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

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More frequent viral load monitoring is recommended in pregnant than non-pregnant individuals because of the importance of rapid and sustained viral suppression in preventing perinatal HIV transmission. In individuals who are adherent to their antiretroviral (ARV) regimen, and do not harbor resistance mutations to the prescribed drugs, viral suppression should be achieved in 12 to 24 weeks. Individuals with higher viral loads and lower CD4 T lymphocyte (CD4) cell counts are more likely to achieve viral suppression later within this range, while those with lower values and those using integrase strand transfer inhibitors (INSTIs) are more likely to achieve suppression in much shorter time frames. Most patients with adequate viral response at 24 weeks of treatment have had at least a 1 log viral load decrease within 1 to 4 weeks after starting therapy.2,3 Viral load should be monitored in pregnant women living with HIV at the initial visit and at least every 3 months during pregnancy.4

Viral load also should be assessed at approximately 34 to 36 weeks’ gestation to inform decisions about mode of delivery and about optimal treatment of newborns (see Transmission and Mode of Delivery). In pregnant women living with HIV, CD4 cell count should be monitored at the initial antenatal visit and every 3 to 6 months during pregnancy.2,3 Monitoring of CD4 cell count can be performed every 6 months in patients on combination antiretroviral therapy (ART) with consistently suppressed viral load who have CD4 counts well above the threshold for opportunistic infection risk (CIII).

Monitoring of the Woman and Fetus During Pregnancy (Last updated November 14, 2017; last reviewed November 14, 2017)
every 3 months during pregnancy. CD4 cell counts can be performed every 6 months in patients who are clinically stable with consistently suppressed viral load who have CD4 counts well above the threshold for opportunistic infection risk.2,5,6

ARV drug-resistance testing—**including transmitted INSTI resistance genotype testing, if INSTI resistance is a concern**—should be performed before initiation of ARV drugs if HIV RNA levels are above the threshold for resistance testing, **but therapy should not be delayed while waiting for resistance testing results** (see Antiretroviral Drug Resistance and Resistance Testing in Pregnancy). If the results demonstrate resistance, then the regimen can subsequently be adjusted. ARV drug resistance testing also should be performed on women taking an ARV regimen who have suboptimal viral suppression (i.e., failure to achieve undetectable levels of virus after an appropriate time frame, as noted above) or who have sustained viral rebound to detectable levels after prior viral suppression on an ARV regimen (see Antiretroviral Drug Resistance and Resistance Testing in Pregnancy). Drug-resistance testing in the setting of virologic failure is most useful if performed while patients are receiving ARV drugs or within 4 weeks after discontinuation of drugs. Even if more than 4 weeks have elapsed since the ARVs were discontinued, resistance testing can still provide useful information to guide therapy, though it may not detect previously selected resistance mutations.

Monitoring for potential complications of ARV drugs during pregnancy should be based on what is known about the adverse effects of the drugs a woman is receiving. For example, routine hematologic monitoring is recommended for women receiving zidovudine-containing regimens and routine renal monitoring should be recommended for women on tenofovir. Liver function should be monitored in all women receiving ARV drugs. Hepatic dysfunction has been observed in pregnant women on protease inhibitors (PI), and hepatic steatosis and lactic acidosis in pregnancy have been related to nucleoside reverse transcriptase inhibitor use. Pregnant women in general are more likely to have elevated liver enzymes than their non-pregnant counterparts.7,8

Pregnancy increases the risk of glucose intolerance. PI drugs have been associated with increased risk of hyperglycemia, new-onset diabetes mellitus, exacerbation of existing diabetes mellitus, and diabetic ketoacidosis.9-12 However, the majority of studies in pregnant women with HIV have not shown an increased risk of glucose intolerance with PI-based regimens during pregnancy.13 A prospective study including detailed evaluations for glucose intolerance and insulin resistance among pregnant women living with HIV did not find differences between women on PI-containing and non-PI-containing regimens.14 In both groups, the rate of impaired glucose tolerance was high (38%), but that may be related to high body mass index and race/ethnicity among trial subjects. Women living with HIV receiving antiretroviral therapy (ART) during pregnancy should receive the standard glucose screening at 24 to 28 weeks’ gestation that is recommended for all pregnant women. Some experts would perform earlier glucose screening in women receiving ongoing PI-based ART initiated before pregnancy, similar to recommendations for women with risk factors for glucose intolerance.

Accurate estimation of date of delivery is critical to planning scheduled cesarean deliveries at 38 weeks’ gestation to prevent perinatal transmission in women living with HIV with elevated HIV RNA viral loads. Therefore, first-trimester ultrasound is recommended to confirm gestational age and to provide the most accurate estimation of gestational age at delivery (see Transmission and Mode of Delivery).15-17 In patients who are not seen until later in gestation, second-trimester ultrasound can be used for both anatomical survey and determination of gestational age.

Although data are still somewhat limited, the risk of HIV transmission does not appear to be increased with amniocentesis or other invasive diagnostic procedures in women receiving effective ART resulting in viral suppression.18,19 This is in contrast to the era before effective ART, during which invasive procedures such as amniocentesis and chorionic villus sampling (CVS) were associated with a two- to four-fold increased risk of perinatal transmission of HIV.20-23 Although no transmissions have occurred among 159 cases reported of amniocentesis or other invasive diagnostic procedures among women on effective ART, a small increase in risk of transmission cannot be ruled out.24-27 Women living with HIV who have indications for invasive testing
in pregnancy (e.g., abnormal ultrasound or aneuploidy screening) should be counseled about the potential risk of transmission of HIV along with other risks of the procedure and allowed to make an informed decision about testing. Some experts consider CVS and cordocentesis too risky to offer to women living with HIV, and they recommend limiting invasive procedures to amniocentesis. At a minimum, pregnant women living with HIV should receive effective ART before undergoing any invasive prenatal testing and, ideally, have an undetectable HIV RNA level at the time of the procedure, and every effort should be made to avoid inserting the needle through, or very close to, the placenta. Consideration can also be given to the use of noninvasive methods of prenatal risk assessment, using tests with high sensitivity and low false-positive rates, such as serum screening alone or combined with nuchal translucency, anatomic ultrasound, and noninvasive molecular prenatal testing. In women with detectable HIV RNA levels for whom amniocentesis is deemed necessary, consultation with an expert should be considered.

References


