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| **Development of Working Definitions of Prenatal-onset Group B Streptococcal (POGBS) Disease Using “Internet Commons” Group B Strep (GBS) Parent and Provider Sources** |
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| **Background:** Classification of early-onset GBS disease is defined as death after birth which misses fetal demise caused by GBS before birth. Therefore, fetal demises caused by GBS are not counted as being due to group B strep disease. **Objective:** Develop and justify epidemiologic, clinically graded (“Proven,” “Likely,” “Possible,” or “Atypical”) case definitions of previously unclassified invasive prenatal-onset group B streptococcal disease in order to inform research, advocacy, public policy, clinical care, and social support.  **Material and Methods** We used quasi-experimental and qualitative techniques (“gedanken” research) to collect, record, and analyze GBS-related questions (FAQ’s) submitted to Group B Strep International’s website ([www.gbs-intl.org](https://correo.sup.org.uy/OWA/redir.aspx?SURL=wDwqZ4z-C-7cV30SlY1tVQyZn9mz0HhR051tt6xDr992TZ4oWFrTCGgAdAB0AHAAOgAvAC8AdwB3AHcALgBnAGIAcwAtAGkAbgB0AGwALgBvAHIAZwA.&URL=http%3a%2f%2fwww.gbs-intl.org)) and at medical professional meetings from 2000-2012. Questions or requests for information arrived unbidden over the worldwide web (“Internet Commons”) or in response to “Survey Monkey” style inquiries to personal contacts made at professional meetings and through the internet from 2000 to 2012. Language was not restricted, but all analyzed responses were in English to prompt spontaneity. No written consent was obtained and the process and analysis were not IRB-approved.  **Results** Twelve years of inquiries and contacts were analyzed. There were no measured differences in question topics among parents or providers. (At professional meetings as many as 500 questions were submitted daily making detailed analysis unreliable.) Queries mainly fell into three categories: 1) clinical “anecdotal cases,” 2) procedural, e.g., how to facilitate communication of GBS status cards, and 3) informal non-evidence-based advice for uncommon or unstudied clinical circumstances, e.g., severe penicillin allergy, prior GBS-associated stillbirth.  Table 1) Proposed Working Classifications of POGBS Disease   |  |  |  |  | | --- | --- | --- | --- | |  | Clinical | Pathology | Microbiologic | | Proven | Maternal fever >38°C if determined  Fetal tachycardia (>160) if available  Stillborn or born with systemic evidence of infection (SIRS) | Visualization of microbes (3-4+) consistent with chorioamnionitis and/or funisitis  Visualization of organisms consistent with GBS in tissue  Abnormal WBC: neutropenia, leukocytosis | GBS positive by culture or non culture when identified from non surface sources, e.g., cord blood, heart blood, spleen, liver, placenta parenchyma | | Likely | Maternal fever >38°C if determined  Perinatal depression APGAR <4 @ 5min.  Arterial cord gas: pH less than 7.1, BE greater than 12 mmol | Any histologic evidence of inflammation in placenta | Any microbiologic or nonculture evidence of GBS including surface sources | | Possible | Nonsystemic finding of infection  Pneumonitis on CXR, UTI, umbilical site infection | 0/+1 microscopic finding of chorioamnionitis or funisitis | Positive GBS surface cultures from perinate placenta | | Atypical | Evidence of mastitis  Growth restriction  Preterm labor or preterm rupture of membranes | Abnormal CXR suggestive of "possible pneumonitis" | GBS infection in mother or maternal asymptomatic bacteriuria with GBS |   **Conclusions** We utilized “internet commons” and other contacts to post working case definitions of “Proven,” “Likely,” “Possible,” or “Atypical” POGBS disease. These proposed definitions may facilitate study of the epidemiology, pathophysiology, and means to further prevent occurrences of POGBS disease. |
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