VCMC/SANTA PAULA HOSPITAL CLINICAL PRACTICE GUIDELINE
HIV in Pregnancy

The contents of this clinical practice guideline are to be used as a guide. Healthcare professionals should use sound clinical judgment and individualize patient care. This CPG is not meant to be a replacement for training, experience, CME or studying the latest literature and drug information.

Antenatal Management

1.) Lab monitoring
    a. Plasma HIV RNA levels should be checked at the initial visit, 2-4 weeks after initiating or changing ARV drug regimen and monthly until viral load is undetectable.
    b. Once undetectable, viral load should be checked every 3 months
    c. HIV RNA level should be drawn between 34-36 weeks to instruct mode of delivery (see section on 'Mode of Delivery' below)
    d. CD4 count should be checked at initial visit and every 3-6 months during pregnancy for consideration of opportunistic infection treatment
    e. Early glucose screening should be considered for patients receiving ongoing protease inhibitors as this is an independent risk factor for developing GDM
2.) If Amniocentesis is desired, it should be delayed until the patient is on effective ARV, or ideally, once viral load is undetectable
3.) All other antenatal management should be in accordance with ACOG standards for prenatal care including timing for ultrasound dating and screening.
4.) AROM can be performed for usual obstetric indications in patients with viral suppression on antiretrovirals, but not in patients with unsupressed or unknown viral titers.
5.) Placement of fetal scalp electrodes and operative vaginal deliveries with forceps or vacuum should be avoided in all mothers with HIV to prevent transmission unless there is a clear obstetric indication
6.) Methergine should be avoided in patients taking protease inhibitors, or should be given in the lowest effective dose due to CYP3A4 inhibition and resultant excess blood levels of methergine.

Special Situations

1.) HIV during pregnancy with positive PPD: All pregnant patients with latent TB should be treated at the TB Clinic.
2.) Breast feeding: All women with HIV should NOT breast feed, even if their viral load is undetectable.

Delivery Mode – Based on 2016 NIH Panel Guidelines (aidsinfo.nih.org), in accordance with ACOG

1.) Patient with > 1000 copies/mL HIV RNA levels should proceed with scheduled cesarean section at 38 weeks to decrease risk of transmission.
2.) Patient with < 1000 copies/mL HIV RNA levels should receive expectant management, IOL of labor or cesarean section for obstetric indications. Transmission rates in this population is low.
3.) Ruptured membranes: In women on ART with < 1000copies/mL HIV RNA, duration of ROM is not associated with an associated increase risk of transmission

National Institutes of Health. 2016. *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*. Retrieved from www.aidsinfo.nih.gov.

Approvals:
FM Committee: 09/2017
Ob/Gyn Committee: 09/2017
MEC: 10/2017
Oversight: 11/2017