

**Table 4 Clinical Scenarios**

					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy				Mode of Delivery	Grade (Table 1)
					Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother		
1) Woman does not need treatment for own health (asymptomatic good CD4) <b>Low VL</b>	> 200 / > 21%	< 10,000	Naive	< 32 weeks	AZT mono 076 regimen (BD dosing) commence late 2 <sup>nd</sup> / early 3 <sup>rd</sup> trimester, but before 32 weeks <sup>a</sup>	AZT mono 076 regimen IV at delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	Stop therapy after delivery	PLCS at 38 weeks	MOD –A  ART – A for prevention of transmission
2) Woman does not need treatment for own health (asymptomatic good CD4) <b>high VL</b>	> 200 / > 21%	> 10,000	Naive	< 32 weeks	“START” suggest: inc AZT by 076 regimen + 3TC+ PI / NNRTI <sup>b</sup> Commence late 2 <sup>nd</sup> trimester	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	If stopping therapy after delivery, give consideration to timing of stopping NVP in relation to NRTI’s, eg 3-5 days prior	PLCS at 38 weeks	MOD – A  ART - C for prevention of transmission
3) Woman needs treatment for own health	< 200 / < 21%  (200 – 350 but steep slope of decline)  (200 – 350)	Any  Any  High	Naive	< 32 weeks	“HAART” suggest: inc AZT by 076 regimen + 3TC+ PI / NNRTI <sup>b</sup> Defer until after 1 <sup>st</sup> trimester, if possible	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A  ART – A for maternal health. C for prevention of transmission
4) Woman presents pregnant on effective ART	Any	< 50	On effective “HAART”	Any time	Continue: <sup>c</sup>	If on AZT, 076 regimen IV at delivery <sup>d</sup> + Oral doses of other ART as usual pre-delivery	Mono-therapy component of the mother’s regimen: e.g. AZT, 3TC, D4T for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A  ART - A for maternal health. C for prevention of transmission

**Table 3: Scenarios for management of HIV Infection in Pregnancy**

**Table 4 Clinical Scenarios**

Scenarios					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy				Mode of Delivery	Grade
					Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother		
<b>5A)</b> On non-suppressive ART	Any	VL > 1000 resistance test  VL = 50-1000 monitor closely for trend, if resistance test	May be multiple drug classes exposed	< 32 weeks	With resistance data Consider change to best option <sup>e</sup>  Seek expert advice	If on AZT, 076 regimen IV at delivery <sup>d</sup> + Oral doses of other drugs in ART as usual pre-delivery	Mono-therapy component of the mother's regimen to which no resistance for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A  ART - B for maternal health. C for prevention of transmission
<b>5B)</b> Failing therapy in late pregnancy		>1000		>37 weeks	Select best combination from therapy history Seek expert advice.			<b>Seek expert advice.</b>	PLCS at 38 weeks	
<b>6)</b> Late presentation, but before delivery	CD4 < 200 + any / no VL CD4 > 200 + VL > 10,000  NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	> 32 weeks, but before delivery. Time to get CD4, but maybe not VL	“START” suggest: inc AZT by 076 regimen + 3TC+ NVP <sup>f</sup> Commence ASAP	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	If > 4 wks maternal Rx: AZT mono. If < 4 wks maternal Rx especially if BL VL high: Triple ART <sup>g</sup>	Continue maternal regimen after delivery until get CD4 + VL. Ideally, do not stop ART until VL < 50	PLCS at 38 weeks	MOD – A  ART - C for prevention of transmission

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Scenarios					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy				Mode of Delivery	Grade
					Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother		
7) Presents in labour – membranes intact	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	In labour Any gestation <b>intact membranes</b>	-----	AZT 076 regimen IV at delivery + Oral doses of NVP + 3TC	Triple ART <sup>g,h</sup>	If labour stops continue “START”. If delivered -continue maternal ART until get CD4 + VL. Ideally, do not stop ART until VL < 50	32 wks – term If labour progresses consider CS  < 32 wks IV antibiotics, tocolysis, steroids. If labour progresses consider CS	MOD – D  ART - C for prevention of transmission
8) Presents with rupture of membranes, +/- labour	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	In labour Any gestation  No labour Any gestation	-----	IV AZT 076 regimen + Oral doses of NVP + 3TC	Triple ART <sup>g,h</sup>	Continue maternal “START” until get CD4 + VL. Ideally, do not stop ART until VL < 50	If labour progresses consider SVD + antibiotics  No labour CS <sup>i</sup> + antibiotics	MOD – D  ART - C for prevention of transmission
9) Presents after delivery	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	After delivery	-----	-----	Triple ART <sup>g,h</sup> Start ASAP, less likely to be effective if > 48hrs after delivery	Assess maternal need for ART	-----	ART - C

Resistance testing should be carried out in women failing therapy. Also consider resistance testing in ART naïve mothers.

Closely monitored / actively managed vaginal delivery may be considered in women with VL < 50.

“START” Short term combination anti-retroviral therapy

“HAART” Highly active anti-retroviral therapy

#### **Table 4 Clinical Scenarios**

- a** An alternative to regimen 1) would be to use regimen 2) “START” for women with “good CD4, low VL, ART naïve”.
- b** When choosing the PI / NNRTI, consider the short-term toxicities of NVP (rash, hepatitis), & short term / long term toxicities of e.g. NEL ( diarrhoea, lipid derangement’s etc)
- c** If AZT unexposed, consider changing one NRTI to AZT after 1<sup>st</sup> trimester. Substitute EFAV with another drug, if presents in 1<sup>st</sup> trimester.
- d** If not on AZT, not necessary to give IV AZT infusion in labour, as long as all regular doses given at correct times. It may be contra-indicated to give AZT if D4T is part of the regimen.
- e** When changing treatment consider the following: VL trend; absolute VL; potential toxicities; available drug choices; At stable low viraemia e.g. < 5,000 it may be possible to continue current treatment regimen
- f** Use NVP in preference because of rapid anti-viral effect and high transplacental concentrations
- g** See table 5 for appropriate infant doses of AZT, 3TC, NVP for 4-6 weeks of treatment
- h** Premature or sick infants may not tolerate oral therapy, only available IV preparation is AZT. See table **XXX** for appropriate infant doses.
- i** If there is extreme prematurity with rupture of membranes, a period of conservative management with steroids, antibiotics and “START”, may be more appropriate for the infant.  
Seek expert advice.