18th Annual Conference of the British HIV Association (BHIVA)



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Managing the pregnancies of elite controllers: what are we doing?

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Background

- Elite control of HIV is the spontaneous and sustained suppression of the virus to <50c/ml, in the absence of ART
- Estimated to occur in <1/300 HIV infected persons¹
- Specific data on managing pregnancy in elite controllers (ECs) are limited to case reports²
- BHIVA 2008 pregnancy guidelines do not mention ECs specifically
 - Can use zidovudine monotherapy (ZDVm) + planned lower cesarean section (PLCS) + iv ZDV in women VL<6,000-10,000
- BHIVA 2012 consultation draft pregnancy guidelines
 - For ECs: ZDVm + spontaneous vaginal delivery (SVD)
 - or combination antiretroviral therapy (cART) + SVD
 - Based on viral load data which suggest ART reduces transmission even when VL<50 c/ml
 - 1. Walker BD. Elite control of HIV Infection: implications for vaccines and treatment. Top HIV Med 2007;15(4):134-136.
 - 2. Rutland E, Mani R. Management of pregnancy in an HIV elite controller. Int J STD AIDS 2010;21(8):604-605.



To describe the management of pregnancy & neonatal outcomes in HIV elite controllers across 9 UK HIV treatment centres.



Retrospective case-note audit

- Clinicians contacted via London HIV Perinatal Research Meeting
- Clinicians identified cases which met inclusion criteria
- Anonymised data collated from paper & electronic records
- Data analysed centrally

Inclusion criteria:

- HIV 1 Ab positive (HIV 2 negative)
- At least two sequential documented HIV VL <50 copies/ml
- VL<50 copies/ml at least 6 months after any prior ART (unless for PMTCT)
- No indication of 'surreptitious' ART
- Pregnancy managed by the HIV treatment centre

Results: baseline characteristics



- 25 singleton pregnancies
- 20 women
- 9 HIV treatment centres
- Year of delivery 1999-2012



South Asia

Mean age at delivery	30 years	Range 18-37
Mean CD4 at diagnosis	609 cells/µL	Range 281-931
Diagnosed during this pregnancy	9/20	45%
Hep B co-infection	1/20	5%
Latent TB co-infection	1/20	5%
Previously received ART	1/20	5%

Results: planned management

- Zidovudine monotherapy (ZDVm)
- Combination ART (cART) 7/25



∞ ZDVm + SVD (5/25)

18/25

- ZDVm + PLCS (13/25)
- **3NRTI + SVD (3/25)**
- 2NRTI + PI + SVD (3/25)

2NRTI + PI + PLCS (1/25)







Year of delivery



Gestation at start of ART:

	Mean gestation (weeks)	Range
ZDVm + PLCS	30	24 - 34
ZDVm + SVD	28.2	26 - 30
cART	27	24 - 33

Analysis of variance F= 1.049, p=0.37

Results: actual mode of delivery



Use of intravenous ZDV at delivery (3/25 not available):

n = 22			
ZDVm + PLCS	5/10	cART + PLCS	1/3
ZDVm + SVD	0/2	cART + SVD	0/3
ZDVm + emLCS	2/3	cART + emLCS	0/1
Overall	46.7%		14.2%

Results: pregnancy outcomes

n = 25	Number	Data unavailable
Live births	25/25	-
Delivered at term (>37 weeks)	23/25	-
VL < 50 c/ml at delivery	23/25*	1/25
Infant given 4 weeks ZDVm	23/25	2/25

Infant HIV status:



- 18m HIV Ab negative (17/25)
- Not yet 18m HIV DNA negative to date (6/25)
- HIV DNA negative at birth, transferred care (1/25)
- Data unavailable (1/25)
- * 1/25 VL 205 c/ml result available after delivery



- Considerable variation in practice for ART and mode of delivery
- Majority of cases were managed with ZDVm (72% vs 9% overall in UK)
- Trend towards aiming for SVD probably reflects overall shift in management of pregnancy in UK
- Increasing numbers of ECs aiming for SVD on ZDVm probably reflects increasing clinician confidence
- Data support the new draft guidance, greater numbers are needed to confirm optimal approach for efficacy & safety

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