UKCAB Meeting

BHIVA 2018 Pregnancy Guidelines Feedback

21st April 2018. Edinburgh

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BHIVA 2018 Pregnancy Guidelines Feedback:

Outline

Overview of HIV & Pregnancy in the UK

When to start treatment

Updated safety on new ARVs

Delivery

Infant PEP

Infant Feeding

Postnatal Management (Aftercare)

BHIVA
British HIV Association

British HIV Association guidelines for the management of HIV infection in pregnant women 2018

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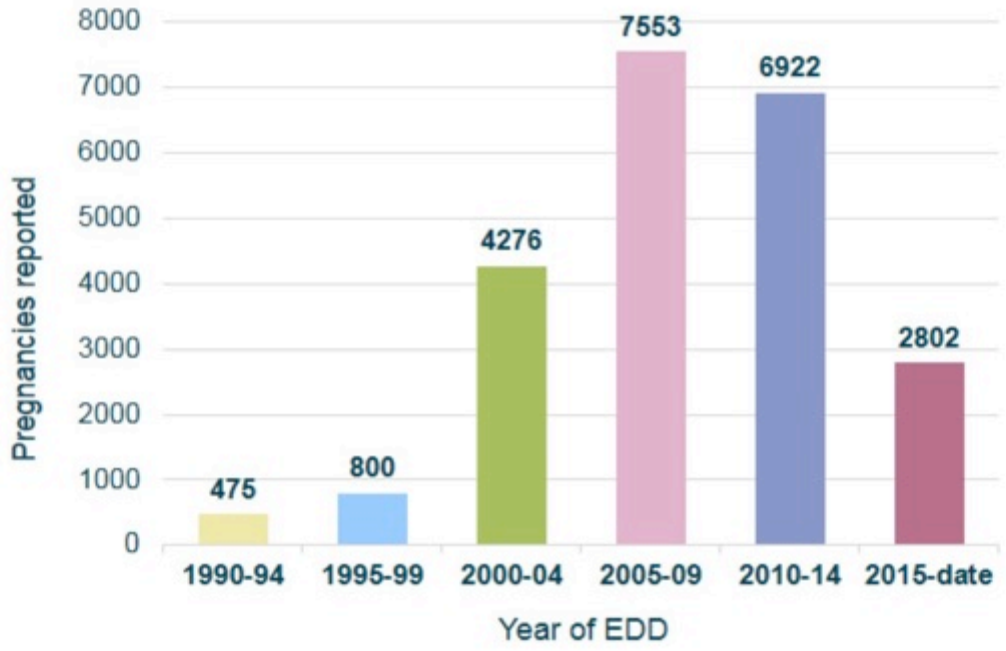
UCL

Obstetric data snapshot: pregnancies over the years

22,828 pregnancies in diagnosed women since 1990 and reported* to the NSHPC by June 2017



Source: pregnancies since 1990 reported to the NSHPC from all sources by June 2017

National Study of HIV in Pregnancy and Childhood
NSHPC

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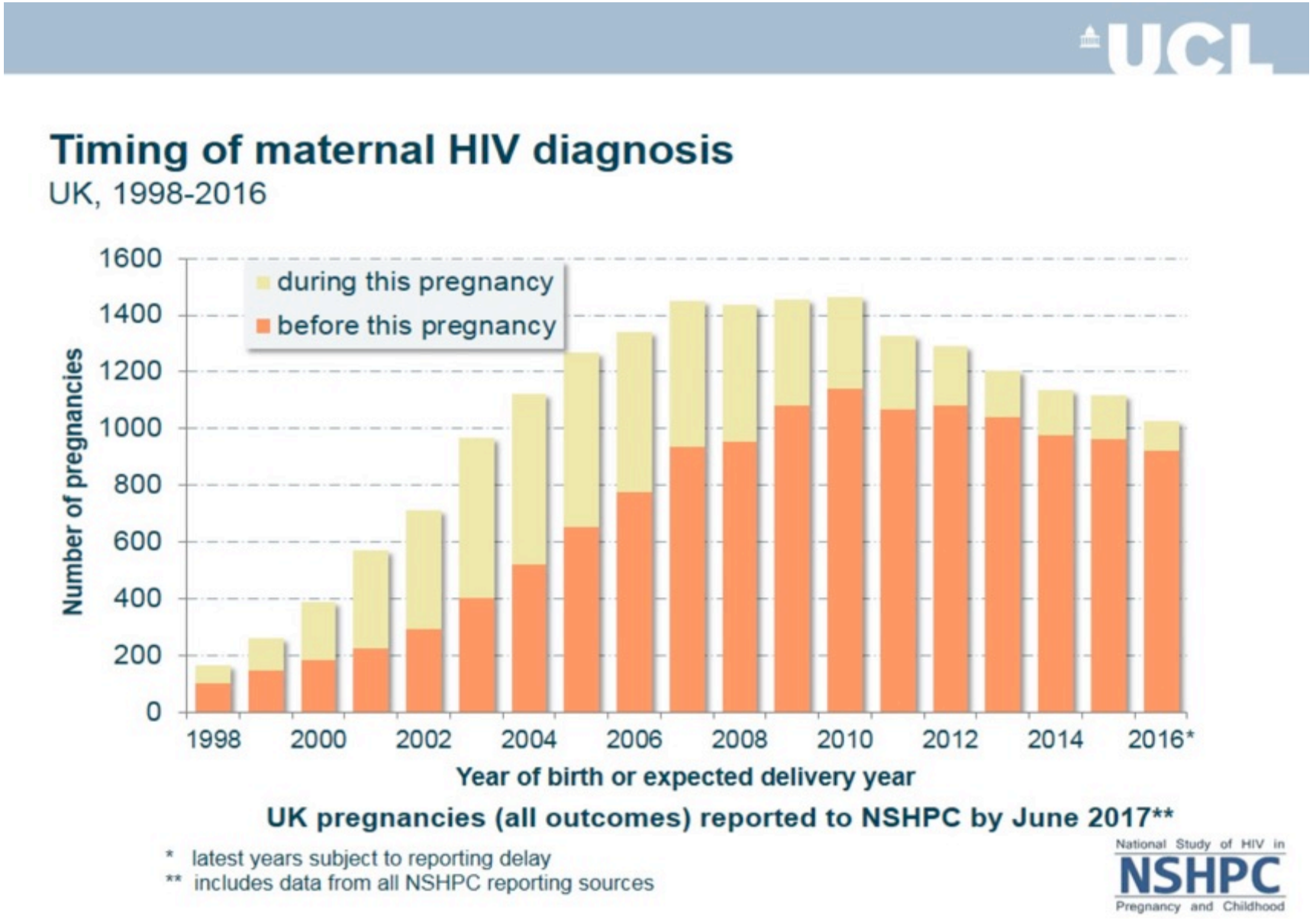

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MTCT rates in diagnosed women, UK & Ireland 2000-2014

- **Most recent update of MTCT rate 0.27% for 2012-14**
- Significant decline over time ($p<0.001$)

Data from 2000-11 from: Townsend *et al*. Earlier initiation of ART and further decline in mother-to-child HIV transmission rates, 2000-2011. AIDS 2014; 28:1049–1057 and data from 2012-14 from Peters *et al*. UK MTCT rates continue to decline: 2012-2014, Clinical Infectious Diseases 2016.

National Study of HIV in Pregnancy and Childhood
NSHPC

When to Start Treatment

- **Conception** – continue with current ARV if viral load is undetectable (some regimens may require review – eg PI monotherapy 2D regimens or those demonstrated to increase pre-term delivery: modified to include one of more agents that cross the placenta)

- **If not on treatment**, start as soon as possible in 2nd trimester if viral load is above 30,000 c/ml; within 1st trimester if viral load is above 100,000 and/or if CD4 count is below 200

- **All start by week 24**; late presenters (28/40) start without delay – may consider vaginal birth if undetectable by week 36 (Integrase inhibitor based cART)

- All **continue** treatment after delivery

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Updated Safety on new ARVs

- **Abacavir, FTC, 3TC, TDF & AZT** considered safe according to Antenatal Pregnancy Registry (APR)
- **AZT** no longer recommended in routine clinical care – though may be suitable for individual women
- Not enough data on **TAF** – though can be used in pregnancy
- **Integrase Inhibitors**– faster reduction of viral load – APR Safety data available on **Raltegravir** only
- Data on **Dolutegravir & Elvitegravir** incomplete. Some data available on DTG presented at IAS 2017 showed DTG/TDF/FTC as safe as EFV/TDF/FTC
- **Protease Inhibitors** and Preterm delivery – data conflicting (where required risk of PTD should be balanced with benefit of prevention of vertical transmission).

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Obstetric Management

8.1 Antenatal management

8.1.1	Fetal ultrasound imaging should be performed as per national guidelines regardless of maternal HIV status.	1D

8.1.3	Invasive prenatal diagnostic testing should not be performed until after the HIV status of the mother is known, and should ideally be deferred until HIV viral load has been adequately suppressed to <50 HIV RNA copies/mL	1C

8.1.4	If not on cART and the invasive diagnostic test procedure cannot be delayed until viral suppression is achieved, it is recommended that women should commence cART to include raltegravir and be given a single dose of nevirapine 2–4 hours prior to the procedure.	1D

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8.2 Mode of delivery

For women taking cART, a decision regarding recommended mode of delivery should be made after review of plasma viral load results at 36 weeks.

8.2.1	For women with a plasma viral load of <50 HIV RNA copies/mL at 36 weeks, and in the absence of obstetric contraindications, a planned vaginal delivery is recommended.	1C
8.2.2	For women with a plasma viral load of 50–399 HIV RNA copies/mL at 36 weeks, PLCS should be considered, taking into account the actual viral load, the trajectory of the viral load, length of time on treatment, adherence issues, obstetric factors and the woman's views.	1C
8.2.3	Where the viral load is ≥ 400 HIV RNA copies/mL at 36 weeks, PLCS is recommended.	1C

Infant Post Exposure Prophylaxis (PEP)

- All infant PEP should be **started within 4 hours of birth**
- Infant PEP – AZT mono therapy for **very low** risk infants & **2 weeks** if mum is undetectable
- Infant PEP – AZT mono therapy for **low risk** infants for **4 weeks**
- Infant PEP – Combination PEP for **high risk** infants: Viral load above 50 or unknown maternal adherence
- PEP should be stopped at 4 weeks

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Infant Feeding

- **Formula feeding** recommended still main Recommendation for UK setting
- **Carbergoline** (tablet to supress lactation) recommendation for all formula feeding women
- **Breastfeeding** – support for women with suppressed viral load and who choose to breastfeed. Imperial (St. Mary's Hospital) Resources to support women and HCPS

  Viral load testing **vital**.

- **Factors that increase risk include:**

  Detectable viral load — Advanced maternal disease

  Longer duration of breastfeeding — Breast infection/inflammation

  Infant GI infection or mixed feeding of infants

- **No data on safety of breastfeeding in the UK yet** –

(Transmission & Maternal exposure to ART)

- NSHPC – **enhanced data collection into breastfeeding**

Post Natal Management (Aftercare)

- Assessment of postnatal depression in accordance to NICE guidelines
- Free formula for women not breastfeeding
- NAT policy statement supporting access to formula for mothers who do not breastfeed but cannot afford formula milk.
- Support needs assessment and postnatal mental health assesment

General Comments/Summary

- Care and assessment delivered by a Multi Disciplinary Team
- Assessment and guidance for antenatal & postnatal depression
- STI screens
- Vaginal Delivery if viral load is undetectable and no obstetric contraindications
- Neonatal immunisation as per national schedule. Do not delay BCG in low risk infants
- Support for women who choose to breastfeed
- Overall positive use of language – Vertical Transmission instead of MTCT, Women Living with HIV instead of HIV+ women…

Acknowledgements

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and

- Helen Peters & Kate Francis - National Study of HIV in Pregnancy & Childhood, UCL
- Dr Hermione Lyall – Imperial (St Mary's)

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Questions?

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