HIV Positive: Management of the Woman and her Neonate

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This document should be read in conjunction with the Disclaimer
Key Points
1. HIV screening is strongly recommended for all pregnant women and should be offered as a routine component of initial prenatal care.
2. Optimal management of HIV in pregnancy has been demonstrated to reduce perinatal transmission to <1%.
3. Management of HIV positive pregnant women requires co-ordination of care between adult and paediatric HIV management teams and the Maternal Fetal Medicine obstetric team.
   - Antiretroviral treatment is recommended for all HIV Infected women who are pregnant
4. If maternal HIV viral load is undetectable on treatment, vaginal birth may be offered as an option.
   - If maternal HIV viral load is undetectable intrapartum maternal Zidovudine may not be required
5. HIV may be transmitted in breast milk. HIV positive women are recommended not to breastfeed.
6. No additional infection prevention precautions beyond Standard Precautions are required.

Antenatal Management

Screening
All women should be, with their consent, tested for HIV optimally in early pregnancy and informed of their results with appropriate counselling.

Screening for HIV is conducted by an initial ELISA for HIV antibody and if positive, the result is confirmed by a Western Blot.

Notification to the Health Department for NEWLY diagnosed HIV positive women
Complete the ‘Notification of HIV infection or AIDS or death in a person with HIV infection’ Government of Western Australia Department of Health form.

Management
1. All women living with HIV and those with newly diagnosed HIV are referred to the Maternal Fetal Medicine Service for obstetric care and co-ordination of multidisciplinary management for both the woman and her neonate.
2. A written referral from the MFM Service shall be sent to the Combined Immunodeficiency Clinic at PMH/PCH via the Immunology Clinical Nurse Specialist (CNS) available at PMH on page 8311/ext. 7406.
   - The PMH/PCH Immunology CNS will liaise with the obstetrician, adult physician, paediatrician, neonatologist, social workers and other multidisciplinary staff to discuss the individual case. A Paediatric Infectious Diseases Physician will be assigned to manage the newborn. The
Immunology CNS will arrange a meeting with the parents and the assigned Paediatrician. Wherever possible, this meeting should occur at least 1 month prior to the expected due date.

- A neonate anti-retroviral regimen is formulated and documented on an “MR409 Antiretroviral Regimen and Management Plan for the Neonate form” and circulated to the Multidisciplinary Pregnancy Team one month prior to the expected date of delivery. The KEMH CMS for the MFM Service will insert the completed form in the shadow file which is located in the mother’s KEMH medical record with the protocol for management of neonates born to HIV positive women.

3. Accurate pregnancy dating with ultrasound should be confirmed as soon as possible.

4. Antiretroviral therapy (ART) is indicated for all HIV positive women. The HIV physician will create the ART regimen for each woman, tailored to her viral resistance studies and lifestyle. If the woman is not on ART prior to conception, this will be commenced by the HIV physician at the end of the first trimester.

5. Women are encouraged to bring their own antiretroviral medications to hospital when admitted to KEMH, to ensure no interruption to treatment schedules. Antiretroviral agents are restricted under KEMH antimicrobial stewardship guidelines but are considered approved if prescribed by an HIV physician. Additional microbiologist approval is not required.

6. The maternal HIV viral load and T-cell subsets are assessed every trimester for women with an undetectable viral load and at 36 weeks gestation. Testing is more frequent when maximal viral load suppression has not been achieved. The maternal HIV viral load at 36 weeks gestation has consistently been demonstrated to reflect the perinatal HIV transmission risk.

7. Prenatal diagnostic tests such as CVS/amniocentesis may be offered as appropriate, however such procedures do appear to increase the risk of antenatal HIV transmission and should be performed only after full discussion with the woman. In general, NIPT is a more reasonable option for fetal assessment of chromosomal disorders and may be considered as a first line screening test in HIV positive women given its lower false positive rate than other currently available methods.

8. Mode of delivery will be decided by the Maternal Fetal Medicine Service obstetric team and the woman, based on obstetric and HIV viral load factors.

9. The requirement for intrapartum Zidovudine depends on maternal viral load and regimen adherence.

10. Women should be advised that the safest option for her child for maximal reduction of MTCT is to completely avoid breastfeeding.
Intrapartum Management

Admission

- A booked woman with HIV
  Inform:
  1. the Labour and Birth Suite Co-ordinator
  2. Registrar/Senior registrar who will liaise with the MFM Obstetric Registrar/Consultant
  3. PMH/PCH Immunology CNS

- An unbooked women presenting with HIV, and no involvement of the Paediatric HIV team or the Multidisciplinary pregnancy group
  1. Inform the Co-ordinator of the labour and birth suite.
  2. Inform the Consultant on duty for labour and birth suite.
  3. Contact the On-Call Paediatric Infectious Diseases Consultant via PMH switchboard immediately as prophylaxis for the neonate is recommended to commence within 4 hours of birth.

- Admission of a woman with an unknown HIV status, but thought to be at high risk for HIV
  1. Contact the Clinical Microbiologist on call to discuss urgent testing
  2. Paediatric Infectious Diseases Consultant on call from Princess Margaret Hospital to discuss maternal and neonatal prophylaxis

Maternal Zidovudine Regimen

Vaginal Birth

Zidovudine is no longer required for women receiving ART with an undetectable viral load in whom there are no concerns regarding adherence

Elective Caesarean Section

IV Zidovudine is no longer required for women receiving ART with an undetectable viral load in whom there are no concerns regarding adherence who are scheduled for an elective caesarean birth.

For women with a detectable viral load or who have not received antiretroviral therapy antenatally, Zidovudine will be required.

Commence Zidovudine as soon as diagnosis of labour is made or 4 hours prior to elective caesarean birth. Continue the infusion until birth of the baby and clamping of the umbilical cord.

See Pharmacy Guideline Zidovudine for administration advice and drug compatibility information.

If the above strategies are followed, perinatal transmission rates of ≤ 1% are expected.
At Birth

Notify

- On-call Consultant neonatologist / Senior Registrar KEMH
- On-call Paediatric Infectious Diseases Consultant at PMH/PCH
- Refer to the neonate’s antiretroviral Regimen and Management Plan for Neonate form (MR409) in the correspondence section of the mother’s medical chart regarding bloods and medications required for the neonate. This form must be transferred to the neonate’s chart with the neonate’s UMRN label attached.

- The neonate must be bathed in the Labour and Birth Suite BEFORE the administration of any injections.

- If any injection is necessary prior to bathing, carefully clean the site with an alcohol swab prior to administration.

Recommended Medications for the Neonate

See Clinical Guideline HIV Prevention in Infants born to HIV Positive Women (PMH/PCH)

Postnatal Maternal Management

- The recommendation to reduce the risk of post-partum transmission is for exclusive formula feeding from birth with complete avoidance of breast feeding or mixed breast / formula feeding.
- Refer to the neonate’s antiretroviral Regimen and Management Plan regarding the plan for mode of feeding for the neonate
- Administer Cabergoline 1mg for lactation suppression. Contact the Clinical Midwifery Consultant (KEMH Breastfeeding Centre) for support with lactation suppression
- Antiretroviral Therapy (ART) will be prescribed by the HIV physician.
- Expert contraceptive advice is essential prior to discharge.

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Standards Applicable: NSQHS Standards: 1 Clinical Care is Guided by Current Best Practice
4- Medication Safety;

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