis is indicated if **any** of the following apply:

- Group B *Streptococcus* detected vaginally or rectally during the **current** pregnancy
- Group B *Streptococcus* detected in urine during the **current** pregnancy
- History of a previous baby who was affected by Group B *Streptococcus* infection
- Women in labour who have preterm rupture of membranes irrespective of Group B *Streptococcus* status

Choice of antimicrobial prophylaxis should be based on culture sensitivities, where this is available.

If the patient becomes febrile or septic in labour, antibiotic treatment is required. (see Prenatal Maternal Sepsis/Endometritis)

Organisms

Streptococcus agalactiae (group B haemolytic Streptococcus - GBS)

First Line

Benzylpenicillin 3 g intravenous infusion in 50 to 100 ml sodium chloride 0.9% or glucose 5% over 20 to 30 minutes at onset of labour followed by 1.5 g slow intravenous infusion in 50 to 100 ml sodium chloride 0.9% or glucose 5% over 20 to 30 minutes every 4 hours until delivery

Mild Penicillin Allergy

Cefuroxime 1.5 g intravenous injection over 3 to 5 minutes at onset of labour followed by 750 mg intravenous injection over 3 to 5 minutes every 8 hours until delivery

Severe Penicillin Allergy

If sensitive to clindamycin

Clindamycin 900 mg intravenous infusion in 50 ml sodium chloride 0.9% or glucose 5% over 30 minutes at onset of labour, then every 6 hours until delivery

Sensitivity not known or clindamycin resistance

Teicoplanin: dose based on booking weight (see below) intravenous injection over 5 minutes. Repeat every 12 hours for up to 3 doses until delivery.

booking weight	dose
<50 kg	400 mg
50- 65 kg	600 mg
>65 kg	800 mg

Reference:

RCOG. Prevention of Early-onset Neonatal Group B Streptococcal Disease. Green-top Guideline no. 36. September 2017

References

NICE Clinical Guidance (CG132). Caesarean section. Published Nov 2011, updated Aug 2012. https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance, accessed 01/11/2017

RCOG. Prevention of Early-onset Neonatal Group B Streptococcal Disease. Green-top Guideline no. 36. September 2017