We were very concerned to see the article by Plumb and Clayton (2013) in the July/August issue of *The Practising Midwife*. While we acknowledge that group B streptococcus (GBS) is a potentially serious infection in babies, some of the information in Plumb and Clayton's paper is both misleading and incorrect. Current evidence does not support the introduction of routine antenatal screening, and this is endorsed by the UK National Screening Committee (NSC 2012), National Institute of Health and Care Excellence (NICE 2012) and the Royal College of Obstetricians and Gynaecologists (RCOG 2012). Midwives have a professional duty to give care and information that is based on the best available evidence (Nursing and Midwifery Council (NMC) 2008) and it is therefore irresponsible to suggest, as Plumb and Clayton do, that midwives should give advice that contradicts this evidence. In the second paragraph of their article, Plumb and Clayton suggest that 'Following GBS meningitis, 50 per cent [of babies] suffer disabilities.' However, current evidence (NSC 2012) indicates that more than 85 per cent of cases of GBS meningitis are late-onset and would not be prevented by intrapartum antibiotic prophylaxis (IAP). The diagram that is included as *Figure 1* within the article needs careful interpretation. As Plumb and Clayton acknowledge, the incidence of early-onset GBS has not changed in recent years. While the total number of cases of GBS appears to have increased, this is likely to represent more effective and efficient notification, as much as any increase in real terms. Moreover, while the total number of reported cases appears to have increased from 250 to approximately 400 between 2001 and 2011, this figure must be understood in terms of an increasing birth rate - which, for England and Wales in the same period, rose from 594,634 live births to 723,913 (Office for National Statistics (ONS) 2013).

Plumb and Clayton suggest (p29) that 'Fifty-80 per cent of [early onset GBS] would have been preventable had existing screening guidelines been followed.' These are alarmist statistics, but the source of the data is not identified. The use of IAP, which they recommend for all women with GBS colonisation or other risk factors, is not a benign intervention. Current evidence demonstrates that the impact of prophylaxis is unknown, in either the short- or long-term (NSC 2012). However, the chief

medical officer, Dame Sally Davies, has identified antibiotic-resistant diseases as 'an apocalyptic threat', and recently asked that antibiotic resistance be added to the national risk register (Sample 2013).

We hope that midwives will have the wisdom to continue to follow professional guidelines, and have the confidence to reassure parents that routine antenatal screening for GBS is not necessary.

Yours sincerely,

Mary Stewart, *Research Midwife, Life Study, University College London,* and Mandie Scamell, *Lecturer in Midwifery* and Alison McFarlane, *Professor of Women's and Child's Health, both at City University, London*

References

NMC (2008). *The Code: standards of conduct, performance and ethics for nurses and midwives*, London: NMC.

NICE (2012). *Antibiotics for the prevention and treatment of early-onset neonatal infection*, London: NICE.

NSC (2012). *Screening for Group B Streptococcal infection in pregnancy*, v 5, London: Bazian Ltd.

ONS (2013). *Annual data: live births*, London: ONS. Plumb J and Clayton G (2013). 'Group B streptococcus infection: risk and prevention'. *The Practising Midwife*, 16(7): 27-30. RCOG (2012). *The prevention of early-onset neonatal group B streptococcal disease* (2nd edition), London: RCOG. Sample I (2013). Antibiotic-resistant diseases pose 'apocalyptic' threat, top expert says'. *The Guardian*, 23rd January.