24/7 ILLINOIS PERINATAL HIV HOTLINE

BEST PRACTICES FOR HIV-POSITIVE WOMEN IN LABOR

24/7 Illinois Perinatal HIV Hotline
GIVE BIRTH TO A FUTURE WITHOUT HIV/AIDS
800-439-4079
hivpregnancyhotline.org

LABOR & DELIVERY AND POSTPARTUM CARE FOR PREGNANT WOMEN LIVING WITH HIV, WOMEN WITH A POSITIVE RAPID HIV TEST, AND HIV-EXPOSED NEWBORNS

PURPOSE

To establish best practices for the delivery and postpartum care of pregnant women living with HIV (including those with a positive rapid HIV test at L&D) and HIV-exposed newborns.

I. Considerations for LABOR and DELIVERY

A. All pregnant women in Illinois should receive HIV counseling and opt-out testing two times during pregnancy (as early in pregnancy as possible and again in the third trimester). The third trimester test should be done between the 27th week of pregnancy and delivery, but preferably before 36 weeks gestation to optimize confirmatory testing and initiation of interventions. Any pregnant woman who does not have documentation of a negative HIV test result from after 27 weeks of the current pregnancy must be offered a rapid HIV test.

- ***Per Illinois law, the Illinois Perinatal HIV Hotline must be called within 12 hours, but no later than 24 hours, of the test result for all pregnant patients and exposed newborns found to be preliminarily positive with rapid HIV testing.***
- ***It is recommended to call the Hotline as soon as the positive test results. The Hotline can provide care recommendations, advise on supplemental HIV tests to confirm HIV status, and link women to case management services***

B. When a pregnant patient with HIV **arrives** in L&D (or at the time of a positive rapid HIV test result), notify an obstetrician with expertise in HIV perinatology or an infectious disease specialist. The **24/7 Illinois Perinatal HIV Hotline (800-439-4079)** is available to provide consultation if no hospital-based specialist experienced in perinatal HIV is available.

C. The Hotline recommends that for all pregnant women with HIV, regardless of HIV RNA (viral load), intravenous (IV) AZT (zidovudine) be started as soon as possible after the patient presents in labor. Similarly, if a scheduled cesarean delivery is planned, the Hotline recommends that women receive IV AZT (zidovudine) for 3 hours prior to surgery regardless of viral load. The maternal IV AZT (zidovudine) infusion provides the infant with pre-exposure AZT (zidovudine) prophylaxis that will continue as post-exposure prophylaxis postnatally while the infant receives oral AZT (zidovudine) for 4-6 weeks.

- The Hotline views the use of intrapartum IV AZT (zidovudine) regardless of viral load to be consistent with and complementary to the recommendation for postnatal AZT (zidovudine). The Hotline acknowledges these recommendations differ from but are not inconsistent with the Department of Health and Human Services Perinatal Guidelines. The federal Perinatal Guidelines state the following: "IV zidovudine is not required for HIV-infected women receiving ART with HIV RNA ≤1,000 copies/mL in late pregnancy and/or near delivery and for whom there are no concerns about adherence to or tolerance of their ART regimens; IV zidovudine should continue to be administered to HIV-infected women with HIV RNA >1,000 copies/mL near delivery (or unknown HIV RNA levels), regardless of antepartum regimen. However, regardless of viral load, the clinician may elect to use intrapartum IV zidovudine based on clinical judgement." The Hotline recommends use of intrapartum IV AZT (zidovudine) due to 1) methodological limitations of the current evidence that led to the policy change, 2) the complementary benefit of both pre- and post-exposure

prophylaxis for individuals at risk of HIV acquisition, and 3) the public health benefit of simple and consistent messaging across hospital systems that ensures consistent access to AZT (zidovudine) for intrapartum prophylaxis.

- AZT (zidovudine) dosage is based on the patient's weight. Patients admitted in preterm labor with a significant chance of delivery should be started on IV AZT (zidovudine).
    - IV AZT (zidovudine) dosing is as follows: 2 mg/kg loading dose over 1 hour followed by 1 mg/kg/hour maintenance infusion until the cord is clamped.
- **AZT (zidovudine) is not compatible with all medications.** Please check with pharmacy before running AZT (zidovudine) in the same line with other medications.
- In situations where IV AZT (zidovudine) is not available, oral AZT (zidovudine) should be administered to the mother as soon as possible (600mg loading dose and then 300mg PO q3 hrs). The 24/7 Illinois Perinatal HIV Hotline should be consulted.

D. Invasive procedures should be avoided if possible (fetal scalp electrodes, fetal scalp blood sampling, artificial rupture of membranes (AROM) and operative vaginal delivery).

E. Route of delivery for a previously diagnosed woman is determined by the patient's HIV disease (viral load).

- Cesarean delivery should be offered to women with clinically significant viral loads (>1000 copies/ml) as cesarean delivery is associated with a reduced risk of transmission when performed prior to active labor and rupture of membranes in these settings. Women who are scheduled for cesarean section should receive IV AZT (zidovudine) for 3 hours prior to surgery.
- For women with undetectable or low viral loads (<1000 copies/ml) and receiving antiretroviral therapy, the risks of cesarean section may outweigh any theoretical benefit of reduced transmission.

F. Route of delivery should be carefully considered for women who test preliminarily positive in labor by a rapid HIV test and whose confirmed HIV status is unknown.

- If the woman is truly positive and has not received antiretroviral therapy, a cesarean delivery performed early in labor with intact membranes may still be beneficial.
- Consultation should be sought with a Maternal-Fetal Medicine or Infectious Disease Specialist experienced in perinatal HIV. The 24/7 Illinois Perinatal HIV Hotline is available for this consultation.

G. If the pregnant patient does not have documentation of a negative HIV test result from after 27 weeks of the current pregnancy or later and refuses HIV testing for herself, then her infant must be administered a rapid HIV test according to Illinois law. For infants with preliminarily positive rapid HIV tests, continue to the recommendations in sections II-V.

II. Considerations for MOTHER-BABY RECOVERY

A. Infants should be given an early bath.

- They should be suctioned and bathed as soon as possible to remove maternal blood contamination **before** vitamin K and antibiotic eye prophylaxis (Erythromycin) administration. This early infant bath should occur in the delivery room if possible and should be documented in the medical record.
- If Narcan or other medications need to be given urgently, cleanse the site with alcohol followed by Betadine prior to injection.

B. Infant AZT (zidovudine) syrup should be given **as soon as possible after birth, with the goal of within 1 hour**.

- Simplified weight-band dosing for AZT (zidovudine) for infants ≥35 weeks gestation given orally twice daily is: 2 to <3kg = 1mL, 3 to <4kg = 1.5mL, 4 to <5kg = 2mL. For low-risk infants, AZT should be administered for 4 weeks. In high-risk scenarios, a 6-week regimen of infant AZT should be used. Call the Hotline at 800-439-4079 for more information or consult the federally approved Perinatal Guidelines.

- Preterm infants <35 weeks will require a dose reduction and the 24/7 Illinois Perinatal HIV Hotline should be consulted.
- In order to expedite the process, the pharmacy should be notified of the imminent need for a stat AZT (zidovudine) syrup order when the patient is admitted to Labor and Delivery. **Have AZT (zidovudine) syrup available at delivery.**
- An infant unable to tolerate oral feedings may be given the oral dose via a feeding tube or intravenous preparation. The recommended dose for infants $\geq$ 35 weeks is 75% of the oral dose if given intravenously.

C. Infant risk status should be determined. Infants considered at high-risk for transmission will require additional antiretroviral medications - Viramune (Nevirapine) and 3TC (Lamivudine/Epivir). In some cases, clinicians may wish to use Raltegravir (Isentress) instead of Nevirapine (e.g. mother has known viral resistance to Nevirapine or Efavirenz, Nevirapine is not available, etc.) In these cases, clinicians should review proper instructions on Raltegravir preparation and dosing and weigh the complexity of Raltegravir preparation/dosing with the benefits of its administration (see *Guidelines for Care for Infants with Perinatal Exposure to HIV* for additional information). **Consultation with the 24/7 Illinois Perinatal HIV Hotline is strongly recommended in cases where Raltegravir will be used.**

D. **High Risk** for HIV infection is defined as **AT LEAST ONE** of the following. See *Guidelines for Care for Infants with Perinatal Exposure to HIV* for complete information on determination of infant risk status and antiretroviral prophylaxis.

  - All infants born <33 weeks gestation
  - Infants born to women whose HIV viral load was detectable (anything greater than 20 copies/mL) after 28 0/7 weeks gestation
  - Infants born to women who did not receive antepartum antiretroviral therapy
  - Infants born to women who started antiretroviral therapy after 13 0/7 weeks gestation
  - Infants born to women who became infected with HIV or seroconverted during pregnancy
  - Infants born to women diagnosed with HIV during labor or postpartum

- **Low Risk** for HIV infection
  - All other infants

III. Considerations for POSTPARTUM UNITS

A. **Breastfeeding is contraindicated for women living with HIV** given the continued risk to the neonate from virus excretion in breast milk.

- Women should be instructed in measures to suppress lactation such as supportive/tight bras, ice or cold compresses and ibuprofen to reduce discomfort.
- If the patient has a **preliminary HIV-positive result from a rapid HIV test and desires to breastfeed while awaiting her confirmatory HIV test result**, she can be instructed to pump and store her breast milk until the confirmatory test results are available. This can be done to optimize development of a milk supply for a patient that desires to breastfeed if her confirmatory HIV test result comes back **negative**. **The patient needs clear counseling regarding the importance of not using her breast milk to feed the baby until the confirmatory test result is negative**.

B. Universal precautions should be reviewed prior to discharge with particular attention to vaginal bleeding and disposal of sanitary pads.

C. Contraceptive and STD counseling should be performed prior to the patient's discharge.

D. Social work consultation is advised to address disclosure counseling and partner notification. Disclosure of HIV status is a sensitive issue and should be addressed in a confidential and non-judgmental manner.

E. Follow-up appointments for the mother and newborn must be scheduled prior to discharge. The Hotline is available to provide a list of resources in the area for referral as well as case management for women at risk of loss to follow-up.

- For women or newborns with a preliminary positive rapid HIV test, confirmatory HIV testing must be sent prior to discharge. **The positive rapid HIV test result must be reported to the 24/7 Illinois Perinatal HIV Hotline (800-439-4079) within 12 hours, but no later than 24 hours, of the test result.** Follow-up for this confirmatory testing is essential.

IV. Considerations for HIV-EXPOSED NEWBORNS

A. All HIV-exposed infants should have an HIV DNA PCR or RNA PCR or Total Nucleic Acid (TNA) test performed on peripheral blood at $\geq$2 weeks of age. **High-risk infants should be tested at birth**. See *Guidelines for Care for Infants with Perinatal Exposure to HIV* for detailed information on infant HIV testing.

B. **Rapid HIV tests are required by Illinois law to be performed on infants born to mothers who do not have documentation of a negative HIV test result from after 27 weeks of the current pregnancy.** It is not necessary to do a rapid HIV test on an infant born to a mother previously diagnosed with HIV or a mother that had a preliminary positive rapid HIV test.

C. Instruct mothers on how to draw up and administer HIV medications to infants with HIV exposure.

- Nurses should observe and document that the mother can draw the correct dosage and administer the medication to the infant successfully prior to discharge (see Section II for dosage information).
- **Newborns should be discharged with a 2-week supply of medications.** AZT (zidovudine) syrup and other antiretroviral medications used for infant prophylaxis are not readily available from community pharmacies and patients often have difficulty obtaining them. The 24/7 Illinois Perinatal HIV Hotline is available to assist institutions in successfully discharging infants with this medication. It is **critical** that medication doses are administered at scheduled times**.**

D. A physician experienced in pediatric HIV should evaluate all infants with HIV exposure within 7-10 days of discharge. Referral resources as well as case-management resources are available through the 24/7 Illinois Perinatal HIV Hotline at 800-439-4079.