British HIV Association
BHIVA

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COMPETING INTEREST OF FINANCIAL VALUE ≥ £1,000:	
Speaker Name	**Statement**
Dr Yvonne Gilleece	Has received travel bursaries, educational grants and speaker fees from Janssen-Cilag Pharmaceuticals and Bristol-Meyer Squibb
Date	**October 2014**

National survey of management of Pregnancy in women living with HIV

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Pregnancy in women living with HIV

Presented today:

- Results of survey of management arrangements

For Spring BHIVA 2015:

- Results of audit using data routinely reported to National Study of HIV in Pregnancy and Childhood for women with EDD in 2013

Survey method and responses

- BHIVA invited audit lead clinicians at UK HIV services to participate
- Requested to consult maternity and paediatric colleagues for relevant data

- 112* HIV services responded, listing 124 corresponding maternity services

*2 excluded from obstetric section and 1 from paediatric as data not obtained.

Multidisciplinary working

Guidelines: MDTs, dedicated HIV specialist midwife and/or women's HIV Clinical Nurse Specialist are recommended

111 services have MDT, 1 did not

110 stated composition:

- All included HIV physician
- 1 had no obstetrician
- 2 had no paediatrician
- 8 had no midwife

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- 8 had no midwife

29 (26%) services had neither an HIV midwife nor women's HIV CNS

31 (28%) had both HIV midwife/HIV CNS

29 (26%) HIV midwife

21 (19%) HIV CNS

2 (0.02%) not answered

Time to be seen in HIV clinic after diagnosis via routine antenatal screen

Guidelines: Women needing HAART for own health to start within 2 weeks of diagnosis

Same or next working day	40 (35.7%)
2-3 days	23 (20.5%)
Within a week	29 (25.9%)
1-2 weeks	19 (17.0%)
Not answered	1 (0.9%)

Sexual health screen

Guidelines: Recommend near start of pregnancy if newly diagnosed, suggest for all. Consider repeat at 28 weeks

Start of pregnancy

Screen all women with HIV	84 (75.0%)
Newly diagnosed during pregnancy	24 (21.4%)
Only if considered at risk	3 (2.7%)
Not answered	1 (0.9%)

3rd trimester (repeat)

Screen all women with HIV	55 (49.1%)
If vaginal delivery planned	5 (4.5%)
Only if considered at risk/STI earlier in pregnancy	50 (44.6%)
Other	2 (1.9%)

ART in pregnancy

109 (97.4%) services have a policy, 2 did not, 1 no answer.

Regimen preferences were mainly in line with guidelines, but for pregnant woman with VL <10,000 copies/ml, CD4 >350 cells/mm^3:

- 35 (31.3%) included DRV/r among preferred agents
- 7 (6.3%) included NVP

Use of raltegravir

Widely used. For woman presenting after 28 weeks with VL >100,000 copies/ml:

Use routinely	56	50.0%
May use	43	38.4%
No policy, situation not arisen	11	9.8%
Would not use	1	0.9%
Not sure	1	0.9%

Resistance testing after stopping short-term ART

Guidelines: Resistance test is recommended to ensure mutations are not missed with reversion while off-treatment

Do routinely	55 (49.1%)
Not routine	49 (43.8%)
Not sure	8 (7.1%)

Of those testing routinely

- 77.4% do so within 6 weeks
- *7.5% defer until needing to re-start ART*

Urgent HIV testing

Guidelines: Recommend urgent test for women presenting in labour/with ROM /needing delivery and no HIV result. If reactive, act immediately

Arrangement for urgent lab test	95 (84.8%)
POCT available in all delivery units	15 (13.4%)
Urgent lab test not available	1 (0.9%)
Not sure	1 (0.9%)

Urgent HIV testing, cont.

Guidelines: Recommend urgent test for women presenting in labour/with ROM /needing delivery and no HIV result. If reactive, act immediately.

Problem with urgent tests

Problems experienced	10 (8.9%)
Provided without problems	40 (35.7%)
Need not arisen	55 (49.1%)

Timing for urgent tests

> 2 hours during working hours	21 (18.8%)
> 2 hours outside working hours	56 (50.0%)

Mode of delivery

Have a policy	107 (95.5%)
No policy	2 (1.8%)
Not sure/not answered	3 (2.7%)

Mode of delivery, on highly active ART, VL <50 copies/ml at >36 weeks

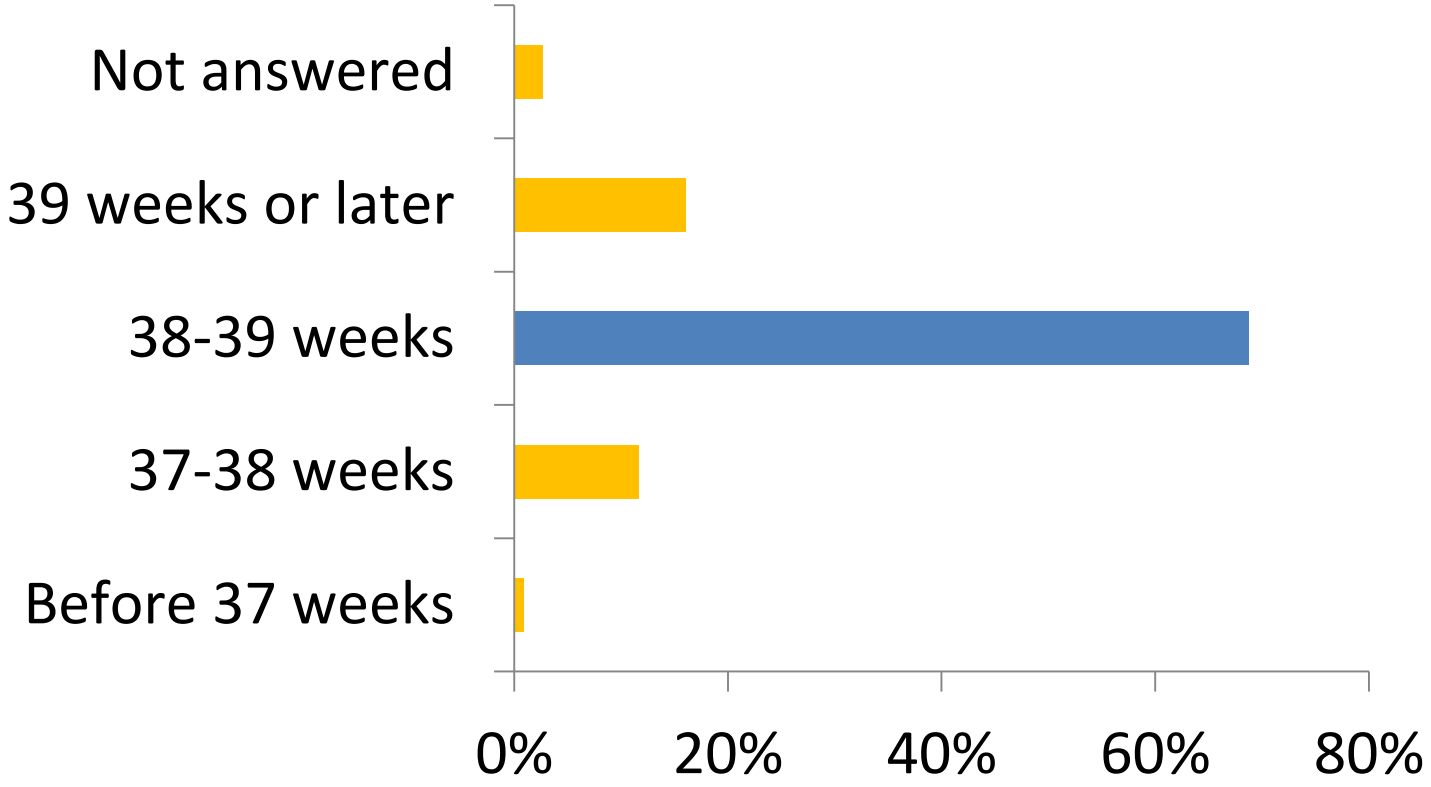
Guidelines: Recommend planned vaginal delivery

- Planned vaginal delivery
  95 (84.8%)
- Maternal choice
  9 (8.0%)
- Pre-labour CS
  3 (2.7%)
- Other/not answered
  5 (4.5%)

Timing of PLCS

Guidelines: Recommend PLCS 38-39 weeks

If solely for MTCT prevention:



Pre-labour rupture of membranes

Guidelines: At term, expedite delivery. If VL <50 copies/ml, induce labour.

At or after 36 weeks, VL <50 copies/ml	
Induce labour	92 (83.6%)
Immediate caesarean	8 (7.3%)
Other	6 (5.5%)
Not sure/not answered	4 (3.6%)

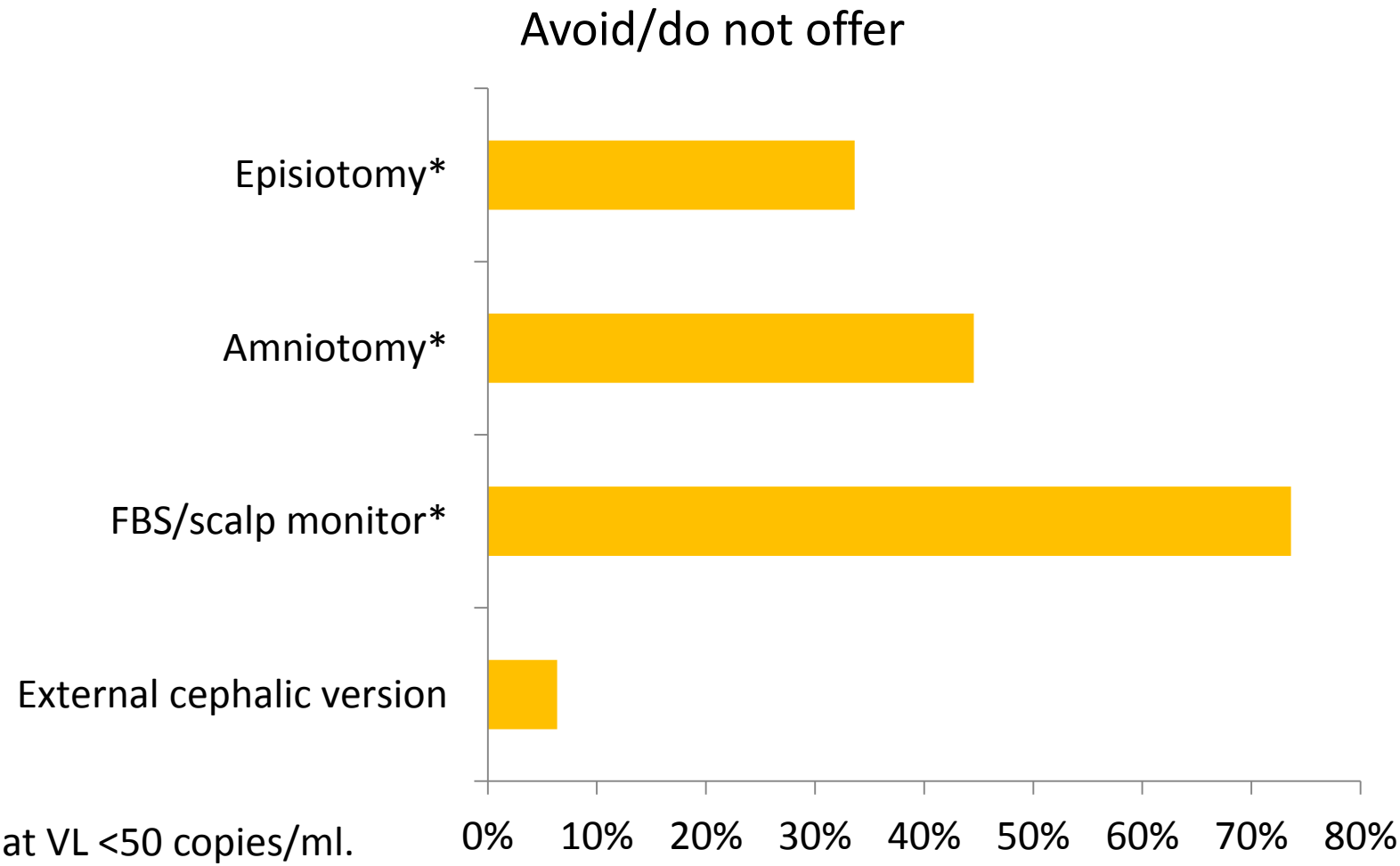
Amniocentesis

Guidelines: Defer until HIV status known, and ideally until VL suppressed

Defer if possible until VL <50 copies/ml	70	63.6%
Offer as for women without HIV	9	8.2%
Always avoid	3	2.7%
Other	24	21.8%
Not sure/not answered	4	3.6%

Obstetric procedures

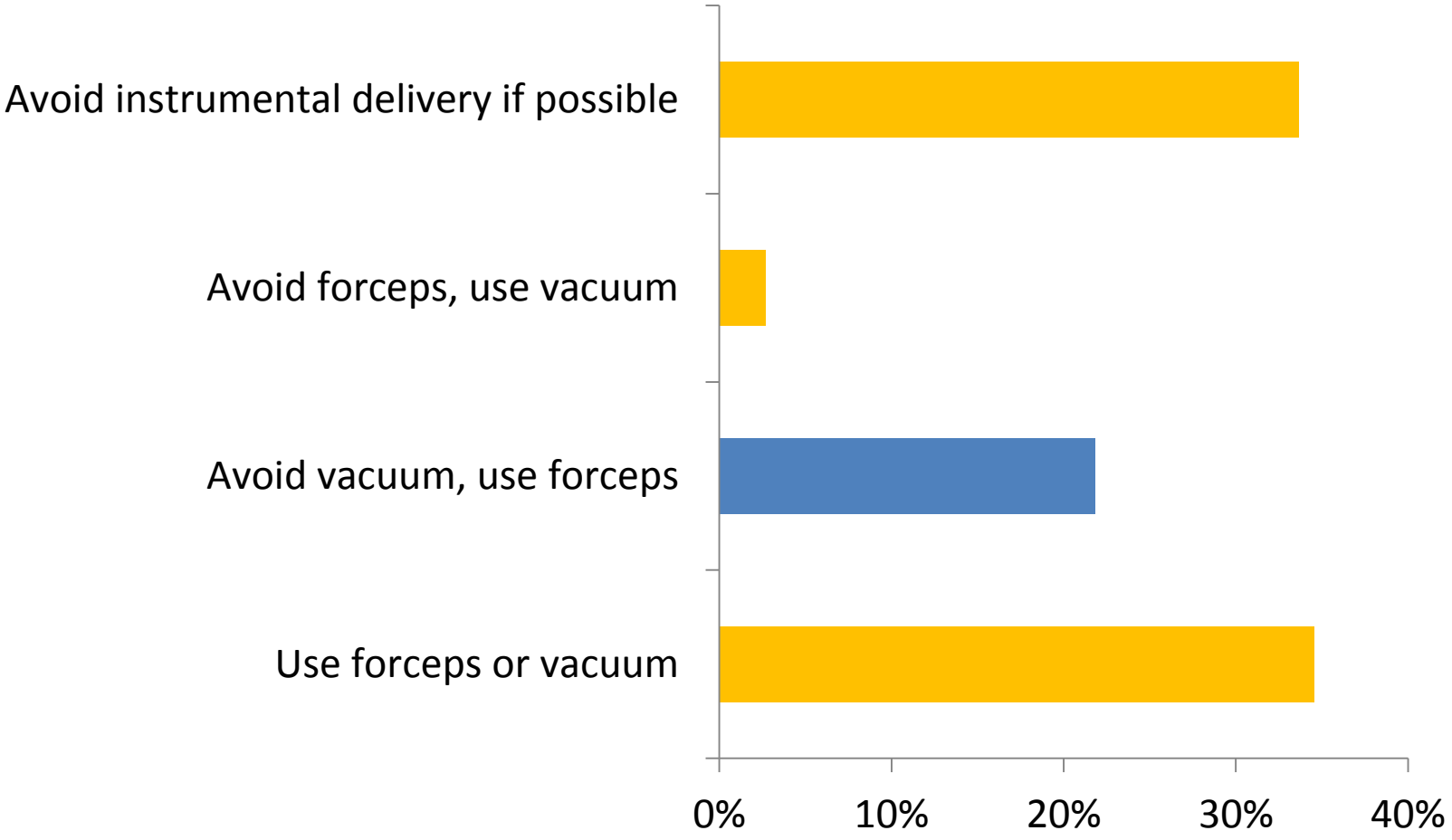
Guidelines: No evidence for avoiding these, treat as if HIV negative



*at VL <50 copies/ml.

Instrumental delivery*

Guidelines: Avoid vacuum, forceps preferred



*at VL <50 copies/ml.

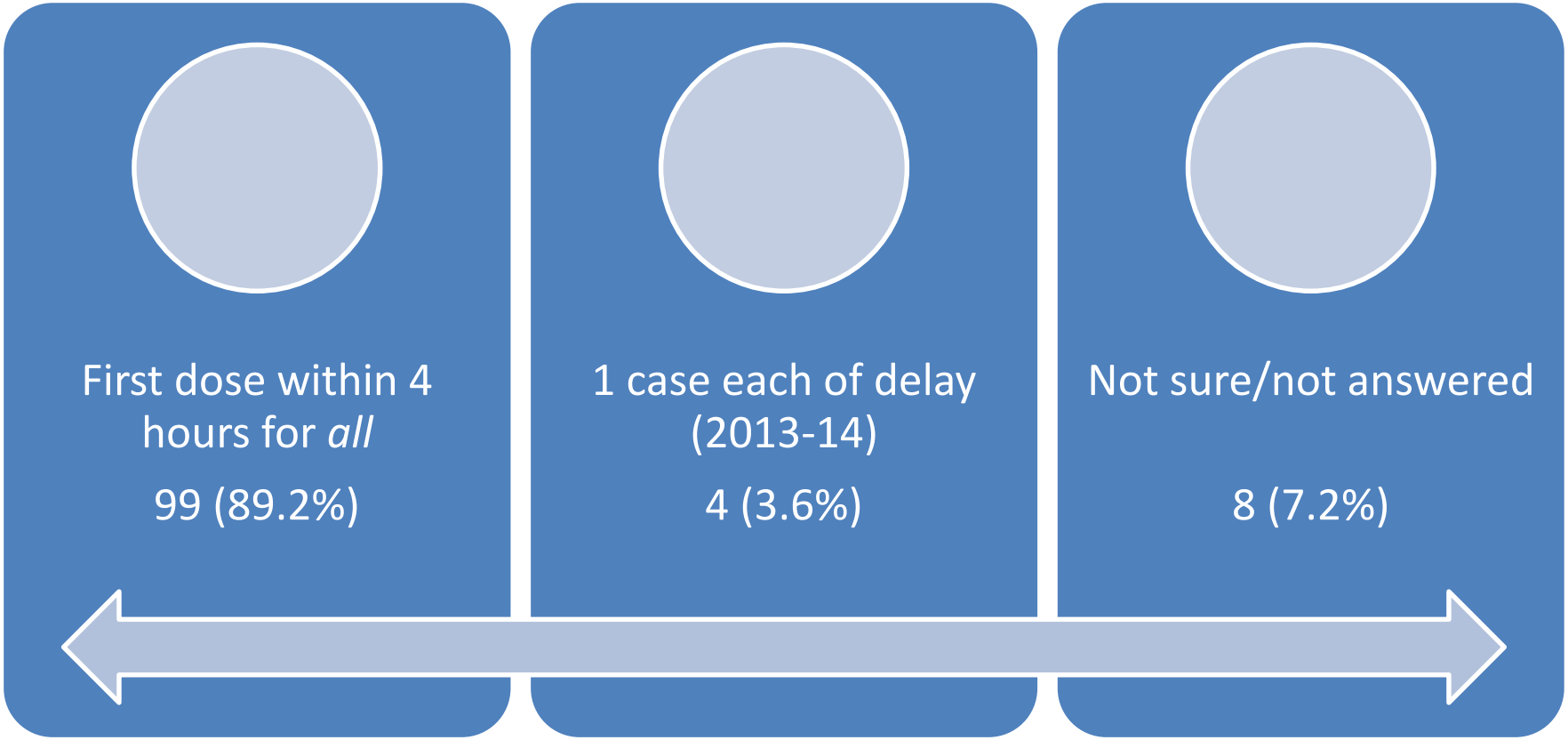
Cabergoline to suppress lactation

Guidelines: No recommendation

Offer routinely	62 (56.4%)
Do not use	21 (19.1%)
Offer in some circumstances	18 (16.4%)
Not sure/not answered	9 (8.2%)

Infant ART prophylaxis

Guidelines: Commence very soon after birth, "certainly within 4 hours"



Infant co-trimoxazole

Guidelines: If infected, HIV RNA/DNA+ or maternal VL >1000 copies/ml*

▪ Only if infected/HIV RNA/DNA positive	32 (28.8%)
▪ Also if maternal VL >1000 copies/ml	41 (36.9%)
▪ Also if infection not excluded	15 (13.5%)
▪ Other	21 (18.9%)
▪ Not answered	2 (1.8%)

*and infection not excluded.

Testing of infants/children

Guidelines: All potentially exposed infants/children should be tested

Infants born to HIV+ mother

- 110 (99.1%) have arrangements in place
- 1 not answered

Comments: arrangements mostly highly effective, all infants followed up.

Existing children of women diagnosed antenatally

- 103 (92.8%) have arrangements in place
- 8 (7.2%) not sure/not answered

Comments: effective at many sites, others report challenges.

Conclusions

Management appears broadly in line with guidelines, but it is of concern that:

- Urgent HIV testing takes >2 hours for 50% of services out of hours, and for 19% in hours
- 17% of HIV services take >1 week to see women diagnosed via antenatal screening
- Only 49% of services routinely test for resistance after stopping short term ART, and some of these delay test until mutations may have reverted

Conclusions, cont.

Areas of concern, continued:

- PLCS is being offered unnecessarily
- Some obstetric procedures may be being avoided unnecessarily
- Cabergoline is not routinely offered in all services
- Testing existing children of newly diagnosed women sometimes remains a challenge

Recommendations

- Maternity, HIV and laboratory services should review their management to ensure adherence to guidelines
- In particular, effective procedures are needed for urgent HIV testing of women who present in labour/with ROM/needing delivery
- PLCS and obstetric procedure policy requires review
- Future guidelines should address the use of cabergoline

Pregnancy audit using NSHPC data

Results spring 2015, outcomes including adherence to guidelines on:

- Timing of ART initiation
- Choice of ART regimen
- Planned mode of delivery
- Sexual health screening

Acknowledgements

Thanks to all HIV, maternity and paediatric services which contributed information to the survey.

Audit & Standards Sub-Committee: A Freedman, D Asboe, A Brown, F Burns, D Churchill, K Clay, H Curtis, V Delpech, K Doerholt, Y Gilleece, P Gupta, J Musonda, C Okoli, O Olarinde, E Ong, S Raffe, M Rayment, A Rodger, C Sabin, A Sullivan, H Veerakathy.