

Perinatal Guidelines: What's old / What's New

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Key Points: ANTEPARTUM PERIOD

- ▶ ART is recommended for all pregnant HIV+ women regardless of VL or CD4 count
- ▶ Include ZDV unless there is significant toxicity or resistance
- ▶ Perform resistance studies before starting tx
- ▶ If on ART and VL is detectable perform resistance test before modifying therapy
- ▶ Discuss known risks and benefits of ART during pregnancy
- ▶ Emphasize importance of adherence
- ▶ Coordinate services among prenatal care providers, primary care and HIV specialty care providers, mental health and drug abuse treatment services, peer educators, childbirth and parenting classes and public assistance programs

Choice of ART should be individualized

- ▶ Gestational age of the pregnancy
- ▶ The **health** of the woman
- ▶ The efficacy of regimens for **prevention** of perinatal transmission
- ▶ Effects of ART on the fetus and newborn, on the outcome of pregnancy, and for the woman
- ▶ HIV antiretroviral drug resistance studies.

Women Who are Currently Receiving ART

- ▶ Counsel risks/benefits of ART during the first trimester
- ▶ Continue tx if effective in suppressing viral replication and is safe for fetus
 - avoid use of efavirenz especially in the first trimester.
- ▶ Resistance testing if the woman has detectable viremia on therapy



ART Naive women who need ART for their own health

- ▶ Pregnant women who meet standard criteria for initiation of ART per adult treatment guidelines should receive ART as recommended for non-pregnant adults, taking into account what is known about use of specific drugs in pregnancy
 - For women who require immediate initiation of therapy for their own health, it is safe to start ART in the first trimester.

ART Naive women who do not require ART for their own health

- ▶ Three drug combination ART for prophylaxis of perinatal transmission
 - Can consider delaying ART until after 1st trimester in women who need ART solely for prevention of MTCT
- ▶ Use of ZDV is recommended when feasible
- ▶ ART solely for fetal protection should be discontinued PP
 - Triple nucleoside combination (ZDV + lamivudine + abacavir) may be considered
 - High CD4 and VL < 1000 may consider AZT mono tx if woman is resistant to taking combination tx

Women Who Have Previously Received ART for Treatment or Perinatal Prophylaxis But are Not Currently Receiving Any Drugs

- ▶ Perform resistance testing prior to initiating repeat antiretroviral prophylaxis or therapy
- ▶ Use repeat resistance testing to change therapy in cases of virologic non-response
- ▶ Get detailed history of previous ART and resistance history

MONITORING DURING PREGNANCY

- ▶ CD4 at initial visit and at least every 3 months during pregnancy
- ▶ VL at initial visit, 2 to 6 weeks after initiating (or changing) ART, monthly until VL is undetectable, and then at least every 2 months during pregnancy
- ▶ Repeat VL 34-36 weeks gestation to determine mode of delivery
- ▶ Resistance testing with detectable VL

SPECIAL CONSIDERATIONS

- ▶ Some protease inhibitors may require altered dosing during pregnancy
- ▶ Nevirapine can be used in women with CD4+ \leq 250
- ▶ Efavirenz is FDA category D drug and should not be used in the first trimester
 - Women on efavirenz should be counseled to avoid pregnancy
- ▶ D4T with DDI has increased potential for lactic acidosis in HIV+ pregnant women
 - Use with caution and only when other NRTIs have failed or have caused unacceptable toxicity or side effects

Intrapartum Management

- ▶ Intrapartum IV ZDV for all HIV + pregnant women, regardless of antepartum regimen
- ▶ If D4T used as an antepartum regimen, discontinue D4T during labor while IV ZDV is administered
- ▶ Continue ART on schedule as much as possible during labor and prior to scheduled Cesarean

Women with no Prenatal Care or unknown HIV status at Labor

- ▶ Perform rapid HIV antibody testing ; if preliminary positive start IV ZDV and send Western Blot
- ▶ Presents in labor with no antepartum ART:
 - IV ZDV during labor and six weeks of infant ZDV
 - Option to combine the intravenous/newborn ZDV regimen with single-dose intrapartum/newborn NVP
 - If single-dose NVP is given, consideration should be given to maternal ZDV/3TC for 3 to 7 days postpartum, which may reduce development of NVP resistance.

Cesarean Section

- ▶ Scheduled C/S recommended at 38 weeks
 - VL >1,000 (whether receiving or not receiving antepartum ART) near the time of delivery
 - Unknown VL near the time of delivery
- ▶ Scheduled C/S has no known additional benefit when VL < 1000 given the low rate of transmission in this group
- ▶ Counselor regarding the limitations of the current data.
- ▶ Respect the woman's autonomy to make an informed decision regarding route of delivery
- ▶ It is not clear that cesarean delivery after rupture or onset of labor provides benefit in preventing perinatal transmission
 - Management must be individualized based on duration of rupture, progress of labor, VL, current ART, and other clinical factors

Time of ART administration

Regimen

Antepartum

HAART to maximally suppress virus
Include ZDV if possible
Start after 1st trimester unless appropriate to start/con't ART

Intrapartum

IV ZDV in a one hour initial dose:
2 mg/kg/body weight followed by
continuous infusion 1mg/kg/body weight
4 hours prior to C/S

Postpartum

Oral ZDV to newborn (syrup 2mg/kg body weight.) Dose every 6 hours for first 6 weeks of life beginning 8-12 hours after birth

Pregnancy Registry

▶ Telephone:

- 800-258-4263

▶ Fax:

- 800-800-1052

▶ Internet

- www.APRegistry.com

