



HIV and Pregnancy



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- “I always wanted to have a baby but didn't think it was possible when I was diagnosed HIV positive”.....



...Now I know it is possible



Where does pregnancy start?

Planned

discussion

Unplanned

sex

Planned

- Discussion with partner
- Discussion with Clinician
- Careful management
- A healthy baby



Unplanned

- Can be very complex to manage
- Can raise some very serious physiological issues for the women AND the man



Case study's

- Case study 1
- Case study 2
- Case study 3
- Case study 4



Conception, how to

- Discuss with Clinician
- Both partners HIV then – hey roll on and have some fun!
 - Swiss statement BHIVA statement etc
 - Important to remember intimate and long lasting conception of a baby
 - Timed unprotected sex i.e. fertile period



HIV positive women negative man

- If on ART undetectable then ok to conceive naturally (Swiss statement, BHIVA, NHS, Canada, Germany etc)
- DIY insemination (involves a plastic syringe. Advice should be sought on how to do it properly)
- Use of PrEP for the man



HIV positive man negative women

- Sperm washing – sperm is washed then inserted into the women – inside the body fertilisation
- IVF (In Vitro Fertilisation) outside the body fertilisation
- Very carefully timed natural conception – requires very good management undetectable V/L and no signs of virus in semen
 - ??? Things are changing here with the use of ARVS
- Use of PrEP for the women

Bingo...

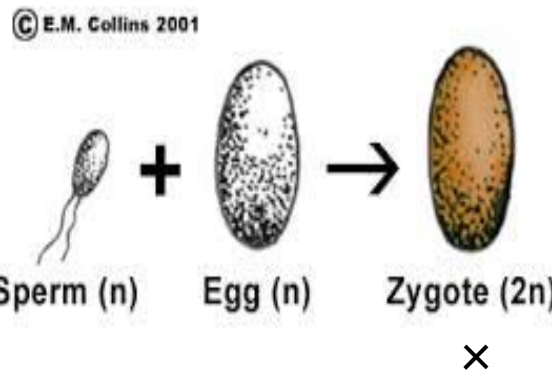
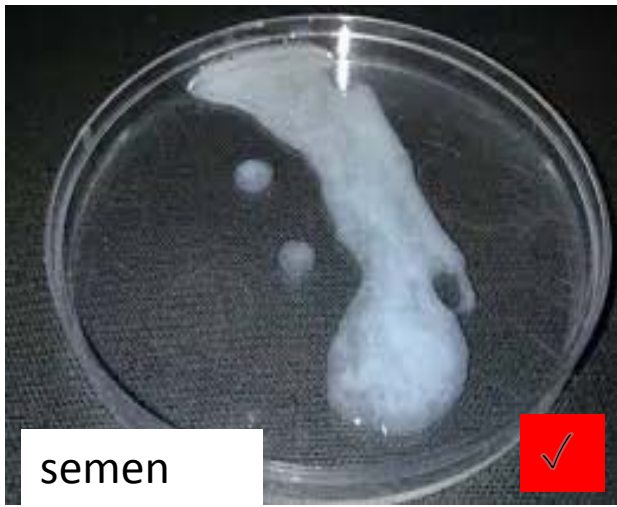
- We have a baby

–And some sleepless nights ahead



Vertical Transmission or Mother to Child Transmission (MTCT)

- This is a language issue.
- Mother to Child Transmission (MTCT)
 - VERY damaging as it has a “blame” attached to it
- Vertical Transmission
 - Is not “blaming” and reduces the “burden” of blame on women



How is HIV transmitted from mother to child?

- Transmission of HIV in the womb is rare due to the placenta
- However;
 - A high V/L low CD4 count and advanced HIV infection can increase risk.
 - Presence of STI
 - Exposure of maternal blood – either through invasive procedures OR trauma / injury

Labour

- If a labour has been long or a protracted – runs the risk of damage to the internal linings of the womb and vaginal canal
- The use of forceps – often these rupture the skin of both the women and baby causing blood contamination



Breast feeding

- Breast milk contains high volume and high quality of the HIV virus
- Breast feeding should be avoided where formula milk is available
- If breast feeding is to be used, do not mix formula milk and breast milk or breast milk and solid food. No breast after 6 months of age.
- Water / Infection / ARVS's all play a key role here!

Treatments during pregnancy

- If not already on ART's for own health then;
- Start ART by week 20 of pregnancy (first trimester) – aims to have an undetectable V/L before week 36
- Treatment given will depend on area and availability of drugs;
 - Recommended; zidovudine plus lamivudine tenofovir plus emtricitabine or abacavir plus lamivudine plus recommended 3rd agent efavirenz or nevirapine or a boosted PI

Late presenters treatment

- After week 28 commence ART without delay
- A 3 or 4 drug regime recommended - to include raltegravir

Labour presenters move FAST!

- Untreated women presenting in labour at term;
 - Stat dose of nevirapine and commence fixed dose of zidovudine with lamivudine and raltegravir
 - Intravenous zidovudine for the duration of labour and delivery

- Women presenting with ruptured membrane (ROM) with no test, urgent HIV test. If reactive / positive follow interventions to prevent MTCT
- Elite controllers
 - Zidovudine monotherapy or abacavir/lamivudine/zidovudine
 - Aim for vaginal birth
 - Formula feed only

Delivery

- Vaginal delivery recommended if;
- On HAART with an HIV V/L <50 at 36 weeks
- 50 – 399 HIV RNA V/L AT 36 weeks – a planned C Section should be considered
- >400 HIV RNA V/L at 36 weeks recommended C Section



- Monotherapy of zidovudine should be PLCS (planned C section)
- Elite controllers exempt and vaginal birth should be aimed for
- All planned C Sections (PLCS) should take place between week 38 and 39 gestation



After delivery

- Recommended to stay on ART, if stopping then follow guidelines on how to stop
- Co-infected remain on ART
- CD4 count under 500 stay on ART



NEONATAL MANAGEMENT

Zidovudine monotherapy recommended if maternal V/L <50 HIV RNA copies/ml at 36 weeks or mother delivered by planned C section

- Infants <72 h old, born to untreated HIV-positive mothers, should immediately initiate three drug therapy for 4 weeks.
- Three-drug infant therapy is recommended for all circumstances where maternal VL at 36 weeks' gestation/delivery is not <50 HIV RNA copies/mL.

- Neonatal post exposure prophylaxis (PEP) should commence soon after birth, certainly within 4hrs
- Neonatal PEP continued for 4 weeks
- Pneumocystis pneumonia (PCP) prophylaxis, with co-trimoxazole, should be initiated from age 4 weeks in:
 - HIV-positive infants.
 - Infants with an initial positive HIV DNA/RNA test result (and continued until HIV infection has been excluded).
 - Infants whose mother's VL at 36 weeks gestational age or at delivery is >1000 HIV RNA copies/mL despite HAART or unknown (and continued until HIV infection has been excluded).

Time to enjoy your hard work

- Or put another way, this is where the hard work starts!



DAB's

- Drug Addicted / Dependent neonates
- DO NOT put in a cot and leave them. This could kill them.
- Follow the Finnegan's Score card and get EXPERT help
 - Beware of DDI's



Thanks to;

- Angelina Namiba
- BHIVA
- Useful links to use;
- <http://i-base.info/guides/pregnancy>
- [http://www.positivelyuk.org/docs/The Pregnancy Journey.pdf](http://www.positivelyuk.org/docs/The_Pregnancy_Journey.pdf)
- [http://www.rcog.org.uk/files/rcog-corp/PI HIV and pregnancy.pdf](http://www.rcog.org.uk/files/rcog-corp/PI_HIV_and_pregnancy.pdf)

