

# **Obstetric Antimircobial Prophylaxis Guidelines**

Key Document code:	WAHT-TP- 094	
Key Documents Owner/Lead:	Dr Hillman	Consultant Obstetrician
Approved by:	Maternity Governance Meeting	
Date of Approval:	15 <sup>th</sup> November 2019	
Date of review:	15 <sup>th</sup> November 2022	

# **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 <u>WAHT MRSA policy</u>. 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**<sup>#</sup> 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

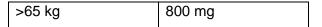
#if known resistance to clindamycin add

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

## Page **1** of **5**

# Obstetric Pathways WAHT-TP-094





## **Post Procedure**

No further prophylactic antibiotics are required after the procedure.

# Caesarean Section - history of MRSA colonisation

- Review previous Microbiology record for significant culture results
- Screen patient for MRSA antenatally, if high-risk, according to the <u>WAHT MRSA policy</u>. 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

#### $\Delta ND$

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

#### AND

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



# 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

#### **AND**

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.



# **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 <u>Prenatal Maternal Sepsis/Endometritis</u>)

# **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. <a href="https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance">https://www.nice.org.uk/guidance/cg132/chapter/1-Guidance</a>, accessed 01/11/2017

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