Stopping Antiretroviral Drugs during Pregnancy (Last updated October 26, 2016; last reviewed October 26, 2016)

Panel's Recommendations
• If an antiretroviral (ARV) drug regimen must be stopped during pregnancy (e.g., for severe toxicity), all ARV drugs should be stopped simultaneously and antiretroviral therapy should be reinitiated as soon as possible **(AIII)**.
Rating of Recommendations: *A = Strong; B = Moderate; C = Optional*
Rating of Evidence: *I = One or more randomized trials with clinical outcomes and/or validated laboratory endpoints; II = One or more well-designed, nonrandomized trials or observational cohort studies with long-term clinical outcomes; III = Expert opinion*

Discontinuation of antiretroviral (ARV) drug regimens during pregnancy may be indicated in some situations, including serious drug-related toxicity, pregnancy-induced hyperemesis unresponsive to anti-emetics, or acute illnesses or planned surgeries that preclude oral intake. Other reasons for discontinuation of ARV drug regimens during pregnancy include lack of available medication or patient request. If an ARV drug regimen must be stopped for any reason, all ARV drugs should be stopped simultaneously and ARV therapy should then be reinitiated simultaneously as soon as possible, whether restarting the same regimen or a new regimen.

Discontinuation of therapy could lead to an increase in viral load with possible decline in immune status and disease progression as well as adverse consequences for the fetus, including increased risk of *in utero* transmission of HIV. An analysis from a prospective cohort of 937 HIV-infected mother-child pairs found that interruption of ART during pregnancy, including interruption in the first and third trimesters, was independently associated with perinatal transmission. In the first trimester, the median time at interruption was 6 weeks' gestation and length of time without therapy was 8 weeks (interquartile range [IQR], 7–11 weeks); in the third trimester, the median time at interruption was 32 weeks and length of time without therapy was 6 weeks (IQR, 2–9 weeks). Although the perinatal transmission rate for the entire cohort was only 1.3%, transmission occurred in 4.9% (95% CI, 1.9% to 13.2%; adjusted odds ratio [AOR] 10.33; $P = .005$) with first-trimester interruption and 18.2% (95% CI, 4.5% to 72.7%; AOR 46.96; $P = .002$) with third-trimester interruption.[1]

Continuation of all drugs during the intrapartum period generally is recommended. Women who are having elective cesarean delivery can take oral medications before the procedure and restart drugs following surgery. Because most drugs are given once or twice daily, it is likely that no doses would be missed or that at most, the postpartum dose would be given a few hours late.

When short-term drug interruption is indicated, all ARV drugs generally should be stopped simultaneously and reintroduced simultaneously as soon as possible. This can be problematic with drugs (e.g., efavirenz) that have long half-lives and low thresholds for developing HIV viral resistance. However, in conditions such as serious or life-threatening toxicity, severe pregnancy-induced hyperemesis unresponsive to antiemetics, or other acute illnesses precluding oral intake, the clinician has no choice but to stop all therapy at the same time. Efavirenz can be detected in blood for longer than 3 weeks after discontinuation;[2,3] if an efavirenz-containing regimen must be stopped for more than a few days due to toxicity, consideration should be given to assessing for rebound viremia and potential drug resistance.[4]

In the rare case in which a woman has limited oral intake that does not meet food requirements for certain ARV agents, decisions about the antiretroviral therapy administered during the antepartum or intrapartum period should be made on an individual basis and in consultation with an HIV treatment expert.

References

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