CARE OF PREGNANT WOMEN WITH HIV / AIDS

Preventing Perinatal Transmission

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Disclosure of Financial Interests

The presenter does not have any financial interests or relationships to disclose

The presenter will not discuss any off-label use or investigation product during the presentation

This slide set has been peer reviewed
Learning Objectives

Upon completion of this event, attendees will be able to:

• Define HIV perinatal transmission.

• Review the HIV perinatal transmission data for Florida and specifically for Miami-Dade county.

• Identify major risk factors that contribute to perinatal HIV transmission.

• Describe current recommendations and interventions to prevent perinatal HIV transmission.
## HIV Infected Newborns 2010 - 2015

![Map of Florida with counties shaded and marked for HIV infected newborns from 2010 to 2015.](image)

### Number of Cases vs Year of Birth

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Year of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>2010</td>
</tr>
<tr>
<td>3</td>
<td>2011</td>
</tr>
<tr>
<td>8</td>
<td>2012</td>
</tr>
<tr>
<td>10</td>
<td>2013</td>
</tr>
<tr>
<td>6</td>
<td>2014</td>
</tr>
<tr>
<td>9</td>
<td>2015</td>
</tr>
</tbody>
</table>

Data as of 4/22/16
HIV Status for Babies Born to an HIV-Infected Mother in Florida, 2007-2014

**Exposure only**

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Births</th>
<th># Exposed</th>
<th># Infected</th>
<th>% infected*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>672</td>
<td>655</td>
<td>17</td>
<td>2.5%</td>
</tr>
<tr>
<td>2008</td>
<td>628</td>
<td>617</td>
<td>11</td>
<td>1.8%</td>
</tr>
<tr>
<td>2009</td>
<td>620</td>
<td>611</td>
<td>9</td>
<td>1.5%</td>
</tr>
<tr>
<td>2010</td>
<td>577</td>
<td>571</td>
<td>6</td>
<td>1.0%</td>
</tr>
<tr>
<td>2011</td>
<td>578</td>
<td>575</td>
<td>3</td>
<td>0.5%</td>
</tr>
<tr>
<td>2012</td>
<td>527</td>
<td>519</td>
<td>8</td>
<td>1.5%</td>
</tr>
<tr>
<td>2013</td>
<td>517</td>
<td>507</td>
<td>10</td>
<td>1.9%</td>
</tr>
<tr>
<td>2014</td>
<td>507</td>
<td>501</td>
<td>6</td>
<td>1.2%</td>
</tr>
<tr>
<td>2015</td>
<td>502</td>
<td>493</td>
<td>9</td>
<td>1.8%</td>
</tr>
</tbody>
</table>

* Annual Rate of Transmission.

A total of 502 babies were known to be born to HIV-Infected mothers in Florida in 2015, of which 9 (1.8%) were known to be HIV-infected. (Data as of 04/22/16).

Note: Perinatal exposure became reportable 11/20/2006, therefore 2007 is the first complete year.

In 2001, 38 HIV + infants born = 2.5% transmission.
Perinatal HIV in Children Whose Mom’s HIV Status Was Known Prior to Delivery - Born in Florida, 2007-2014, by Receipt of Antiretroviral Therapy (ART) During Delivery and Elective Caesarean Delivery (N=51)

- **ART During Labor**
  - AZT and/or antiretroviral
  - Yes: 78%
  - No: 22%

- **Elective Caesarean Delivery**
  - Yes: 76%
  - No: 24%
Causes of Infected Babies: Florida - 2013 (10)

- **Alachua County**
  (1) Diagnosis late in pregnancy, noncompliant, substance abuse

- **Miami-Dade County**
  (1) History of multiple pregnancies and no PNC, disclosure issues, substance abuse
  (1) Noncompliant, substance abuse
  (1) Multiple missed opportunities- poor reporting from DIS of mothers HIV status, physicians did not follow ACOG testing recommendations, hospital did not test during L&D, baby was not tested

- **Escambia County**
  (1) No Prenatal care [PNC] History of multiple pregnancies, substance abuse
  (1) Noncompliant, substance abuse

- **Gadsden County (AIDS)**
  (1) Acute infection, unprotected sex w/ HIV+ partner

- **Hernando**
  (1) No PNC, substance abuse

- **Hillsborough County**
  (1) No PNC, History of substance abuse and incarceration

- **Pinellas County**
  Late PNC at 26-27 wks. OB/GYN believed that she was only 3-8 weeks along based on the reported LMP date given by mother
Perinatal HIV Infection Cases Born in Selected South Florida Counties, 2007-2014, by Race/Ethnicity (N=27)

Note: Pediatric AIDS in Florida disproportionately affects non-Hispanic blacks. In South Florida, 85%, (23 of 27) of the pediatric HIV/AIDS cases were among blacks.
## Living Female (WCBA ages 15-44) HIV/AIDS by Race and County of Residence thru 2014

<table>
<thead>
<tr>
<th>Race</th>
<th>Miami-Dade</th>
<th>Broward</th>
<th>Palm Beach</th>
<th>Monroe</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black</td>
<td>1968</td>
<td>1806</td>
<td>924</td>
<td>12</td>
<td>4710</td>
</tr>
<tr>
<td>White</td>
<td>116</td>
<td>151</td>
<td>139</td>
<td>7</td>
<td>413</td>
</tr>
<tr>
<td>Hispanic</td>
<td>584</td>
<td>184</td>
<td>136</td>
<td>4</td>
<td>908</td>
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<tr>
<td>Other</td>
<td>36</td>
<td>48</td>
<td>17</td>
<td>1</td>
<td>72</td>
</tr>
<tr>
<td>Total</td>
<td>2704</td>
<td>2189</td>
<td>1216</td>
<td>24</td>
<td>6103</td>
</tr>
<tr>
<td>Perinatal HIV/AIDS Cases by Year of Birth</td>
<td>Pediatric HIV</td>
<td></td>
<td>Pediatric AIDS</td>
<td></td>
<td>TOTAL</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>--------------</td>
<td>--------</td>
<td>----------------</td>
<td>-------</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cases</td>
<td>Row %</td>
<td>Cases</td>
<td>Row %</td>
<td>Cases</td>
</tr>
<tr>
<td>2000</td>
<td>5</td>
<td>71.4%</td>
<td>2</td>
<td>28.6%</td>
<td>7</td>
</tr>
<tr>
<td>2001</td>
<td>6</td>
<td>60.0%</td>
<td>4</td>
<td>40.0%</td>
<td>10</td>
</tr>
<tr>
<td>2002</td>
<td>3</td>
<td>50.0%</td>
<td>3</td>
<td>50.0%</td>
<td>6</td>
</tr>
<tr>
<td>2003</td>
<td>3</td>
<td>75.0%</td>
<td>1</td>
<td>25.0%</td>
<td>4</td>
</tr>
<tr>
<td>2004</td>
<td>1</td>
<td>50.0%</td>
<td>1</td>
<td>50.0%</td>
<td>2</td>
</tr>
<tr>
<td>2005</td>
<td>3</td>
<td>60.0%</td>
<td>2</td>
<td>40.0%</td>
<td>5</td>
</tr>
<tr>
<td>2006</td>
<td>2</td>
<td>66.7%</td>
<td>1</td>
<td>33.3%</td>
<td>3</td>
</tr>
<tr>
<td>2007</td>
<td>1</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
</tr>
<tr>
<td>2008</td>
<td>1</td>
<td>50.0%</td>
<td>1</td>
<td>50.0%</td>
<td>2</td>
</tr>
<tr>
<td>2009</td>
<td>2</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>2</td>
</tr>
<tr>
<td>2010</td>
<td>3</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>3</td>
</tr>
<tr>
<td>2011</td>
<td>1</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
</tr>
<tr>
<td>2012</td>
<td>1</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
</tr>
<tr>
<td>2013</td>
<td>2</td>
<td>66.7%</td>
<td>1</td>
<td>33.3%</td>
<td>3</td>
</tr>
<tr>
<td>2014</td>
<td>1</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>1</td>
</tr>
<tr>
<td>2015</td>
<td>5</td>
<td>100.0%</td>
<td>0</td>
<td>0.0%</td>
<td>5</td>
</tr>
<tr>
<td>Total Confirmed Perinatal Cases</td>
<td>40</td>
<td>71%</td>
<td>16</td>
<td>29%</td>
<td>56</td>
</tr>
</tbody>
</table>
HIV Infected Moms With Live Birth Deliveries
Miami-Dade

2010 - 2014
544

2015
108
Causes of Infected Babies - Miami-Dade - 2015

1) Substance abuse; homelessness; non-compliance; mental disorders. Late prenatal/HIV care at 28 weeks; multiple children placed by DCF

2) A Prior delivery after HIV diagnosis; Depression between pregnancies; no HIV treatment between pregnancies; 1st prenatal/HIV visit at 21 weeks ultrasound at 14 weeks but hospital did not offer/perform HIV test

3) Arrived from Haiti not aware of diagnosis; No prenatal/HIV care

4) One of triplets: Hx of multiple pregnancies and no
• prenatal/HIV care; Mother of 12/31/2013 case; delivered
• HIV (-) boy in 2015; substance abuse; mom left the hospital the day after delivery never return

5) Two of triplets (one not infected)
PREGNANCY IMMUNOLOGY (PRIM) STATISTICS
HIV Infected Moms With Live Birth Deliveries
2015

MIAMI-DADE
108

PRIM
71 (65.74%)

UM - OB / Gyn Data Base

Florida HEALTH
PRIM deliveries = 80

- Mental Health Problems 17 (22%)
- Substance Use 15 (19%)
- Domestic Violence 6 (9%)
- Homelessness 2 (3%)
- One or more 28 (35%)
MAJOR RISK FACTORS FOR HIV PERINATAL INFECTION
MAJOR RISK FACTORS FOR HIV PERINATAL INFECTION

- Medical
- Psychological
- Social
- Community
- System
- Patient’s related

(Understanding of the diagram requires visual interpretation.)
MEDICAL FACTORS
MEDICAL RISK FACTORS FOR HIV PERINATAL INFECTION

- No pre-conceptive care and testing
- No prenatal care or late entry
- Failure to follow ACOG testing recommendations
- No testing during L+D
- No newborn testing
- Acute infection
- Sexually Transmitted Disease
- Unplanned pregnancy
- No combined Antiretroviral Therapy (cART)
- Non-compliance
- Co-morbidities
- Problems with continuum in Care
Diagnosed People Living with HIV (PLWH) in Florida, Including Selected Stages of Continuum of Care, 2014

In Florida, 83% of those diagnosed with HIV in 2014 had documented HIV-related care within 3 months of diagnosis.

- **109,969** PLWH
- **99,516** 90% EVER IN CARE
- **78,124** 71% IN CARE
- **70,287** 64% RETAINED IN CARE
- **74,218** 64% ON ANTIRETROVIRAL THERAPY (ART)
- **64,230** 58% WITH SUPRESSED VIRAL LOAD

The CDC estimates that 12.4% of PLWH in Florida are undiagnosed.

http://www.floridahealth.gov/_documents/HIV/_images/continuum-x.svg
PSYCHO-SOCIAL FACTORS
PSYCHO-SOCIAL RISK FACTORS FOR HIV PERINATAL INFECTION

- Substance use
- Mental Health Disorders
- Homelessness
- Disclosure issues
- Intimate partner violence (IPV)
- Cognitive deficit / Neurodevelopmental issues
- Non-compliance
Mental Health Issues

- Relationships between stress, depression, and other psychosocial factors with disease progression
- Six times the national rate of post-traumatic stress disorder
- Chronic depression has been associated with greater decline in CD4 cells
- HIV-positive woman with chronic depression are more than twice as likely to die than HIV-positive women with limited or no depression
- Ineffective coping skills
- Anxiety
- Bipolar disorder / Schizophrenia
- Cognitive deficit

www.cdc.gov/violenceprevention
Substance Use

- Increase substance use in Miami-Dade
- Consequences of substance use
- Limited detox programs
- Limited rehabilitation programs
- Limited access to methadone and buprenorphine
- DCF involvement
- Homelessness or unstable housing

Recovery clinic at PRIM
- 35.4% were HIV positive (Preliminary data from Recovery Clinic – Dr. Curry)
- 27% had undetectable viral load on entry to care
Disclosure

Lack of disclosure has been described legally as fraud, criminal negligence, criminal nuisance, and many other charges in additional jurisdictions. However, these charges assume that everyone can disclose their HIV status at the time of every sexual act. Numerous recent studies demonstrate that there are many valid cultural reasons why individuals do not disclose their HIV status, including fear of domestic violence, fear of familial or partner abandonment, and community rejection. These real impacts make disclosure of one’s status nearly impossible for many, particularly for newly diagnosed individuals who are already trying to absorb the shock of their possible death. For some individuals it is likely that nondisclosure was tied to denial of HIV status and what the implications of that status might mean in terms of safe sex practices.

Heather Worth, Cindy Patton and Diane Goldstein, 2008.
Abuse

- Rate of IPV among HIV positive women (55%) was double the national rate
- Rates of childhood sexual abuse (39%) and childhood physical abuse (42%) were more than double the national rate
- HIV-positive women may experience abuse that is more frequent and more severe
- HIV sero-status disclosure may be an initiating or contributing factor for partner violence
- IVP and trauma history can compromise the health and prevention practices of women living with HIV
- Associations between IPV and decrease T-cells

www.cdc.gov/violenceprevention
COMMUNITY / SYSTEM FACTORS
COMMUNITY /SYSTEM RISK FACTORS FOR HIV PERINATAL INFECTION

• Community
  - Stigma
  - Child care

• System
  - Poor reporting of mother HIV's status
  - No timely referral
  - Lack of coordination of services
  - Medical Insurance / Pharmacy / Authorization
  - Transportation
  - Housing problems
FACTORS RELATED TO THE PATIENT
RISK FACTORS RELATED TO THE PATIENT

• Denial of HIV diagnosis
• Lack of family and social support
• Cognitive deficit / Neurodevelopmental issues
• Health Literacy
• Low educational level
• Unemployed
• Unmarried
• Foster care
• Stigma
RECOMMENDATIONS TO PREVENT PERINATAL TRANSMISSION
<table>
<thead>
<tr>
<th>Missed Opportunities</th>
<th>Prevention Opportunities</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV-infected woman: known status</td>
<td>Primary HIV prevention for women and girls</td>
</tr>
<tr>
<td>HIV-infected woman: unknown status</td>
<td>Adequate preconception care and family planning services</td>
</tr>
<tr>
<td>No Preconception Care</td>
<td>Accessible, affordable, welcoming prenatal care</td>
</tr>
<tr>
<td>Become Pregnant</td>
<td>Universal prenatal HIV testing (routine, opt-out)</td>
</tr>
<tr>
<td>No Frenatal Care</td>
<td>Providing ARV prophylaxis to all eligible</td>
</tr>
<tr>
<td>No HIV Test</td>
<td>Utilize Cesarean delivery if maternal viral load is &gt;1000 copies/ml</td>
</tr>
<tr>
<td>Inadequate ARV Prophylaxis</td>
<td>Education and support on avoidance of breastfeeding</td>
</tr>
<tr>
<td>No Cesarean Delivery</td>
<td>Comprehensive services for mother and infant</td>
</tr>
<tr>
<td>Breastfed Infant</td>
<td></td>
</tr>
<tr>
<td>Child Infected Despite Treatment</td>
<td></td>
</tr>
</tbody>
</table>

# Rating Scheme for Recommendations

<table>
<thead>
<tr>
<th>Strength of Recommendation</th>
<th>Quality of Evidence for Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A:</strong> Strong recommendation for the statement</td>
<td>I: One or more randomized trials with clinical outcomes and/or validated laboratory endpoints</td>
</tr>
<tr>
<td><strong>B:</strong> Moderate recommendation for the statement</td>
<td>II: One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes</td>
</tr>
<tr>
<td><strong>C:</strong> Optional recommendation for the statement</td>
<td>III: Expert opinion</td>
</tr>
</tbody>
</table>

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• Pre-conception

• Antepartum
  • First trimester
  • Third trimester

• Intrapartum
  • Rapid test
  • Confirmatory test

• Newborn
  • At birth, 2 weeks, 1 month, 4 months

• Partner testing
Special Provisions for Pregnant Women (This requirement was effective June 10, 2005)

- Florida law (s. 384.31, F.S. and Rule 64D-2.004, F.A.C.) requires a healthcare provider who attends a pregnant woman for conditions relating to her pregnancy to **test for HIV and other STDs at the initial visit** and counsel her on the availability of treatment if she tests positive.
- If a pregnant woman tests HIV negative, **test again at 28-32 weeks** gestation and **at labor and delivery** under the circumstances outlined in Rule 64D-3.042, F.A.C.
- The physician shall inform the woman she will be tested for HIV and other STDs and of her right to refuse.
- If the pregnant woman objects to testing, a reasonable attempt must be made to obtain a written statement of objection, signed by the patient, which shall be placed in her medical record.
- Emergency departments of hospitals licensed under Chapter 395, F.S. may satisfy the testing requirements under this rule by referring any woman identified as not receiving prenatal care after the 12th week of gestation, to the CHD. The referral shall be in writing and a copy shall be submitted to the CHD having jurisdiction over the area in which the emergency department is located. **Emergency rooms and the local CHD should develop protocols.**
SERODISCORDANT COUPLES
Serodiscordant Couples

- The HIV-infected partner should be receiving combination antiretroviral therapy and demonstrate sustained suppression of plasma viral load below the limits of detection (AI).

- Preconception administration of antiretroviral pre-exposure prophylaxis (PrEP) for HIV-uninfected partners may reduce the risk of sexual transmission (CIII).

- For Discordant Couples with HIV-Infected Women, the safest conception option is artificial insemination, including the option of self-insemination with a partner’s sperm during the peri-ovulatory period (AIII).

- For Discordant Couples with HIV-Infected Men, the use of donor sperm from an HIV-uninfected man with artificial insemination is the safest option (AIII). Other options: sperm preparation techniques coupled with either intrauterine insemination or in vitro fertilization (All).

http://aidsinfo.nih.gov/guidelines
PrEP
PrEP

- Pre-exposure prophylaxis (PrEP) is a way to help prevent HIV by taking a pill every day

- Tenofovir and Emtricitabine – PrEP approved on July 2012

- Better results when used consistently

- Guidelines for PrEP use

- F/U visits and HIV testing every three months

- Evaluation of renal function

- Assess pregnancy intent

- Pregnancy test every three months

- Appropriate counseling, safe sex practices

ANTEPARTUM CARE
ANTEPARTUM

• Assessment:
  • HIV disease status
  • Initiation or modification of combination antiretroviral therapy (cART) (AIII).

• All pregnant HIV-infected women should be in cART to prevent perinatal transmission (AI).

• Combined antepartum, intrapartum, and infant antiretroviral (ARV) prophylaxis. (AI).

• Benefits and potential risks of all medications, including ARV’s (AIII).

• Emphasized the importance of adherence. (AII).

• ARV drug-resistance studies before starting or modifying regimens (AIII).

• Coordination of services among OB, primary care and HIV care providers, and if needed, with mental health, substance treatment services, and public assistance programs (AIII).

http://aidsinfo.nih.gov/guidelines
ANTEPARTUM

• Same regimens recommended for treatment of non-pregnant adults should be used in pregnant women. (AII).

• Multiple factors must be considered when choosing a regimen for a pregnant woman including:
  • comorbidities
  • convenience
  • adverse effects
  • drug interactions
  • resistance testing results
  • pharmacokinetics
  • experience with use in pregnancy (AIII).

• Pharmacokinetic changes in pregnancy
  • \[\rightarrow\] lower plasma levels of drugs
  • \[\rightarrow\] increased dosages, more frequent dosing, or boosting – PI’s (AII).

http://aidsinfo.nih.gov/guidelines
ANTEPARTUM

• Because maternal antenatal viral load correlates with risk of perinatal transmission of HIV, suppression of HIV RNA to undetectable levels should be achieved as rapidly as possible (AII).

• Monitor CD4 and HIV VL.

• Check for Liver toxicity

• If failure of viral suppression:
  Assess adherence and resistance (AII).
  Consider regimen modification (AIII)
  Consult an HIV expert (AIII).

• Scheduled cesarean if VL >1,000 near the time of delivery (AII).

http://aidsinfo.nih.gov/guidelines
Antiretrovirals during pregnancy

• **Preferred**
Regimens with clinical trial data in adults demonstrating optimal efficacy and durability with acceptable toxicity and ease of use, PK data available in pregnancy, and no evidence to date of teratogenic effects or established adverse outcomes for mother/fetus/newborn.

• **Alternative**
Regimens with clinical trial data demonstrating efficacy in adults but one or more of the following apply: experience in pregnancy is limited, data are lacking or incomplete on teratogenicity, or regimen is associated with dosing, formulation, toxicity, or interaction issues

• **Use in Special Circumstances**
## Preferred 2-NRTI Backbone Regimens

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ABC/3TC</td>
<td>FDC Once daily HLA-B* 5701 negative test</td>
</tr>
<tr>
<td></td>
<td>Potential of HSR</td>
</tr>
<tr>
<td>TDF/FTC OR 3TC</td>
<td>FDC Once daily Potential of renal toxicity</td>
</tr>
<tr>
<td>ZDV/3TC</td>
<td>FDC Most experience Twice daily Potential of hematological toxicity</td>
</tr>
</tbody>
</table>

Preferred PI Regimens

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATV/r + preferred two-NRTI backbone</td>
<td>Once daily</td>
</tr>
<tr>
<td></td>
<td>Extensive experience in pregnancy</td>
</tr>
<tr>
<td></td>
<td>Maternal hyperbilirrubinemia</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>DRV/r + preferred two-NRTI backbone</td>
<td>Twice daily</td>
</tr>
<tr>
<td></td>
<td>Better tolerance than LPV/r</td>
</tr>
<tr>
<td></td>
<td>PK data available</td>
</tr>
<tr>
<td></td>
<td>Increasing experience during pregnancy</td>
</tr>
</tbody>
</table>
INITIAL COMBINATION REGIMENS FOR ANTIRETROVIRAL-NAÏVE PREGNANT WOMAN

Preferred NNRTI Regimens

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>EFV + preferred 2-NRTI backbone</td>
<td>Birth defects on primates&lt;br&gt;Risks in humans unclear&lt;br&gt;May initiated &gt;8 wks of pregnancy&lt;br&gt;PP contraception&lt;br&gt;Preferred in particular cases</td>
</tr>
</tbody>
</table>
Preferred Integrase Inhibitor Regimen

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAL + preferred 2-NRTI backbone</td>
<td>Twice daily PK data available Increasing experience in pregnancy Rapid viral reduction Useful when there are concerns about drug interactions with PI regimen</td>
</tr>
</tbody>
</table>

## Alternative PI Regimens

<table>
<thead>
<tr>
<th>Drug</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>LPV/r + preferred 2-NRTI backbone</td>
<td>Twice daily PK in pregnancy Abundant experience More nausea</td>
</tr>
</tbody>
</table>

INTRAPARTUM CARE
INTRAPARTUM

• Continue cART on schedule as much as possible during labor and before cesarean (AIII).

• IV zidovudine should be administered to HIV-infected women with HIV RNA >1,000 copies/mL (or unknown HIV RNA) near delivery (AI).

• Scheduled cesarean delivery at 38 weeks if VL >1,000 near delivery (AI).

• If unknown HIV status, expedited HIV testing (AII). If positive, a confirmatory HIV test asap.

• The following should generally be avoided because of a potential increased risk of transmission, unless there are clear obstetric indications:
  • Artificial rupture of membranes (BIII)
  • Fetal scalp electrodes for fetal monitoring (BIII)
  • Operative delivery with forceps or a vacuum extractor and/or episiotomy (BIII)

• The antiretroviral drug regimen a woman is receiving should be taken into consideration when treating excessive postpartum bleeding resulting from uterine atony: methergine

http://aidsinfo.nih.gov/guidelines
POST-PARTUM (PP)

- Unique challenges to ARV adherence, arrangements for supportive services should be made before hospital discharge (AII).

- Breastfeeding is contraindicated for HIV-infected women in the US (AII)

- Contraceptive counseling is a critical aspect of postpartum care (AIII).

- Continue with cART

- Continuity of HIV care and management

- Medical problems management: HTN, DM

- Mental Health follow-up / Risk of PP depression

- PP precautions

- Newborn f/u Ped, Ped SI

- NO pre-masticated food

http://aidsinfo.nih.gov/guidelines
NEWBORN / INFANT CARE
NEWBORN / INFANT CARE

- 6-weeks neonatal zidovudine prophylaxis regimen (AI).

- Zidovudine, at gestational age-appropriate doses, should be initiated as close to the time of birth as possible, preferably within 6 to 12 hours of delivery (AII).

- Infants at higher risk when mother:
  - received only intrapartum ARV’s (AI) or
  - have not received antepartum or intrapartum ARV’s (AI) or
  - have received antepartum ARV’s but suboptimal viral suppression (BIII)

- Infants at higher risk of HIV acquisition should receive:
  - Zidovudine for 6 weeks combined with
  - Nevirapine in the first week of life (at birth, 48 hours later, and 96 hours after the second dose), begun as soon after birth as possible.

- Review feeding practices:
  - No breastfeeding
  - No pre-mastication

http://aidsinfo.nih.gov/guidelines
SUMMARY
RECOMMENDATION TO PREVENT HIV PERINATAL INFECTION

- Mental Health
  - Substance Use Services
- Perinatal Guidelines
- Social Services
- Community Resources
- Medical Insurance
- Education
  - Empower
SUMMARY

• Unfortunately, there are still cases of HIV perinatal transmission

• Risk factors present in HIV-positives newborns are more related to psychosocial issues: substance use, mental health problems.

• The care for HIV-infected patients should be a collaborative effort involving patients, primary care / OB clinicians, mental health providers and when necessary, case managers, substance use counselors, relatives, pharmacies, insurance companies, domestic violence service providers, housing and transportation services should also be involved.

• The most effective means of promoting adherence in patients with mental health disorders is through adequate stabilization of their mental health symptoms and integration of mental health treatment into the comprehensive treatment plan.

• Current clinical guidelines provide a tool to prevent perinatal transmission.

• Clear information about resources: medical insurance and requirements as prior authorization, transportation, housing among others, will help to achieve the goal of zero perinatal transmission.
REFERENCES
REFERENCES

• Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the United States download from
  • http://aidsinfo.nih.gov/guidelines
  • http://www.cdc.gov/hiv/resources/factsheets/index.htm
  • www.cdc.gov/violenceprevention
  • www.doh.state.gov

• Questions?

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The AIDS Education and Training Center (AETC) Program is the training arm of the Ryan White HIV/AIDS Program. The AETC Program is a national network of leading HIV experts who provide locally based, tailored education, clinical consultation and technical assistance to healthcare professionals and healthcare organizations to integrate high quality, comprehensive care for those living with or affected by HIV.
The **South FL SE AIDS Education and Training Center** within the University of Miami, Department of Medicine, Division of Clinical Immunology, has over thirty faculty members and staff dedicated to caring for patients with HIV/AIDS and includes some of the world’s most renowned researchers in infectious diseases. We have specialty clinics in adult medicine, and obstetrics/gynecology that provide state of the art clinical care for those individuals infected with HIV and other STIs. HIV clinical care is provided by the UM physicians for inpatient care at Jackson Memorial Hospital (JMH) and University of Miami Hospital, and outpatient care at numerous sites on the UM/JMH medical campus. UM HIV faculty also provide off site care at Federally Qualified Health Centers.
The **South FL SE AETC** includes the following counties: Polk, Hardee, Highlands, Indian River, Okeechobee, St. Lucie, Hernando, Pasco, Pinellas, Hillsborough, Manatee, Sarasota, DeSoto, Martin, Palm Beach, Broward, Miami-Dade, Monroe, Charlotte, Glades, Lee, Hendry and Collier.
The U.S. Department of Health and Human Services (DHHS) has released updated versions of its antiretroviral treatment guidelines for adults and adolescents, and for children with HIV. The new adult guidelines include revised recommendations for first-line antiretroviral therapy (ART) as well as management of treatment-experienced patients. The revised pediatric guidelines include a discussion of very early treatment for HIV-infected infants.

References
HHS Panel on Antiretroviral Guidelines for Adults and Adolescents. *Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents*. Updated April 8, 2015.
TRAINING OPPORTUNITIES

Preceptorships
An intensive clinical training program offered to healthcare providers in Florida who have an interest in learning more about the diagnosis and management of HIV/AIDS, opportunistic infections, and co-morbid conditions. Each preceptorship is structured to meet the unique needs of the individual participant based on his or her previous experience, geographic location, and time available. Experience 4 to 240 hours of clinical training at adult, pediatric, obstetric, and/or family practice clinics where care is provided to HIV-infected patients. All training provided is consistent with current guidelines from the Department of Health and Human Services or other nationally recognized guidelines when available.

Individual and/or Group Clinical Consultations
Individual and group clinical consultations are offered. Individual clinical case consultation is provided on the diagnosis, prevention, and treatment of HIV/AIDS and related conditions. These consultations take place by telephone, email or face-to-face meetings. Group clinical consultation with case-based discussions include information on pharmacology, clinical antiretroviral therapy updates, drug-drug interactions, and antiretroviral resistance.
TRAINING OPPORTUNITIES Cont’d

Chart Reviews
The chart review program offers clinics that provide HIV/AIDS care an opportunity to assess adherence to current Department of Health and Human Services (DHHS) and other published guidelines utilized in the care and treatment of HIV-infected individuals. Using a team of specially-trained F/C AETC faculty, a review of selected patient charts is completed to identify the strengths of the healthcare team, as well as areas of opportunity for education and training to support quality improvement efforts.

Web-Based Education (Webinars)
We offer numerous web-based educational opportunities to increase the knowledge and skills of HIV healthcare providers. Our web-based educational opportunities cover a wide range of HIV-related topics. Trainings are provided both as live webinars or on-demand recorded webinars. Web-based education offers participants a way to stay up-to-date on current topics.

Telehealth Case Based Group Consultations
This model uses a live audio-video-based platform (Adobe Connect) to provide educational experiences through the creation of a learning network comprised of clinicians serving HIV/AIDS patients, novice to expert throughout our region.
National HIV/AIDS Clinicians’ Consultation Center
UCSF – San Francisco General Hospital

Warmline
National HIV/AIDS Telephone Consultation Service
*Consultation on all aspects of HIV testing and clinical care*
Monday - Friday
9 am – 8 pm EST
Voicemail 24 hours a day, 7 days a week

PEPline
National Clinicians’ Post-Exposure Prophylaxis Hotline
*Recommendations on managing occupational exposures to HIV and hepatitis B & C*
9 am - 2 am EST, 7 days a week

Perinatal HIV Hotline
National Perinatal HIV Consultation & Referral Service
*Advice on testing and care of HIV-infected pregnant women and their infants*
*Referral to HIV specialists and regional resources*
24 hours a day, 7 days a week

HRSA AIDS ETC Program & Community Based Programs, HIV/AIDS Bureau
& Centers for Disease Control and Prevention (CDC)
www.nccc.ucsf.edu
Upcoming Events

Wednesday, AUGUST 17th
HIV and Oral Health in the Era of ART Therapy
Mark Schweizer, DDS

Wednesday, AUGUST 24th
PrEP Group Clinical Consultation
Susanne Doblecki-Lewis, MD

Friday, SEPTEMBER 2nd
Care & Treatment of the Transgender Patient
Laura Beauchamps, MD
Need Additional Information?

Contact the South FL SE AIDS Education and Training Center

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or visit:

http://hivaidsinstitute.med.miami.edu/partners/se-aetc
Thank you!

We thank you for participating in today’s webinar and encourage you to stay on WebEx and fill out the Performance Evaluation after the call ends. This is a HRSA requirement that helps us ensure continued funding.