

## Preconception and Antepartum Checklist for Management of Pregnant Women with HIV

✓ *Patient Safety Checklist*

*Created on: 02/25/2016*

*This checklist is a general guide to care for an HIV positive prenatal patient.*

### **Pre-Conception**

- Discuss methods of safe conception
- Ensure an undetectable HIV viral load prior to attempting conception
- Ensure combined antiretroviral therapy (cART) medications are appropriate for use during pregnancy
- Discuss disclosure of patient's HIV status to her partner and offer partner testing if the partner is HIV negative
- Offer partner(s) testing (is/are her partner(s) aware of her status? Are they HIV positive? Is their viral load undetectable?)
- Discuss PreP
- Ensure vaccines are up to date (pneumococcal, hepatitis B, (hepatitis A, influenza, MMR, chickenpox, HPV, tDAP, seasonal influenza, if appropriate)

### **Antepartum**

*First visit:*

- If new diagnosis:
  - Determine:
    - HIV viral load
    - CD4 T lymphocyte cell count
    - Antiretroviral drug resistance (genotype) panel
    - G 6PD and HLA-B\* 5701
    - toxoplasmosis immunity
    - Hepatitis B surface antigen, hepatitis B surface antibody, hepatitis A total antibody
    - hepatitis C antibody
  - PPD (or quantiferon)
- Begin cART regimen that contains three active medications based on perinatal guidelines recommendations and/or consult with specialist<sup>1</sup>

It is not necessary to wait for genotype results to start treatment

If HLA-B\* 5701 positive, do not use abacavir

If G6PD deficiency present cannot use trimethoprim/sulfamethoxazole for pneumocystis jirovecii prophylaxis or treatment

o If previous diagnosis:

o Determine:

viral load

CD4 T lymphocyte cell count.

Obtain records or draw:

- G6PD
- HLA-B\* 5701
- toxoplasmosis immunity

If viral load >500 copies/mL check HIV genotype (do not delay treatment)

Begin cART regimen based on perinatal guidelines recommendations and/or consult with specialist

- If HLA-B\* 5701 positive, do not use abacavir

If currently on effective combined antiretroviral therapy (cART), continue that same treatment during pregnancy unless contraindicated

If CD4 count <200 copies/mL begin prophylaxis against opportunistic infections

If assistance regarding clinical care or referral to another provider is needed, consult Perinatal HIV hotline:

<http://nccc.ucsf.edu/clinician-consultation>. 1-888-448-8765

### *Early Visits*

Recheck CD4 T lymphocyte cell count every 3 months

- o can reduce to 6 months for patients with consistently suppressed viral load with CD4 count >200 copies/mL

Recheck viral load 2-4 weeks after initiating (or changing) cART.

Recheck viral load monthly until RNA levels are undetectable, then every 1-3 months thereafter

Assess adherence and tolerance to cART at every patient visit

Give vaccines if needed (pneumococcal, hepatitis A and B, influenza)

If on protease inhibitor based regimen, consider early glucose screening

### *Second Trimester*

- If failure of viral suppression is found
  - Assess viral resistance if viral load remains >500 copies/mL with HIV genotype testing
  - Assess adherence
  - Consult an HIV treatment expert

### *Third Trimester*

- Repeat RPR, GC/CT at 28-34 weeks
- Reassess viral load at 34-36 weeks for delivery planning
- If viral load is not suppressed:
  - assess adherence
  - assess viral resistance
- Make a postpartum plan for cART
- Determine plan for contraception after delivery
- Make delivery plan including whether zidovudine will be used and route of delivery
- If viral load is greater than or equal to 1000 copies/mL at 37-38 weeks, schedule cesarean delivery at 38 weeks

*Disclaimer: This checklist reflects emerging clinical, scientific, and patient safety advances as of the date issued and is subject to change. The information should not be construed as dictation of an exclusive course of treatment or procedures to be ordered.*

*This checklist can be used as a prospective guide to managing pregnant patients with HIV and can also be used to audit the performance of a specialist providing comprehensive care for a pregnant patient with HIV.*

## References

1. Panel on Treatment of HIV-Infected Pregnant Women and Prevention of Perinatal Transmission. 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. Available at <http://aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf> Accessed 10.25.2015
2. Panel on Opportunistic Infections in HIV-Infected Adults and Adolescents. Guidelines for the prevention and treatment of opportunistic infections in HIV-infected adults and adolescents: recommendations from the Centers for Disease Control and Prevention, the National Institutes of Health, and the HIV Medicine Association of the Infectious Diseases Society of America. Available at [http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult\\_oi.pdf](http://aidsinfo.nih.gov/contentfiles/lvguidelines/adult_oi.pdf) Accessed 10.25.2015
3. Branson, B, Owen, S. M, Wesolowski, L, et al. Laboratory testing for the diagnosis of HIV infection : updated recommendations. <http://stacks.cdc.gov/view/cdc/23447>. Accessed 10.25.2015
4. UCSF National Perinatal HIV Clinical Consultation Center: <http://nccc.ucsf.edu/clinician-consultation>. 1-888-448-8765