Guidelines for Use of HIV Antiretroviral Therapy in Pregnancy

- Antiretroviral (ARV) therapy should not be withheld during pregnancy unless known adverse effects to mother, fetus or infant outweigh benefit to the woman.
- Potential impact on fetus/infant is unknown. Research studies are ongoing.
- The woman should make the decision after talking with her provider about the known and unknown benefits and risks of ARV treatment for her and her infant.

Therapy Goals:

- Treating the woman's HIV infection
- Reducing the risk of perinatal HIV transmission

Initial assessment of pregnant woman and need for ARV:

- Degree of immunodeficiency (CD4+/percentage)
- History of prior ARV
- Viral load (HIV-RNA)
- Gestational age

For all pregnant women, recommend the 3-part zidovudine (ZDV) regimen to reduce perinatal transmission.

- Antepartum ZDV dose: 100mg po 5x daily, start after 14 wks. gestation or acceptable alternative regimen ZDV 200mg po TID or ZDV 300mg po BID
- Intrapartum IV ZDV: loading dose 2mg/kg over 1hr., then 1mg/kg/hr. until delivery
- Newborn dose: ZDV syrup 2mg/kg po q 6 hrs. for 6 wks., beginning 8–12 hrs. after birth. *Premature infant doses vary. Contact an HIV specialist.*

For women on ARV therapy before/during pregnancy, consider adding or substituting ZDV if on other NRTIs. (Note: Do not administer ZDV and d4T concomitantly.)

1st trimester of pregnancy, ARV naïve women:

- Evaluate woman's need for ARV therapy
- Counsel woman on risks/benefits of starting ARV therapy during this time
- Consider, if possible, delaying ARV until 12 wks. gestation

1st trimester of pregnancy, women receiving ARV therapy:

- Evaluate and counsel as above
- If decision is to temporarily stop ARV therapy, stop all drugs together and restart them together after 1st trimester to avoid inducing viral resistance to the drugs
- If pregnancy is identified after 1st trimester, continue therapy

Women in labor with no prior ARV have these regimens available:

- Intrapartum IV ZDV: loading dose 2mg/kg over 1 hr., then 1mg/kg/hr until delivery. For the newborn, ZDV syrup 2mg/kg po q 6 hrs. for 6 wks. beginning 8–12 hrs. after birth
- ZDV 600mg po at onset of labor followed by 300mg po q 3 hrs. until delivery **and** 3TC 150mg po at the onset of labor, followed by 150mg po q12 hrs. until delivery. For the newborn, ZDV syrup 4mg/kg **and** 3TC 2mg/kg po q 12 hrs. for 7 days
- Single dose nevirapine (NVP) 200mg po at onset of labor. For the newborn, single dose NVP 2mg/kg po at age 48–72 hrs.
- Intrapartum IV ZDV: loading dose 2mg/kg over 1 hr., then 1mg/kg/hr until delivery and NVP single 200mg po dose at onset of labor. For the newborn, ZDV syrup 2mg/kg po q 6 hrs. for 6 wks. and NVP single 2mg/kg po dose at age 48–72 hrs.

Counseling regarding scheduled cesarean section (C-section):

- Plasma HIV-1 RNA levels should be monitored during pregnancy and the most recent viral load value used when counseling a woman regarding mode of delivery
- For women with HIV RNA levels <1,000 copies/ml, given the low rate of transmission, it is unlikely that scheduled C-section would further reduce transmission
- For women with unknown HIV RNA levels who are not on ARV or who are only on ZDV for prophylaxis, C-section reduces perinatal transmission
- Women with HIV RNA levels >1,000 copies/ml should be counseled regarding the benefits of C-section delivery
- Women should be informed of the risks associated with C-section delivery. Risks to the mother should be balanced with the potential benefits expected for the neonate
- Scheduled C-section delivery should be performed at 38 weeks gestation (rather than at 39)

Post-delivery recommendation:

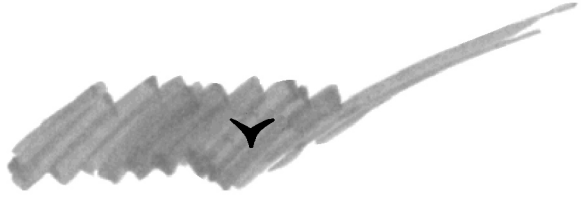
- Refer for specialty HIV care
- Possible changes in therapy:
  - Discontinue ZDV if given for sole purpose of preventing perinatal transmission
  - Return to previous combination ARV regimen or
  - Continue on current combination ARV regimen or
  - Start on combination ARV regimen or
  - No ARV (if viral/immune parameters don't warrant therapy)

Follow-up Care for Infants Born to Mothers with HIV Infection

Whether or not mothers have received ARV during pregnancy or delivery

- Neonatal ARV regimen should be discussed with mother
- Perform CBC at baseline, 6 wks. and 12 wks. of age
- Within 48 hrs after birth, an HIV DNA PCR should be performed
- If HIV DNA PCR positive, confirm with repeat PCR as soon as possible after positive test results
- In consultation with Pediatric HIV Specialist, consider antiretroviral combination therapy
- If HIV DNA PCR is negative, repeat PCR at 14 days if possible, at age 1–2 mos., and at 3–6 mos.
- HIV is diagnosed by 2 positive HIV DNA PCR tests on specimens at 2 time points
- HIV infection can be reasonably excluded with 2 or more negative PCR performed at >1mo. and >4 mo. (or 2 or more negative HIV IgG antibody tests at >6 mo.)
- TMP-SMX for PCP prophylaxis should be started at 6 wks. of age for all infants exposed to HIV
- Refer infant for follow up care to an HIV specialist

To obtain the most current recommendations, visit
www.aidsinfo.nih.gov



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