Guidelines for the Prevention and Treatment of Opportunistic Infections Among HIV-Exposed and HIV-Infected Children

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What's New

After the 2013 full guidelines release, Panel on Opportunistic Infections in HIV-Exposed and HIV-Infected Children (the Panel) modified its process so that individual sections would be published as they were updated, allowing for more timely appearance of new recommendations. Each section will be marked with the date of its last update and the summary of changes will be listed below. For a full description of the *Guidelines for the Prevention and Treatment of Opportunistic Infections in HIV-Exposed and HIV-Infected Children*, see the updated Summary.

Additionally, the evidence review and recommendation rating system underwent major changes; this new approach is incorporated into sections as they are individually updated. As a result, topics not yet updated since the 2013 release reflect the former rating system, and sections updated since 2013 use a newer, modified GRADE system. A description of the methods of collecting and synthesizing evidence and formulating and rating recommendations appears in the Background and Recommendations Rating Scheme section.

Major section revisions within the last 6 months are as follows:

July 25, 2018

1. **Influenza:** Major revisions include additional graded recommendations on influenza vaccination, chemoprophylaxis, and antiviral treatment for children with HIV. The section has been updated to reflect the new recommendation rating system and additional references were added.

Live-attenuated influenza vaccine **is no longer recommended** because of decreased effectiveness:

- Currently, children with HIV should not receive live-attenuated influenza vaccine (e.g., intranasal administered influenza vaccine, FluMist) **(weak, very low)**.

Chemoprophylaxis recommendations have been further elaborated for pre-exposure and post-exposure scenarios and are based on the degree of immunosuppression and vaccination experience:

- Pre-exposure antiviral chemoprophylaxis with a neuraminidase inhibitor against influenza may be considered in children with HIV with severe immunosuppression (i.e., CD4 T lymphocyte [CD4] cell percentage <15%) while influenza virus is circulating in the community, after careful consideration of risks and benefits as outlined in the Centers for Disease Control and Prevention (CDC) Advisory Committee on Immunization Practices (ACIP) and Infectious Diseases Society of America (IDSA) guidelines **(weak, low)**.
- Post-exposure antiviral chemoprophylaxis with a neuraminidase inhibitor against influenza is recommended in children with HIV with severe immunosuppression (i.e., CD4 percentage <15%), regardless of influenza vaccination status, if antiviral chemoprophylaxis can be started within 48 hours of exposure to an ill person with confirmed or suspected influenza **(strong, moderate)**.
- Post-exposure antiviral chemoprophylaxis with a neuraminidase inhibitor against influenza is recommended in children with HIV with moderate to no immunosuppression in whom influenza vaccination is contraindicated or unavailable **(strong, moderate)** or in seasons in which low influenza vaccine effectiveness is documented **(strong, low)**, if antiviral chemoprophylaxis can be started within 48 hours of exposure to an ill person with confirmed or suspected influenza.

Recommendations for treatment of influenza with antivirals have been updated, including considerations for hospital-based and ambulatory presentations of illness.

- Children with HIV requiring hospitalization for laboratory-confirmed or clinically suspected influenza should receive antiviral treatment as soon as possible according to CDC/ACIP and IDSA guidelines. When influenza is suspected in the hospital setting, empiric antiviral treatment should be given without waiting for confirmatory laboratory testing and without regard to illness duration **(strong, moderate)**. Antiviral treatment may provide benefit when started after 48 hours of illness onset in patients with severe, complicated, or progressive illness, and in hospitalized patients **(weak, low)**.
- Children with HIV in the outpatient setting with laboratory-confirmed or clinically suspected influenza should receive antiviral treatment as soon as possible **(strong, moderate)**. Treatment should be initiated as early as possible regardless of influenza vaccine status and regardless of illness severity according to CDC/ACIP and IDSA guidelines.
- In the outpatient setting, consideration could be given to withholding treatment if symptom duration exceeds 48 hours, the child has no HIV viremia or evidence of immunosuppression, is aged >5 years, and has no other underlying condition that places the child at high risk of complications from influenza **(weak, low)**.

Updates have been made to the main text of the Treatment Recommendations section to remove the adamantane antivirals, because of resistance of circulating influenza A strains, and intravenous (IV) zanamivir, because it is no longer available in the United States.

June 27, 2018

1. **Herpes Simplex Virus:** There are no major changes to the guidance for the diagnosis and management of HSV in children and adolescents living with HIV. The section has been updated to reflect the new recommendation rating system and references were added.