# HIV in Pregnancy Update

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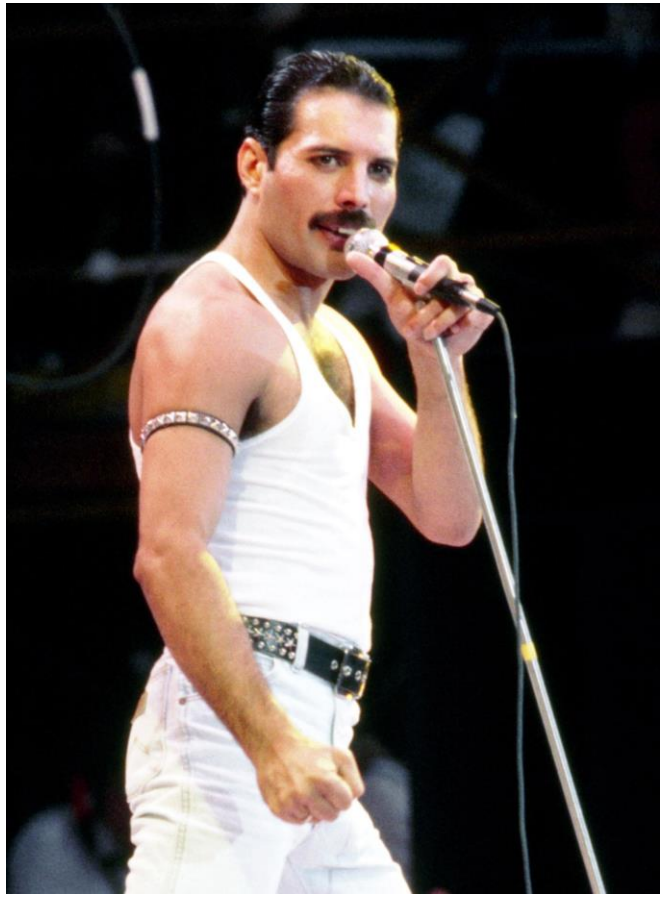
# HIV infection

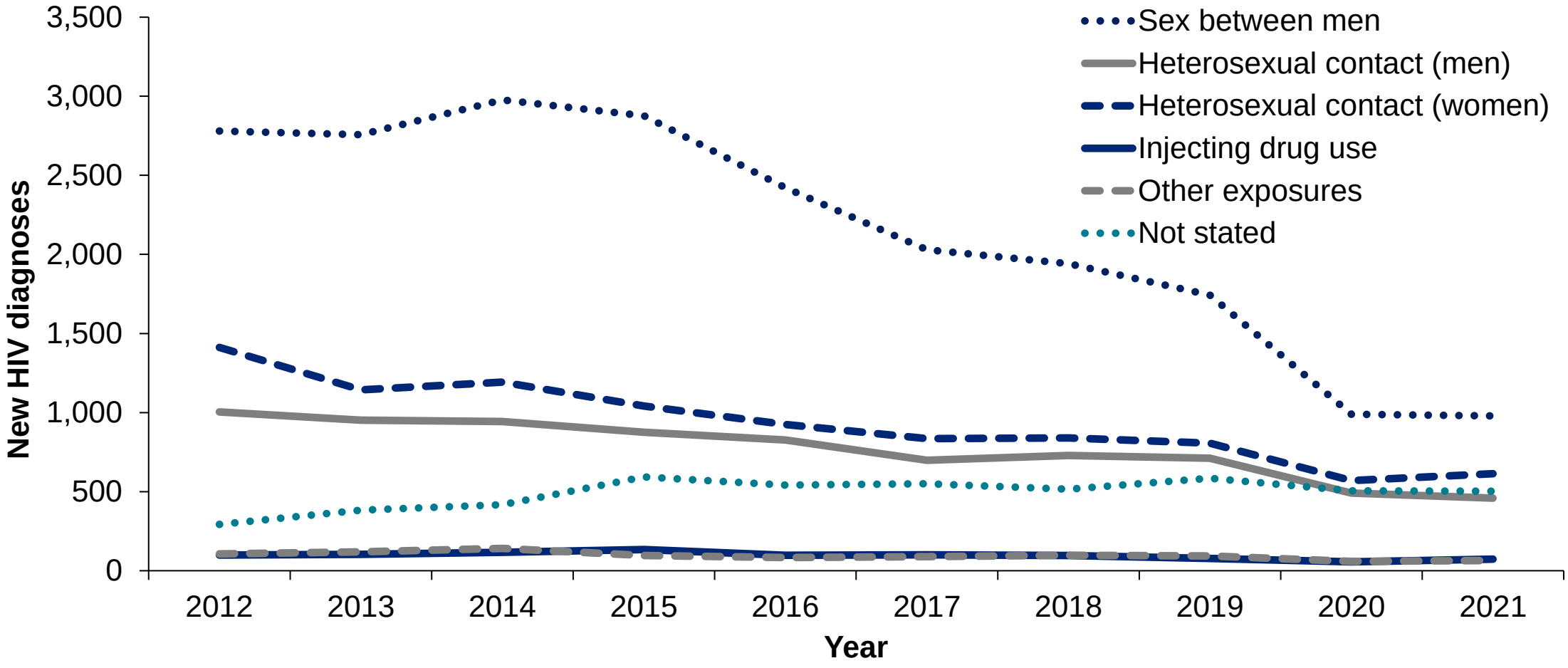
- Main route of transmission is sexual
- In UK higher rates of infection
    - People from sub Saharan Africa
    - Men who have sex with men
- Key is early diagnosis
- Successfully treating HIV is one of medicine’s greatest achievements in the last 30 years
- Aim is for ZERO transmission by 2030



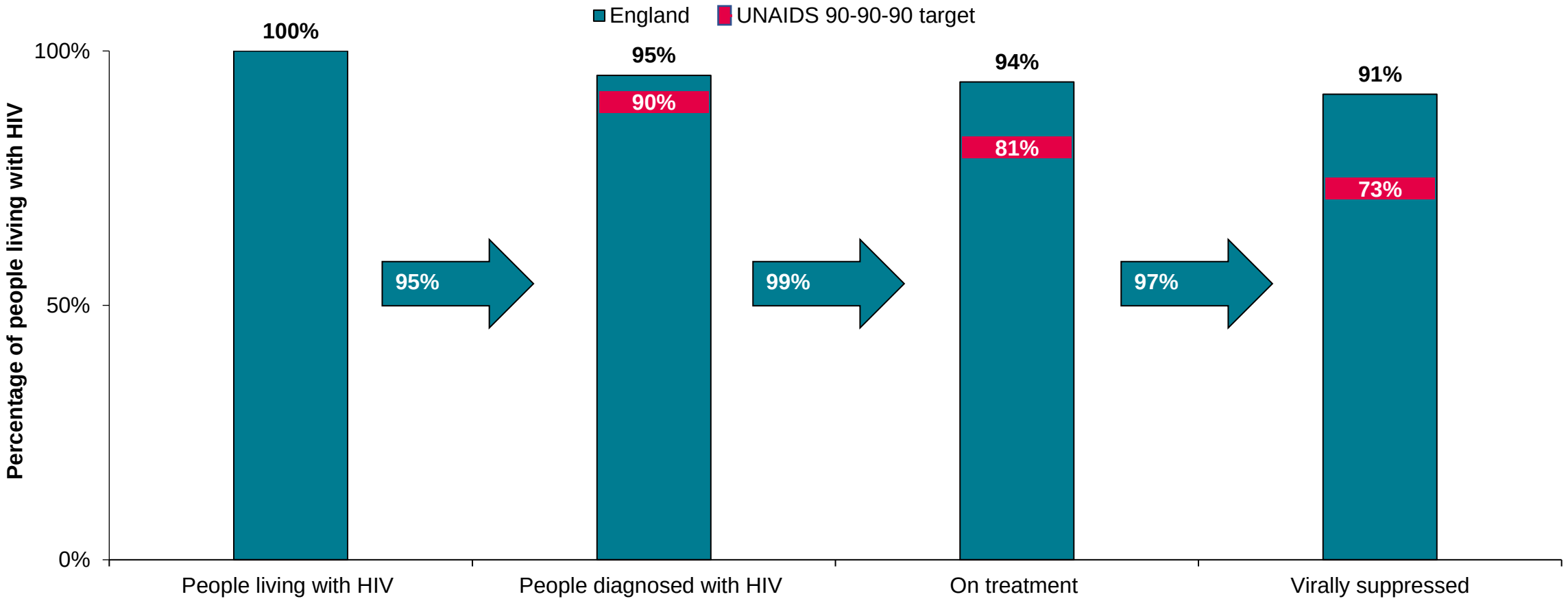


# U=U

# New HIV diagnoses (all people) by probable route of exposure and gender: England, 2012 to 2021



# Continuum of HIV care: England, 2020



# HIV infection in pregnancy

- 35,000 women in UK with HIV
- 1200 become pregnant each year
- Vertical transmission has reduced over the years
  - 2000-2001  2.1%
  - 2006-2007  0.7%
  - 2010-2011  0.5%
  - 2012-2014  0.3%

- Universal testing, HIV treatment, optimised care
- On ART and pVL <50  copies/ml rate is  0.09%

# Antiretroviral therapy in pregnant women living with HIV

- All women not on ART should commence ART:

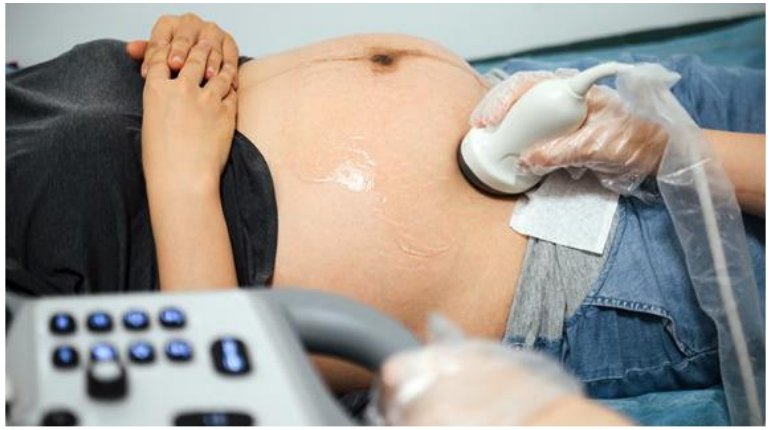
| Viral load (copies/mL) | Gestation |
|---|---|
| <30,000 | ASAP in 2nd trimester |
| 30,000-100,000 | At start of 2nd trimester |
| >100,000 and/or CD4 <200 | In 1st trimester |

- All should have commenced by 24/40

- **Note**
- Need triple ART medication
- May require switch of existing ART to other therapy and /or bd regimes
- May require intensification if pVL not fully suppressed in 3rd trimester

# Screening for anomaly

- U/s imaging as per national guidelines regardless of maternal HIV status
- NIPT recommended for high risk women



- Amniocentesis/CVS - defer until pVL is <50 copies/mL
  - if cannot be delayed, recommended that women should commence ART to include raltegravir and be given a single dose of nevirapine 2–4 hours prior to the procedure

# Mode of delivery

| Viral load (copies/ml) at 36/40 | |
|---|---|
| <50 | Planned vaginal delivery |
| Elite controllers on ART | Planned vaginal delivery |
| 50-399 | Consider PLCS* |
| >400 | PLCS between 38-39/40 |

# Place of birth

- Recommended to give birth in a facility with direct access to  paediatric care

- Scant safety evidence to support water births, however, women who choose a water birth should be supported to achieve this where the viral load is <50 HIV RNA copies/mL

# Antenatal management pre and during labour

- ECV can be performed in women with VL <50 copies/mL at >36/40

- No data on safety of FBS or scalp clip from the HAART era; transmission risk  likely to be low if VL <50 copies/mL
- Data from the pre-HAART era has not found an association between MTCT and use of instrumental delivery, amniotomy and episiotomy
  - the continued avoidance of these procedures is not evidence-based

# Intrapartum zidovudine (AZT) infusion


- women with pVL >1000 copies/mL who present in labour or with SROM or who are admitted for PLCS
- For untreated women presenting in labour or with SROM with unknown pVL
- Consider in women on ART with a pVL 50-1000 copies/mL

# Spontaneous pre-labour ROMs

- Delivery should be expedited – for delivery within 24 hrs

| Viral load (copies/mL) | delivery |
|---|---|
| <50 | IOL |
| 50-399 | CS recommended* |
| >400 | Immediate CS |

- PROMs >34 weeks is managed as per term ROMs with the addition of prophylactic antibiotics
- PROMs <34 weeks requires MDT input, IM steroids as per national guidelines and optimisation of virological control

# Late diagnosis, unsuppressed viral load

**28/40+**

If the viral load is unknown or >100,000 HIV RNA copies/mL, a three- or four-drug regimen  including an integrase inhibitor

**Untreated woman presenting in labour at term**

stat dose of nevirapine 200 mg

Commence oral zidovudine 300 mg and lamivudine 150 mg bd  + raltegravir 400 mg bd

Intravenous zidovudine for the duration of labour

# Breast feeding in the UK

- Recommend use of formula milk
  - should be free
  - cabergoline to suppress lactation
- Should support women who are suppressed on ART with good adherence and who choose to breastfeed
- But should be informed
  - low risk of transmission of HIV (0.58%)
  - Should be exclusive breast feeding and max of 6/12
  - Extra maternal and infant clinical monitoring