

Antibiotics Given to Laboring Mothers

Written by Linda Folden Palmer, D.C.

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Obstetricians are aware that when a bacterium known as group B strep (GBS) is colonizing a mother's vagina during pregnancy, her baby is more likely to develop an early infection with this bacterium after birth. Around 20 to 30 percent of mothers in the United States are found to be colonized with GBS during late pregnancy screenings. Standard practice is to screen pregnant mothers for the presence of this bacterium and provide antibiotics to colonized mothers during labor in an attempt to prevent early GBS infections in their infants.



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GIVEN TO LABORING MOTHERS

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No Good Evidence for Treatment
A 2014 scientific review of available studies on such provision of antibiotics to mothers during labor fails

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reports of a reduction in infections in infants but states that this finding "may well be due to bias." In other words, the researchers found a high risk of bias in study reports, making their conclusions weak.

Antibiotic provision does not always prevent early GBS illness, one study reported that 34 percent of infected babies were born to mothers who had taken antibiotics during labor. Also, many babies who are infected are born to mothers who tested negative for GBS and who were therefore not treated.

I find it difficult to analyze the effects of prophylactic antibiotics on GBS rates because some studies report rates of all colonized infants, some report the rates of seriously ill infants, and others report and compare the rates of infant deaths among those with early GBS infections, rather than the rate of infection.

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No Defined Drop-Rates Indication of Antibiotic Provision
Infant death rates in those with early GBS infections dropped dramatically before preventive antibiotics were first studied. It was 10 percent in 1970 to 22 percent in 1980, before clinical trials began, to 12 percent in 1990, but before standardized testing and treatment became recommended. From 1990 to today there has been a continuation of the slow but steady decline in the mortality rate to today's 5 percent death rate in those infants who become infected with GBS.

U.S. early infant GBS disease rates prior to the establishment of prophylactic antibiotic provisions are reported at 10 to 20 per 10,000 births. The CDC reports the rate remains at 3 to 10/1000, with some sources reporting slightly higher rates.

Another large review of available studies looked at the occurrence of premature births in relation to antibiotic usage. A predominance of undesirable vaginal bacteria is also associated with an increased rate of premature deliveries. This review found that antibiotic provision did decrease the appearance of vaginal bacterial over-colonization (vaginitis), but it did not reduce the rate of preterm births—the chief purpose of the antibiotic drug prescriptions in these cases.

Other Reasons for Drops in Infection Rates
A significant jump in the number of U.S. mothers who initially breastfed their newborns—from 10 percent in the year prior to the beginning of GBS preventive antibiotics to 60 percent only 4 years later, and to 70 percent not long after that—nearly accounts for some of the reduction reported in early infant infections.

Although cesarean births pose many health problems to infants, early GBS infection risks are lower. A 30 percent increase in Cesarean births from 10 percent before the prophylactic antibiotic measures to 23 percent at the present has likely also accounted for some of the drop in early GBS infection rates. Other factors may be involved as well.

The Real Antibiotic Results: More Serious Infections
Even if early serious GBS infections are being reduced by antibiotic provision, there has been an emergence of other types of early infections from bacteria not affected by the kinds of antibiotics used—including a surge of drug-resistant E. coli infections affecting newborns.

Most importantly, the scientific review found that the use of prophylactic antibiotics did not reduce the number of infant deaths—rather than GBS infection was from all causes—and the number of late, serious infections is increased by the use of antibiotics during labor. Late onset infections are defined as developing after one week of age. *Listeria* (broadly) infections are among them, as a direct result of antibiotic exposure.

Infant Bacterial Infections are also increasingly occurring from antibiotic resistant organisms. These are making the illnesses even more challenging to treat. Today, half of late onset infections are with the very dangerous MRSA (methicillin-resistant staph). The conclusion of the above comprehensive review is that antibiotic is being to support prophylactic antibiotic usage.

Industriaal Disease
Women in some other countries average far lower rates of GBS colonization than those in the leading industrialized nations. Rates are as low as 7 percent among nations measured, reflecting greater microbial health in these nations. Plus antibiotic use, consumption of antibiotic-treated animals, low fiber diets and pesticide consumption are among the factors destroying natural health in industrialized nations.

Natural Treatments for Mom
A 2011 study provided either probiotic yogurt or antibiotic to more than 300 GBS colonized pregnant mothers and found equal resolution of vaginal bacterial infection with either treatment. Another study gave garlic tablets as antibiotic drugs to 200 non-pregnant women with bacterial vaginosis. A statistically similar level of bacterial resolution was found between the two treatment groups, while more side effects occurred in those treated with antibiotic drugs. Other women use fresh cut garlic cloves vaginally and find long-term relief of GBS vaginitis, whereas antibiotic treatment is routinely recognized to provide only temporary relief and to result in greater imbalance of vaginal and intestinal flora.

A 2012 STUDY OF 300 PREGNANT MOTHERS FOUND PROBIOTIC YOGURT TO BE AS EFFECTIVE AS ANTIBIOTICS IN RESOLVING GBS BACTERIAL INFECTIONS.

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No Good Evidence for Treatment

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A 2014 scientific review of available studies on such provision of antibiotics to mothers during labor finds reports of a reduction in infections in infants but states that this finding “may well be due to bias.” In other words, the researchers found a high risk of bias in study reports, making their conclusions weak.

Antibiotic provision does not always prevent early GBS illness; one study reported that 38 percent of infected babies were born to mothers who had taken antibiotics during labor. Also, many babies who are infected are born to mothers who tested negative for GBS and who were therefore not treated.

I find it difficult to analyze the effects of preemptive antibiotics on GBS rates because some studies report rates of all colonized infants, some report the rates of seriously ill infants, and others report and compare the rates of infant deaths among those with early GBS infections, rather than the rate of infection.

No Defined Drop Since Initiation of Antibiotic Protocols

Infant death rates in those with early GBS infections dropped dramatically before preventive antibiotics were first studied: from 55 percent in 1970; to 22 percent in 1980, before clinical trials began; to 12 percent in 1990, just before standardized testing and treatment became recommended. From 1990 to today, there has been a continuation of the slow but steady decline in the mortality rate to today’s 5 percent death rate for those infants who become infected with GBS.

U.S. early infant GBS disease rates prior to the establishment of precautionary antibiotic provisions are reported at 10 to 17 per 10,000 births. The CDC reports the current rate at 3 in 10,000, with some sources reporting slightly higher rates.

Another large review of available studies looked at the occurrence of premature births in relation to antibiotic usage. A predominance of undesirable vaginal bacteria is also associated with an increased rate of premature deliveries. This review found that antibiotic provision did decrease the appearance of vaginal bacterial over-colonization (vaginosis), but it did not reduce the rate of preterm births—the chief purpose of the antibiotic drug prescriptions in these cases.

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Other Reasons for Drops in Infection Rates

A significant jump in the number of U.S. mothers who initially breastfed their newborns—from 52 percent in the year prior to the beginning of GBS preventive antibiotics to 60 percent only 6 years later, and to 70 percent not long after that—surely accounts for some of the reduction reported in early infant infections. Although cesarean births pose many health problems to infants, early GBS infection risks are lower. A 50 percent increase in C-section births (from 22 percent before the preemptive antibiotic measures to 33 percent at the present) has likely also accounted for some of the drop in early GBS infection rates. Other factors may be involved as well.

The Real Antibiotic Results: More Serious Infections

Even if early serious GBS infections are being reduced by antibiotic practices, there has been an emergence of other types of early infections from bacteria not affected by the kinds of antibiotics used—including a surge of drug-resistant E. coli infections affecting preemies.

Most importantly, the scientific review found that the use of precautionary antibiotics did not reduce the number of infant deaths—neither from GBS infection nor from all causes—and the number of later, serious infections is increased by the use of antibiotics during labor. (Late-onset infections are defined as developing after one week of age.) Serious Candida (yeast) infections are among these, as a direct result of antibiotic exposure. Later bacterial infections are also increasingly occurring from antibiotic-resistant organisms. These are making the illnesses even more challenging to treat. Today, half of late-onset infections are with the very dangerous MRSA (antibiotic-resistant strep). The conclusion of the above comprehensive review is that evidence is lacking to support preemptive antibiotic usage.

Industrialized Disease

Women in some other countries average far lower rates of GBS colonization than those in the leading industrialized nations. Rates are as low as 7 percent among nations measured, reflecting greater intestinal health in these nations. Prior antibiotic use, consumption of antibiotic-treated animals, low-fiber diets and pesticide consumption are among the factors destroying intestinal health in industrialized nations.

Natural Treatments for Mom

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A 2012 study provided either probiotic yogurt or antibiotics to more than 300 GBS colonized pregnant mothers and found equal resolution of vaginal bacterial infection with either treatment. Another study gave garlic tablets or antibiotic drugs to 120 non-pregnant women with bacterial vaginosis. A statistically similar level of bacterial resolution was found between the two treatment groups, while more side effects occurred in those treated with antibiotic drugs. Other women use freshly cut garlic cloves vaginally and find long-term relief of GBS vaginosis, whereas antibiotic treatment is medically recognized to provide only temporary relief and to result in great imbalance of vaginal and intestinal flora.

Vaginal vitamin C tablets have also been shown to reduce bacterial vaginosis. Some mothers regularly apply probiotics or yogurt vaginally to help balance their floras. Of course, a wide spectrum of oral antimicrobial herbs and nutritional practices can help to improve a mother's floral balance before birth, as can oral probiotics. Such practices can certainly provide other large benefits for mother and baby. More studies are needed on alternatives to antibiotic treatments for the prevention of infant GBS infections.

A pregnant mother can use oral and vaginal treatments with probiotics and other immune-supporting antimicrobials, such as garlic and vitamin C, during her pregnancy. She can then be tested—or retested—for GBS to find out whether these flora-protecting measures are providing the results that doctors would like to see.

Improving Infant Health

Prematurely born infants are the most susceptible to serious infections of all kinds. Kangaroo care, in which a large amount of skin-to-skin contact is provided for an infant, along with frequent and near-exclusive breastfeeding, is shown to cut preemie infection risks in half. Studies also show significant reductions in newborn infection rates in term infants when exclusive human milk feeding is available. These measures help to optimize baby's flora and help to protect against all kinds of potential infections, not just GBS. Donor milk is a proven valuable option when mother's milk is not available.

The infant health effects from exposure to maternal antibiotics during labor have avoided scrutiny because the drugs are given to the mother, not directly to the infant. Because of the potential ramifications of such a study on infants, no one really wants to do it. In 2014, researchers did look into the effects on newborn floral development and found significant reductions in the numbers and variety of health-promoting bifidobacteria in babies from antibiotic-treated mothers. Moreover, they found deficiencies in the very species that actually

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help to fight against GBS.

Antibiotics create havoc in newborn intestines. They not only increase the risk of serious drug-resistant infections during baby's first few weeks after birth but also create serious impacts on floral balance that influence many other short-term and long-term health factors. In many cases, there are healthier options to antibiotic drugs that may bring few or no side effects and greater overall health to mother and child.



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