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Postpartum Group B streptococcal meningitis

Sir,

Group B streptococcal (GBS) (Streptococcus agalactiae) infections cause substantial pregnancy-related morbidity. Group B streptococcal infection contributes to maternal urinary tract infection, chorioamnionitis, endometritis and sepsis. Postpartum meningitis secondary to GBS is very rare. We report a case of postpartum maternal GBS meningitis in a healthy woman developing within 48 h after a normal vaginal delivery.

A 26-year-old primigravida who had antenatal care elsewhere presented to us at 42 weeks gestation for induction of labor. She had no known risk factors for GBS infection such as (a) preterm labor (< 37 weeks’ gestation), (b) prolonged rupture of membranes (18 h), (c) maternal fever (temperature 38.0°C) or (d) GBS bacteriuria during pregnancy, (e) history of a previous newborn with GBS disease. Prostaglandin E2 was instilled intracervically for cervical ripening. Twelve hours later an artificial rupture of membranes was done and induction with oxytocin was started. No epidural anesthesia was administered. Six hours after induction, the fetal cardiotocograph showed variable decelerations for which amnioinfusion was initiated. Three hours later, after episiotomy under local anesthesia she delivered normally a live term baby with Apgar of 5 and 9. On the second postnatal day she developed high-grade fever and became confused and disoriented two hours later. She had no history of headache, vomiting, seizures, ear discharge, sinusitis or any genitourinary focus for the fever. On examination she was delirious and agitated. Her pulse rate was 126/min and BP was 120/60 mm of Hg. Pupils were equal and reacting to light and fundus examination was normal. There were no cranial nerve deficits or motor weakness. Reflexes were normally elicited and plantars were downgoing. Neck stiffness was elicited. Her episiotomy wound was clean and general and systemic examination was otherwise normal.
Letters

Her blood investigations showed leucocytosis WBC =22600 (N90%, L10%) and peripheral smears for malarial parasite were negative. Her biochemical results were normal. A cerebrospinal fluid (CSF) analysis showed turbid fluid with total WBCs of 660 (neutrophils of 88%) protein of 380 mg and sugar of 88 mg% with a concomitant blood sugar of 265 mg%. After blood, CSF and urine cultures were taken she was initiated on IV antibiotics with crystalline penicillin 20 lakhs every two-hourly and Inj Ceftriaxone 2 g twice daily. The blood and urine cultures grew GBS, sensitive to penicillin while the CSF culture was sterile probably due to prior antibiotic therapy. Penicillin G was continued for a total duration of 14 days. Within 24 h her sensorium improved, headache resolved and fever subsided and at discharge she was asymptomatic and well. The baby was well but was given IV antibiotics for five days after the mother’s GBS status was known though cultures and C-reactive protein were negative.

Only nine cases of maternal GBS meningitis have been reported and as in our case have always occurred in previously healthy adults.[3] One of these patients, who also had saline amnioinfusion died of severe meningitis.[4] The other eight cases made a good recovery with no residual neurological deficit.

Vaginal colonization is the source of invasive Group B streptococcal infection in neonates and pregnant women. The prevalence of GBS carriage in asymptomatic women at 35 weeks gestation detected from vaginal and rectal swabs is 20-30%.[5] The pathophysiological relation between pelvic carriage and meningitis is not clear and may be due to the increased pressure in the venous system of the pelvis during vaginal delivery or trauma associated with the episiotomy.[6]

This is the first case of postpartum meningitis due to GBS reported from India. Group B streptococcal meningitis though rare has a favorable outcome with prompt diagnosis and treatment. Group B streptococcal carriage rates range from 10-16% in pregnant Indian women.[2] Screening for GBS is not carried out routinely in India. Current CDC guidelines recommend routine screening for GBS in all pregnant women at 35 to 37 weeks gestational age. Previous CDC guidelines recommended risk-based screening (risk factors listed above). The appropriate screening strategy for a developing country like India is debatable.[2]

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