# ROUTINE MATERNAL HEALTH TESTS IN PREGNANCY

## Summary of tests

<table>
<thead>
<tr>
<th>Condition</th>
<th>Test(s)</th>
<th>Follow-up/rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anaemia</strong></td>
<td>Haemoglobin concentration</td>
<td>Full blood count for women with low haemoglobin concentrations</td>
</tr>
<tr>
<td><strong>Haemoglobin disorders</strong></td>
<td>Full blood count</td>
<td>Further investigations needed for women with abnormal red cell indices, family history or origin in a high-risk country</td>
</tr>
<tr>
<td><strong>Hyperglycaemia</strong></td>
<td>Glycated haemoglobin or fasting blood glucose for women with risk factors</td>
<td>Minimising hyperglycaemia during pregnancy improves outcomes</td>
</tr>
<tr>
<td></td>
<td>Plasma glucose (fasting or following 75 g glucose loading)</td>
<td>Treatment of gestational diabetes reduces the risk of perinatal complications</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>EIA and Western blot</td>
<td>Antiretroviral treatment in pregnancy reduces risk of transmission</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Blood test for HbsAg</td>
<td>Vaccination of the newborn reduces risk of infection</td>
</tr>
<tr>
<td><strong>Hepatitis C</strong></td>
<td>Blood test for hepatitis antibody RNA if antibodies detected</td>
<td>Avoiding certain interventions among women who test positive reduces risk of mother-to-child transmission and direct-acting antiviral therapy used postpartum (or post breastfeeding) is very effective, protecting future pregnancies</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>Treponemal assay confirmed with an alternative treponemal assay</td>
<td>Treatment benefits the mother and prevents congenital syphilis</td>
</tr>
<tr>
<td><strong>Rubella</strong></td>
<td>Blood test for rubella antibody</td>
<td>Vaccination after birth protects future pregnancies. Inadvertent vaccination in early pregnancy is highly unlikely to harm the baby</td>
</tr>
<tr>
<td><strong>Asymptomatic bacteriuria</strong></td>
<td>Midstream urine culture</td>
<td>Treatment reduces risk of pyelonephritis</td>
</tr>
<tr>
<td><strong>Group B streptococcus</strong></td>
<td>Self-collected vaginal-rectal swab culture</td>
<td>Identification of colonisation allows treatment during labour to reduce transmission to the baby</td>
</tr>
</tbody>
</table>

* Specialist care and psychosocial support are required for women with HIV, hepatitis B or hepatitis C.

# Before testing

- Discuss the reasons for testing, harms, benefits and associated treatments and provide appropriate resources
- Give women opportunities to ask questions about tests, implications and treatments
- Reassure women that test results remain confidential (unless the condition is notifiable)
- Inform women that it is their choice to have tests
- Document discussions about consent
- Offer women who decline testing the opportunity to discuss any concerns without coercion

# After a positive test result

- Give women who receive a diagnosis of a condition that may affect pregnancy and/or the health of the baby information about available supports and assist them to access these
- For some conditions, such as haemoglobinopathies (eg thalassaemia), specialist involvement will be required
- If a sexually transmitted infection is identified, offer testing, treatment and contact tracing
- Consider specific supports for women identified as using intravenous drugs
- Follow State/Territory legislation on notification of communicable diseases

# Other considerations

- When offering tests, consult and engage with women
- Keep up-to-date with the latest developments and evidence about tests during pregnancy
- In rural and remote areas, access to tests may be limited, so respond to local needs
- When testing, use standard precautions for infection prevention and control
Anaemia (see Guideline Chapter 30)

Consensus-based recommendation

Routinely offer testing for haemoglobin concentration to pregnant women early in pregnancy (at the first visit) and at 28 weeks gestation.

When should ferritin testing be considered at the first antenatal visit?

In areas where prevalence of iron-deficiency anaemia is high, consider testing for low ferritin at the first antenatal visit.

Assessing haemoglobin concentration during pregnancy

<table>
<thead>
<tr>
<th>Gestational age</th>
<th>Minimum haemoglobin concentration</th>
</tr>
</thead>
<tbody>
<tr>
<td>0–20 weeks</td>
<td>110 mg/dL</td>
</tr>
<tr>
<td>20+ weeks</td>
<td>105 mg/dL</td>
</tr>
</tbody>
</table>

Diagnostic tests

- Full blood count (if this has not already been conducted)
- Serum ferritin
- Specific tests for folate and vitamin B<sub>12</sub>, if mean cell volume is high

When is further investigation required?

Further investigation is required for women with a low haemoglobin concentration for their gestational stage. Repeat testing at 36 weeks may also be required for women who have symptoms or risk factors for anaemia or who live in or have come from an area of high prevalence.

Follow-up

**Recommendations**

<table>
<thead>
<tr>
<th>Recommendations</th>
<th>Grade B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advise iron supplementation for women identified as having iron-deficiency anaemia.</td>
<td></td>
</tr>
<tr>
<td>Advise women with iron-deficiency anaemia that low-dose iron supplementation is as effective as high dose, with fewer side effects.</td>
<td></td>
</tr>
</tbody>
</table>

When should non-oral supplementation be advised?

Oral iron remains first-line treatment for iron-deficiency anaemia identified in the antenatal period.

Practice summary

**When:** Early in pregnancy and at 28 weeks gestation

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- Discuss the reasons for testing for anaemia: Explain that anaemia causes tiredness and can cause shortness of breath and dizziness.
- Explain the causes of anaemia: Iron-deficiency is a common cause of anaemia during pregnancy.
- Take a holistic approach: Consider the availability of iron-rich foods appropriate to the woman’s cultural practices and preferences and the affordability of supplements. For women taking supplements for iron-deficiency, explore culturally appropriate, low cost ways for women to increase their fibre and fluid intake if they are experiencing constipation.
- Consider referral: If there is concern about the quality of dietary iron intake or if the woman would like information about nutrition for herself and her family, consider referral to an accredited dietitian.
- Document and follow-up: Tell the woman her results and note them in her antenatal record. Have a system in place so that women with iron-deficiency anaemia are given information about iron supplementation and receive ongoing follow-up, including further investigation if anaemia does not resolve after pregnancy.
Haemoglobin disorders (see Guideline Chapter 31)

**Consensus-based recommendation**
As early as possible in pregnancy, routinely provide information about haemoglobin disorders and offer testing (full blood count).

**Testing for haemoglobin disorders**
- Mean corpuscular volume (MCV)
- Mean corpuscular haemoglobin (MCH)

**When further investigations are appropriate as part of initial testing?**
Consider offering ferritin testing and haemoglobin electrophoresis as part of initial testing to women from high-risk population groups.

**Women who require further investigation**
- Women who have a MCV ≤80 fL and/or MCH ≤27 pg
- Women with a family history of anaemia, thalassaemia or other abnormal haemoglobin variant
- Women who originate from high-risk population groups: Southern Europe, Middle East, Africa, China, South-East Asia, the Indian subcontinent, Pacific Islands, New Zealand (Maori), South America and some Aboriginal and Torres Strait Islander communities in northern Western Australia and the Northern Territory

**Relevant tests**
- Ferritin testing to exclude iron-deficiency anaemia
- Electrophoresis or high pressure liquid chromatography, to identify haemoglobin variants (red cell indices can be normal in carriers for some haemoglobin disorders)

**Practice summary**
- **When**: At the first antenatal visit
- **Who**: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander Health Practitioner; Aboriginal and Torres Strait Islander health worker; multicultural health worker
- **Discuss the reasons for testing for haemoglobin disorders**: Explain that when both parents are carriers for a haemoglobin disorder, the baby may be affected (1 in 4 chance) with possible serious consequences.
- **Offer testing to fathers**: If a woman is identified as a carrier of a significant haemoglobin disorder, testing should be offered to the father. Other family members may also benefit from being offered testing.
- **Take a holistic approach**: Arrange counselling for parents when both are identified as carriers of haemoglobin disorders.
- **Document and follow-up**: Ensure that women receive timely notice of the results of any tests carried out. Have a system in place so that women identified as carriers of haemoglobin disorders receive ongoing support.
**Hyperglycaemia** (see Guideline Chapter 32)

**Who is at increased risk?**

<table>
<thead>
<tr>
<th>Risk factors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk increases with maternal age</td>
</tr>
<tr>
<td>Women with increased BMI or percentage of body fat</td>
</tr>
<tr>
<td>Women with polycystic ovary syndrome</td>
</tr>
<tr>
<td>Women with previous gestational diabetes, a previous high birth weight baby or previous pregnancy losses</td>
</tr>
<tr>
<td>Women with a family history of diabetes, especially maternal family history or type 2 diabetes in a first-degree relative</td>
</tr>
<tr>
<td>Women who originate from an ethnic group with a high prevalence of type 2 diabetes, including Aboriginal and Torres Strait Islander peoples and people who are of Hispanic, African, Native American, South or East Asian or Pacific Island origin</td>
</tr>
</tbody>
</table>

**Recommendation**

**Evidence-based recommendation**

In the first trimester, assess a woman’s risk of hyperglycaemia — including her age, body mass index, previous gestational diabetes or high birth weight baby, family history of diabetes, presence of polycystic ovarian syndrome and whether she is from an ethnic group with high prevalence of diabetes, such as Aboriginal and Torres Strait Islander peoples.

**Testing for hyperglycaemia**

**Consensus-based recommendation**

When a woman has risk factors for hyperglycaemia in the first trimester, suitable tests are HbA1c or fasting blood glucose.

**Suggested thresholds**

<table>
<thead>
<tr>
<th>Test</th>
<th>Suggested threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>HbA1c</td>
<td>≥41 mmol/mol (5.9%)</td>
</tr>
<tr>
<td>Fasting plasma glucose</td>
<td>6.1 to 6.9 mmol/L</td>
</tr>
</tbody>
</table>

**Follow-up**

**Recommendation**

**Qualified evidence-based recommendation**

Advise women that physical activity and healthy eating during pregnancy help to reduce excessive weight gain, but do not appear to directly reduce the risk of diabetes in pregnancy.

**Testing for previously undiagnosed diabetes and gestational diabetes**

**Consensus-based recommendation**

Between 24 and 28 weeks gestation, advise testing for hyperglycaemia to all women who have not previously been tested in the current pregnancy. Advise repeat testing to women who were tested early in pregnancy due to risk factors and who had a normal result on an initial test.

- Fasting plasma glucose and HbA1c can be used to test for pre-existing diabetes
- Glucose tolerance testing is used to test for gestational diabetes

**Diagnosing diabetes and gestational diabetes**

**Consensus-based recommendation**

Use the WHO/IADPSG tests and criteria (see below) to diagnose diabetes and gestational diabetes in pregnancy.

**Diabetes in pregnancy** — one or more of the following criteria are met

<table>
<thead>
<tr>
<th>Test</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting plasma glucose</td>
<td>≥7.0 mmol/l (126 mg/dl)</td>
</tr>
<tr>
<td>2-hour plasma glucose</td>
<td>≥11.1 mmol/l (200 mg/dl) following a 75g oral glucose load</td>
</tr>
<tr>
<td>Random plasma glucose</td>
<td>≥11.1 mmol/l (200 mg/dl) in the presence of diabetes symptoms</td>
</tr>
</tbody>
</table>

**Gestational diabetes** — one or more of the following criteria are met at any time during pregnancy

<table>
<thead>
<tr>
<th>Test</th>
<th>Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fasting plasma glucose</td>
<td>5.1–6.9 mmol/l (92–125 mg/dl)</td>
</tr>
<tr>
<td>1-hour plasma glucose</td>
<td>≥10.0 mmol/l (180 mg/dl) following a 75g oral glucose load</td>
</tr>
<tr>
<td>2-hour plasma glucose</td>
<td>8.5–11.0 mmol/l (153–199 mg/dl) following a 75g oral glucose load</td>
</tr>
</tbody>
</table>

**Source:** WHO 2013.
Practice summary

When: Assess risk of hyperglycaemia at the first antenatal visit and offer testing to women with risk factors
At 24-28 weeks offer testing to women not already tested and repeat testing to women with risk factors with a previous normal blood glucose level

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health practitioner; Aboriginal and Torres Strait Islander health worker; multicultural health worker; accredited practising dietitian, diabetes educator; endocrinologist; accredited exercise physiologist

- Discuss the reasons for testing for hyperglycaemia: Explain that diabetes in pregnancy can affect the pregnancy and baby and that early identification and managing raised blood glucose can reduce the risk.
- Take a holistic approach: Provide women with practical advice on healthy eating and physical activity (see Guideline Chapter 11), taking into account the woman’s cultural practices and preferences. Explain that insulin or oral hypoglycaemic may be required if lifestyle measures do not control blood glucose levels.
- Discuss monitoring: For women with diagnosed diabetes, highlight the importance of monitoring and controlling blood glucose levels during pregnancy, labour, birth and early feeding of the baby.
- Consider referral: Where possible, refer women diagnosed with pre-existing diabetes for specialist assessment (by an endocrinologist or obstetric physician) and education on nutrition, monitoring and management (eg to a multidisciplinary team involving an accredited dietitian, diabetes educator, endocrinologist, obstetric physician). Where specialist allied health professionals are not available, other written information, video or audio resources or telehealth services may be useful.
- Document and follow-up: Tell women the results of tests and note them in the antenatal record. Have a system in place so that women diagnosed with diabetes receive ongoing follow-up and are encouraged to attend postnatal testing. Explain to women with gestational diabetes that their risk of developing type 2 diabetes is increased, that breastfeeding reduces this risk and the importance of regular assessment and weight maintenance after the pregnancy. Offer registration on the National Gestational Diabetes Register.

Human immunodeficiency virus (see Guideline Chapter 33)

Recommendation | Grade B
--- | ---
Routinely offer and recommend HIV testing at the first antenatal visit as effective interventions are available to reduce the risk of mother-to-child transmission.

Testing for HIV infection

- Standard tests — the enzyme immunoassay and Western blot protocol is highly (>99%) sensitive and specific
- Rapid HIV tests — have similar accuracy and provide results within hours without requiring a return visit; blood-based tests have greater sensitivity than tests using oral fluids

Follow-up

What additional care is required for women diagnosed with HIV?
A system of clear referral paths ensures that pregnant women who are diagnosed with an HIV infection are cared for, and treated by, the appropriate specialist teams.

Practice summary

When: Early in antenatal care

Who: Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- Discuss HIV testing: Explain that it is important to find out whether a woman has HIV because of the risk of transmission to the baby. Testing also gives the woman the opportunity to receive appropriate treatments.
- Document and follow-up: Note the results of HIV testing in the woman’s record and have a follow-up system in place so women who have HIV have access to counselling to discuss the test results and available interventions to prevent transmission during pregnancy.
- Take a holistic approach: If a woman is found to have HIV, specialist advice on management is required. Other considerations include psychosocial support, contact tracing, partner testing, testing for other sexually transmitted infections and continuing follow-up.
### Hepatitis B (see Guideline Chapter 34)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Routinely offer and recommend hepatitis B virus testing at the first antenatal visit as effective postnatal intervention can reduce the risk of mother-to-child transmission.</td>
<td></td>
</tr>
</tbody>
</table>

#### How to test for hepatitis B

- **Testing of blood samples for hepatitis B surface antigen (HbsAg)**
- **Confirmatory testing with a new sample upon a positive result**

#### Practice summary: hepatitis B

**When:** Early in antenatal care  
**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- **Discuss hepatitis B testing:** Explain that it is important to find out whether a woman has or is carrying hepatitis B because of the risk to the baby.
- **Document and follow-up:** Note the results of hepatitis B testing in the woman’s record and have a follow-up system in place so that the babies of women who are found to have hepatitis B are vaccinated on the day of birth. For women with high viral loads (> log 7 IU/mL), discussion with a hepatologist or hepatitis B specialist and maternal antiviral treatment in the third trimester are considerations.
- **Take a holistic approach:** If a woman is found to have or be a carrier of hepatitis B, other considerations include counselling, contact tracing, partner testing, testing for other sexually transmitted infections and continuing follow-up. Consider testing other children, depending on circumstances.

### Hepatitis C (see Guideline Chapter 35)

<table>
<thead>
<tr>
<th>Consensus-based recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>At the first antenatal visit, recommend testing for hepatitis C.</td>
</tr>
</tbody>
</table>

#### Is testing required before an invasive procedure?

*For women who have not previously been tested and who are having a planned invasive procedure (e.g., chorionic villus sampling, amniocentesis), recommend testing for hepatitis C before the procedure.*

#### How to test for hepatitis C

- **Testing of blood samples for hepatitis C antibodies**
- **If positive for hepatitis C antibodies, confirmatory hepatitis C ribonucleic acid (RNA) test**

#### Practice summary

**When:** In the antenatal period  
**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- **Discuss hepatitis C testing:** Explain that if hepatitis C is identified during pregnancy, interventions that increase the risk of transmission can be avoided and that effective treatment can be started after pregnancy/breastfeeding.
- **Document and follow-up:** Note the results in the woman’s record and advise her of her result. Have a system in place so that women who test positive receive education about transmission (e.g., to family members) and ongoing support and their babies are followed up after birth. Offer and arrange referral to an infectious diseases specialist or hepatologist for ongoing management and commencement of direct-acting antiviral therapy postpartum, as well as to hepatitis support groups.
- **Take a holistic approach:** If a woman is found to have hepatitis C, specialist advice on management may be required depending on the severity of disease and the health professional’s expertise. Other considerations include counselling and follow-up.
**Syphilis (see Guideline Chapter 36)**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Evidence-based recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Routinely recommend syphilis testing at the first antenatal contact.</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Consensus-based recommendation**

**Recommend repeat testing early in the third trimester (28–32 weeks) and at the time of birth for women at high risk of infection or reinfection.**

**How to test for syphilis**

In Australia, serum from blood specimens is usually screened with a treponemal assay and confirmed with an alternative treponemal assay using a different platform (ie screening with an enzyme immunoassay and confirmation with a *T. pallidum* particle agglutination)

In people with prior treated syphilis, because the treponemal assays remain reactive for life, a rapid plasma reagin alone is sometimes used to detect reinfection or treatment success

Due to intralaboratory and interlaboratory variation, when a person has a changing non-treponemal antibody result, the current specimen should be tested in parallel with previous specimens

**Caring for women with a positive syphilis test result**

**Consensus-based recommendations**

Seek advice from an expert in sexual health or infectious diseases regarding the care of women who test positive and their partners.

Ensure contact tracing (including offering testing and treatment to identified contacts) is carried out. Involve an expert in contact tracing if required or seek advice from a sexual health clinic or other relevant expert.

**Treatment for women with confirmed syphilis**

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Evidence-based recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>For women with newly confirmed infectious syphilis, recommend an intramuscular dose of 1.8 g (given as two 900 mg injections) benzathine penicillin as soon as possible, ensuring that women receive treatment at least 30 days before the estimated date of birth to ensure adequate treatment before the birth.</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Outbreak management**

**Consensus-based recommendations**

In areas affected by an ongoing syphilis outbreak, recommend testing at the first antenatal visit, at 28 and 36 weeks, at the time of birth and 6 weeks after the birth.

In areas affected by an outbreak, treat women as soon as possible without waiting for confirmatory testing, particularly if there is a risk of loss to follow-up.

**Practice summary**

**When:** Early in antenatal care or at five key times in areas experiencing an outbreak (see Section Error! Reference source not found.)

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker, infectious diseases specialist, public health unit staff

- Discuss the reasons for syphilis testing: Explain that it is important to find out whether a woman has syphilis because of the effects that infection can have on the pregnancy and the baby.

- Monitor changes in risk: Discuss potential symptoms and changes in risk-factors at all antenatal visits, particularly in areas experiencing an outbreak.

- Document and follow-up: Note the results of syphilis testing in the woman’s record, including whether the syphilis is newly diagnosed or was previously treated. Have a follow-up system in place so that women with confirmed syphilis receive timely treatment or referral. Any positive tests should be notified to the relevant public health authority.
**Rubella** (see Guideline Chapter 37)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade B</th>
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</thead>
<tbody>
<tr>
<td>Routinely offer and recommend testing for rubella immunity at the first antenatal visit to identify women at risk of contracting rubella and enable postnatal vaccination to protect future pregnancies.</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inform women who have been vaccinated against rubella before they were aware of the pregnancy that the baby is highly unlikely to have been affected by the vaccine.</td>
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</tr>
</tbody>
</table>

**Follow-up**

**What advice should women identified as non-immune to rubella receive?**

Women identified as non-immune to rubella during pregnancy should be advised to avoid contact with people experiencing possible symptoms of rubella.

**Practice summary**

**When:** Early in antenatal care

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- Discuss rubella non-immunity: Explain that it is important to find out whether a woman is immune to rubella because of the effects that infection can have on the pregnancy and the baby.
- Document and follow-up: Note the results of rubella testing in the woman’s record. Have a follow-up system in place so that non-immune women are offered vaccination after the birth. Some women may not develop immunity even after repeated vaccination.
- Take a holistic approach: If a woman is found to be non-immune to rubella, offer advice on symptoms and transmission of rubella so that she can avoid contact as far as possible. Advise vaccination of family members who may also be non-immune.
- Report inadvertent vaccination: Report inadvertent vaccination with Measles Mumps Rubella vaccine (or Measles Mumps Rubella Varicella vaccine) to the jurisdictional immunisation unit.

**Asymptomatic bacteriuria** (see Guideline Chapter 38)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade A</th>
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</thead>
<tbody>
<tr>
<td>Routinely offer and recommend testing for asymptomatic bacteriuria early in pregnancy as treatment is effective and reduces the risk of pyelonephritis.</td>
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</table>

**How to test for asymptomatic bacteriuria**

- Midstream urine culture is considered the standard for diagnosis of asymptomatic bacteriuria in pregnancy
- Dipstick urinalysis of nitrates may be useful for excluding asymptomatic bacteriuria but not for diagnosis

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Use urine culture testing wherever possible, as it is the most accurate means of detecting asymptomatic bacteriuria.</td>
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</tr>
</tbody>
</table>

**What is an appropriate approach to testing in rural and remote areas?**

Where access to pathology services is limited, dipstick tests may be used to exclude infection, with positive results confirmed by urine culture. Appropriate storage of dipsticks is essential to the accuracy of these tests.

**Practice summary**

**When:** Early in antenatal care

**Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health worker; multicultural health worker

- Discuss testing for asymptomatic bacteriuria: Explain that identifying urinary tract infection enables women to be treated with antibiotics and avoids the risk of complications.
- Document and follow-up: Note the results of testing in the woman’s record and have a follow-up system in place so that appropriate treatment is provided if a woman is found to have bacteriuria.
Group B streptococcus (GBS) (see Guideline Chapter 39)

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade C</th>
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</thead>
<tbody>
<tr>
<td>Offer either routine testing for GBS colonisation or a risk factor-based approach to prevention, depending on organisational policy.</td>
<td></td>
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</tbody>
</table>

How to test for group B streptococcus

- Cultures collected in late pregnancy have a high positive predictive value for colonisation during labour
- Detection rates of GBS are higher when a combined vaginal-rectal swab is taken
- Self-collection of vaginal-rectal specimens has similar culture yields to collection by a health professional

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade B</th>
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<tbody>
<tr>
<td>If offering testing for GBS, arrange for testing to take place at 35-37 weeks gestation.</td>
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</table>

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Grade C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encourage women to self-collect vaginal-rectal specimens and offer information about how to do this.</td>
<td></td>
</tr>
</tbody>
</table>

Practice summary

- **When:** At around 35 weeks gestation
- **Who:** Midwife; GP; obstetrician; Aboriginal and Torres Strait Islander health practitioner; Aboriginal and Torres Strait Islander health worker; multicultural health worker

  - **Discuss prevention:** Explain that treatment during labour may be offered to women who are colonised with GBS, have previously had a baby with GBS and/or have risk factors for transmission during labour.
  - **Give information about the test:** Unless the woman would prefer the specimen to be collected by a health professional, provide the test for her to carry out in the health care setting or at home.
  - **Take a holistic approach:** Explain that women with a positive test result or prior GBS may not be able to give birth in their planned setting and treatment may not be possible if labour is very short. For women who need to travel to give birth, explain the importance of testing at 35-37 weeks.
  - **Document and follow-up:** Tell women their test results and note results in their antenatal record. Inform women with a positive result or a previous infant with GBS infection about the importance of sharing this information with the health professionals involved in their care during labour.