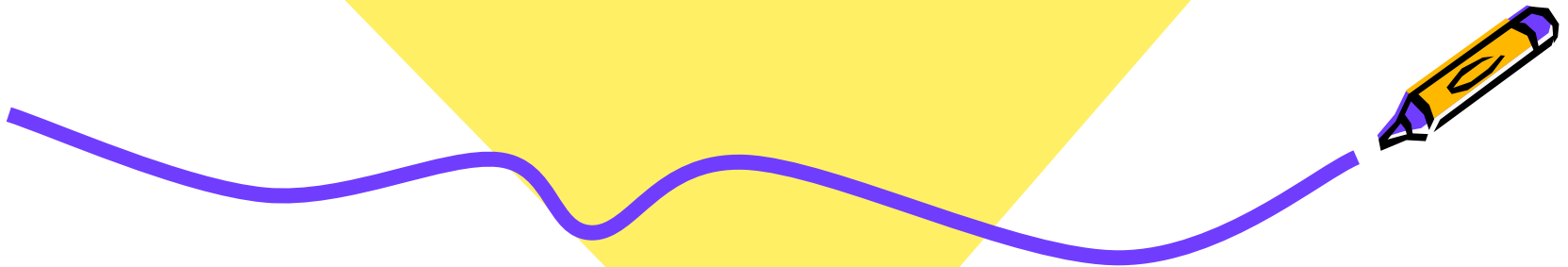


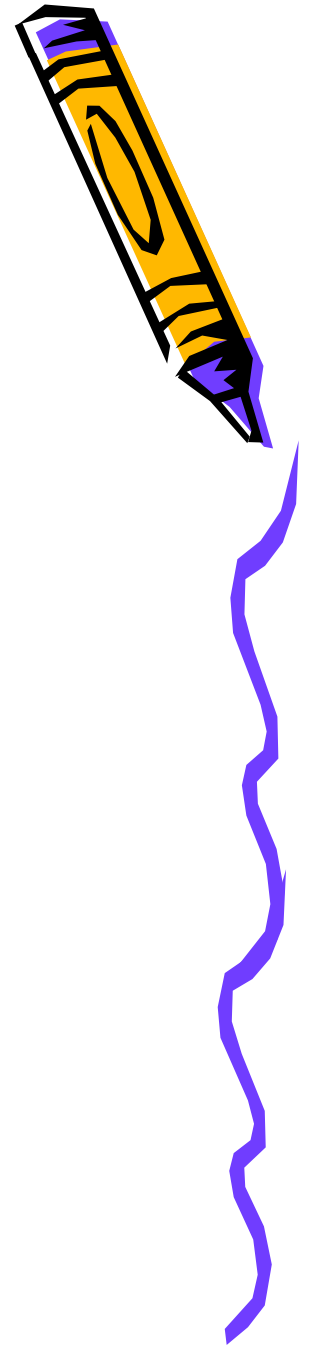
ARV USE DURING PREGNANCY

Dr Sebitloane

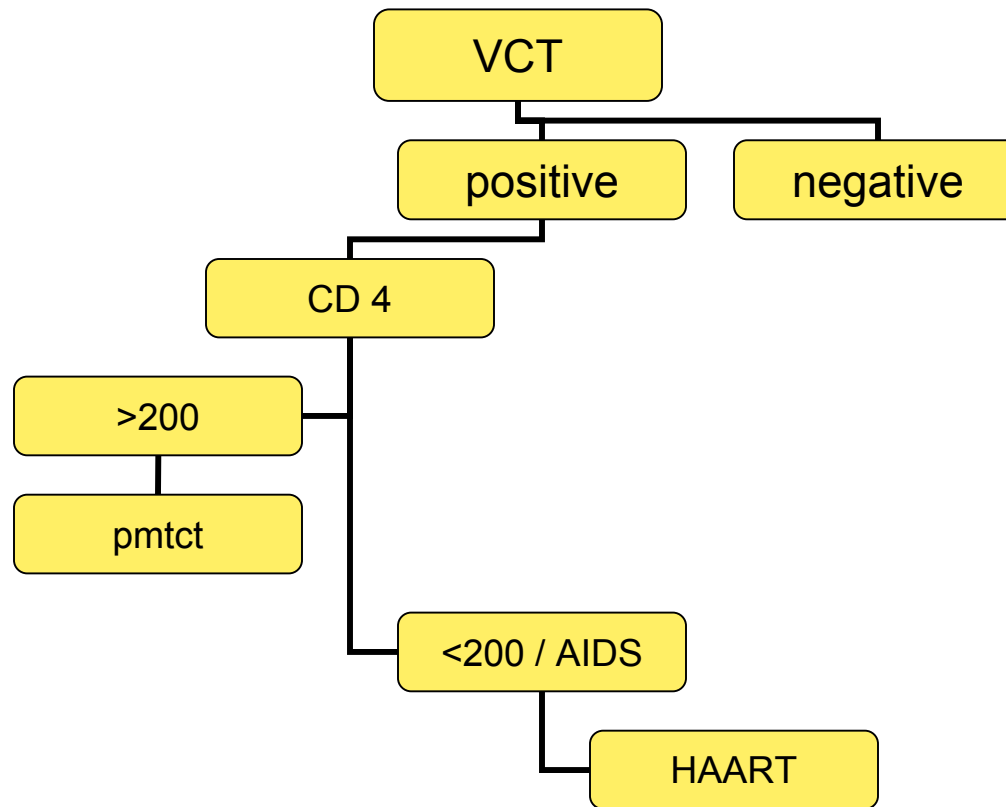
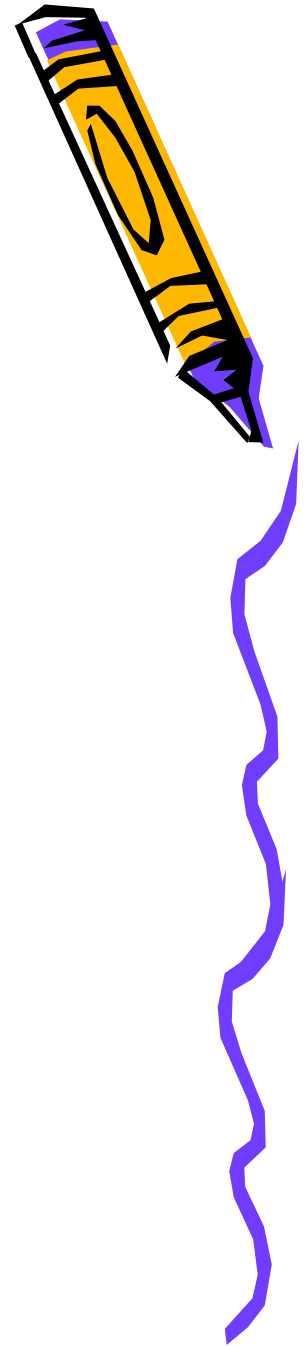


Introduction

- 36% in KZN antenatal clinics
- AIDS leading cause of maternal deaths nationally
- 5 - 10% of pregnant women with clinical AIDS
- Pmtct success and missed opportunities

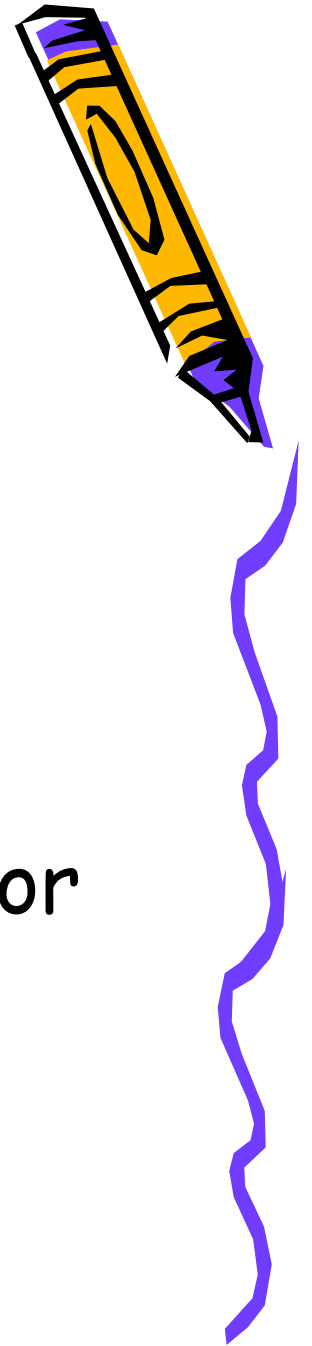
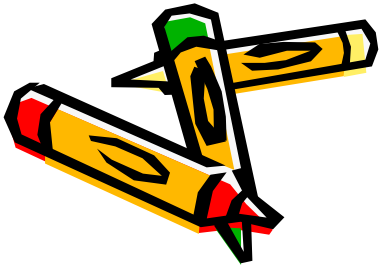


Intergration into pmtct



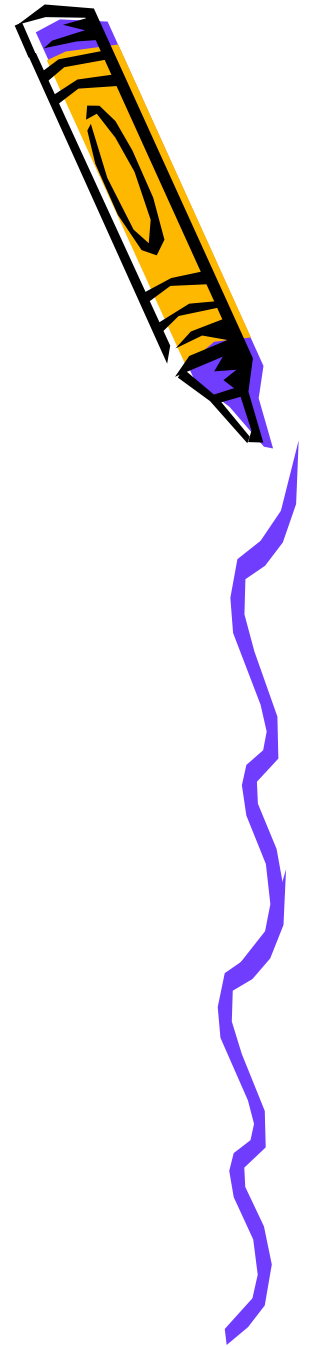
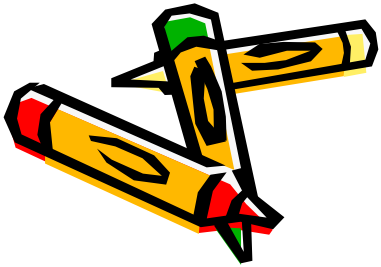
Goals of ARV therapy

- Improve mother's own health
 - 5 - 10% of women
 - entry criteria as for all adults
- Pmtct
 - mothers who do not require ARV for their own health
 - standard nevirapine programme



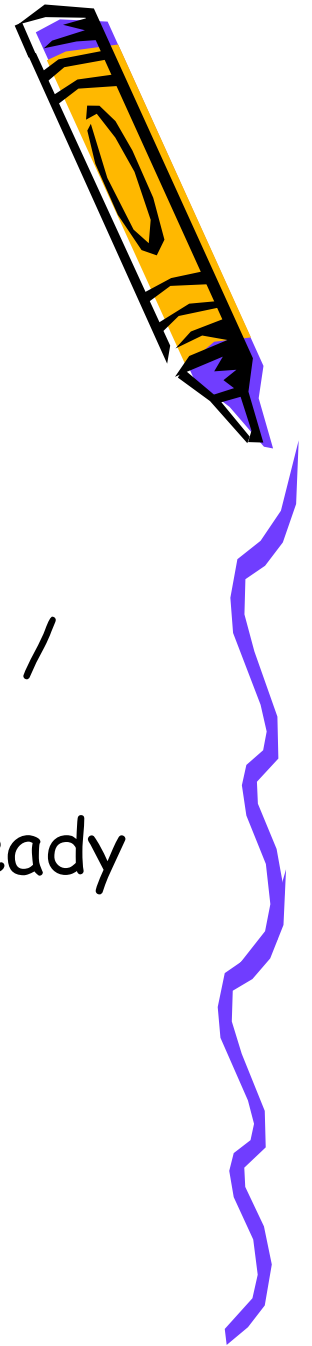
Choice of drugs

- Same as for adult females
- Avoid efavirenz in pregnancy - replace with nevirapine
- avoid stavudine(d4T), didanosine (ddI) together
- If unable to use NVP - 2nd line



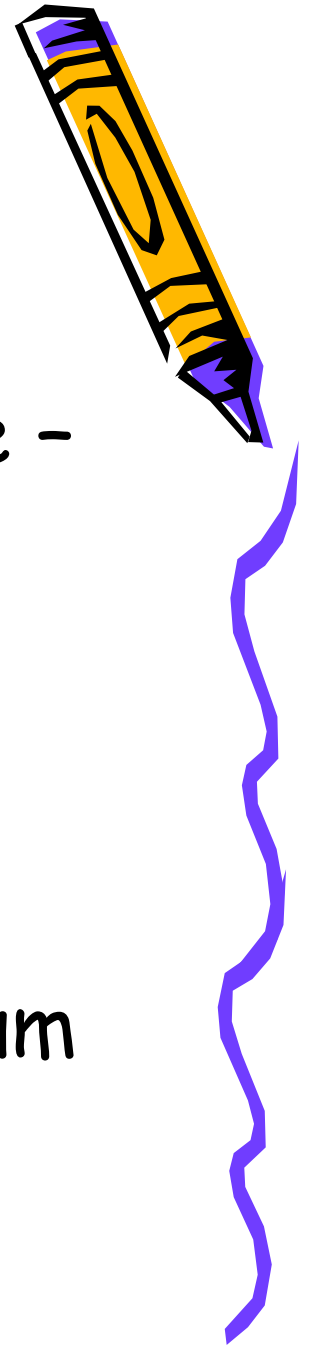
When to start

- Drug preparedness to be accelerated
- Start as soon as pt ready - >14 weeks
- <14 weeks - only if serious AIDS illness / CD4 < 50 cells (Counsel mom)
- Later in pregnancy - start as soon as ready
- If delivers before ARV initiation- Std pmtct



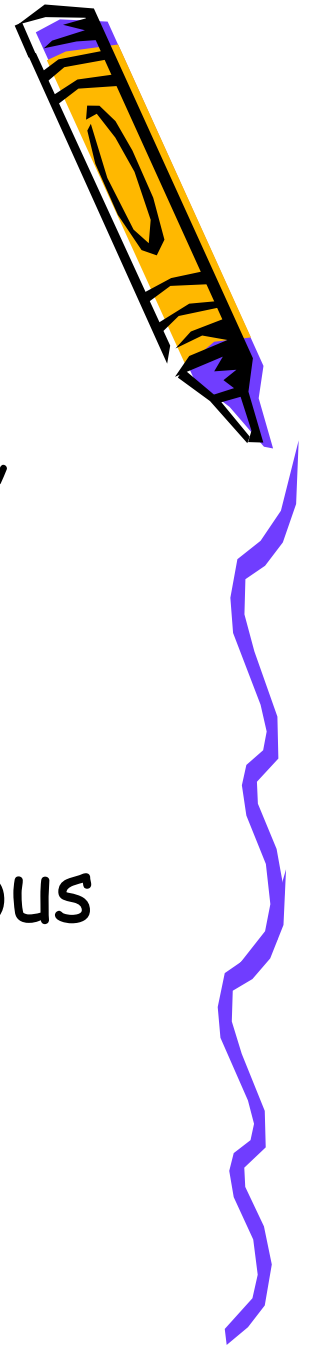
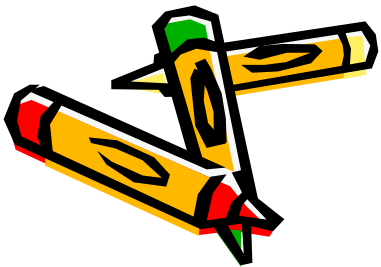
team

- Multi- disciplinary (doctor / nurse - with experience in obstetrics / midwifery / counselor-support and adherence / social worker
- Aim to see pregnant women on one day
- To continue to the end of pueperium



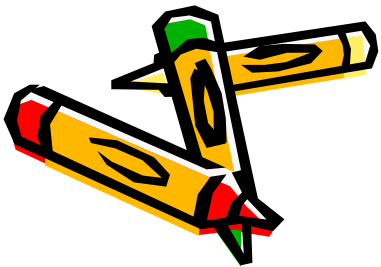
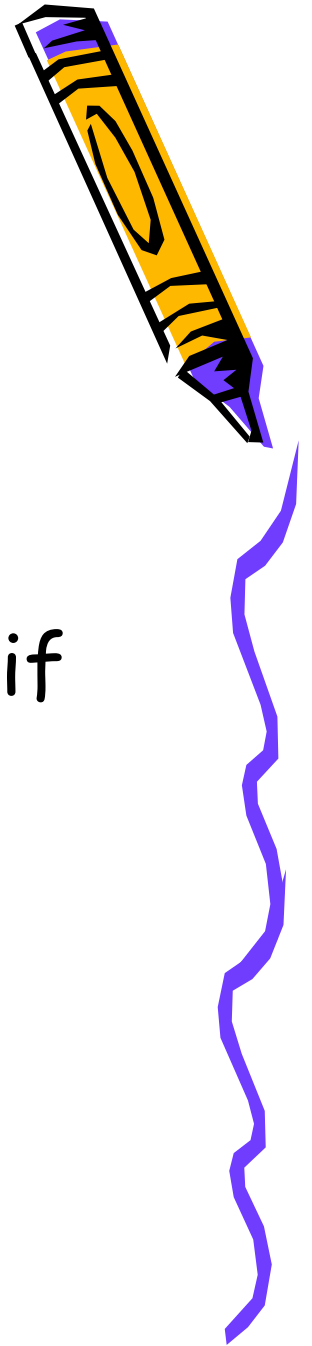
monitoring

- Review weekly at start of therapy, then every 2 weeks
- If on NVP - ALT every 2 weeks initially, then monthly
- Confirm adherence / exclude serious side effects



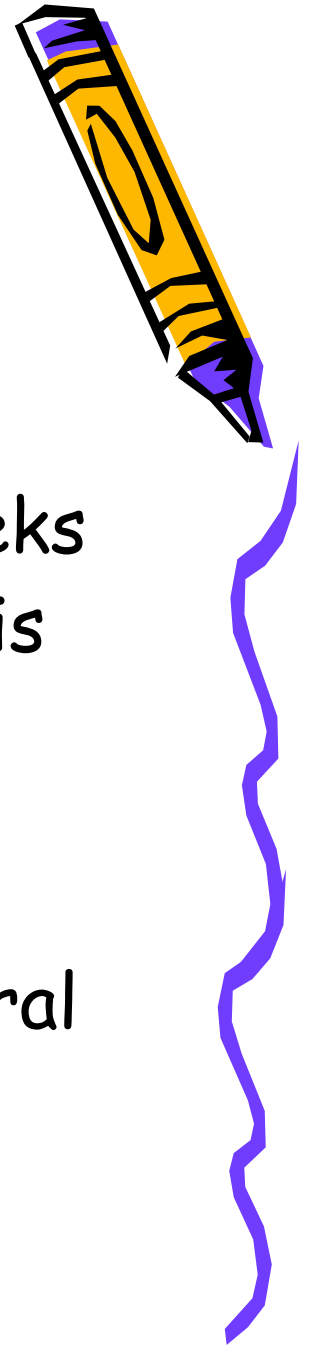
delivery

- Therapy to continue as scheduled
- C/S for obstetric indications - treatment not to be omitted even if starved
- Vaginal delivery with modified practices according to PMTCT



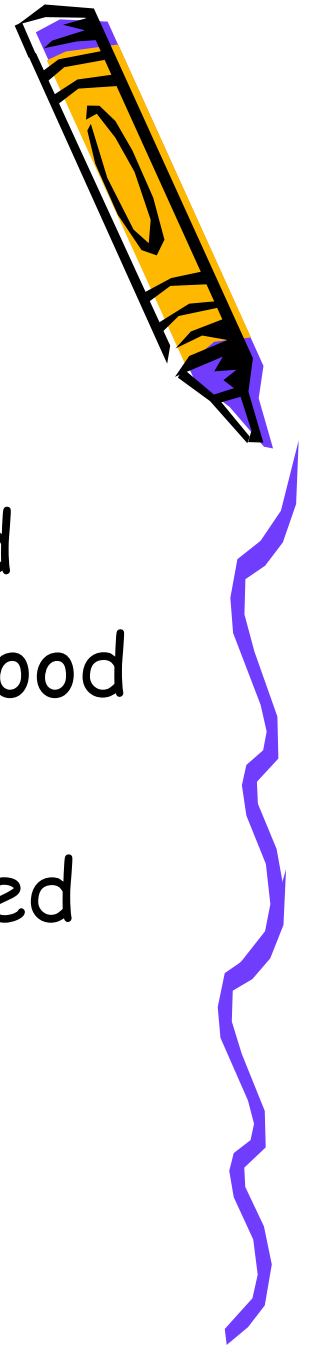
postdelivery

- Treatment as scheduled
- Appointment for review - 1st; 2nd; 6 weeks
 - Monitor adherence; watch out for sepsis
 - Discuss and implement contraceptive methods
 - Pap at 6w if none in past 12m
- Managed by same team - refer to general care after 6 weeks



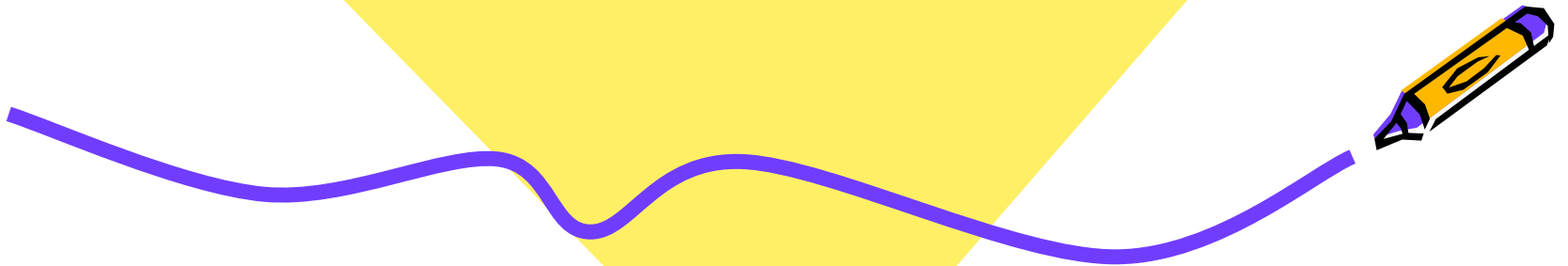
contraception

- Side effects of both ARV and hormonal method may be worsened
- Both NNRTI's +PI's may reduce blood levels of estrogen
- Alternative methods may be advised





Special scenarios



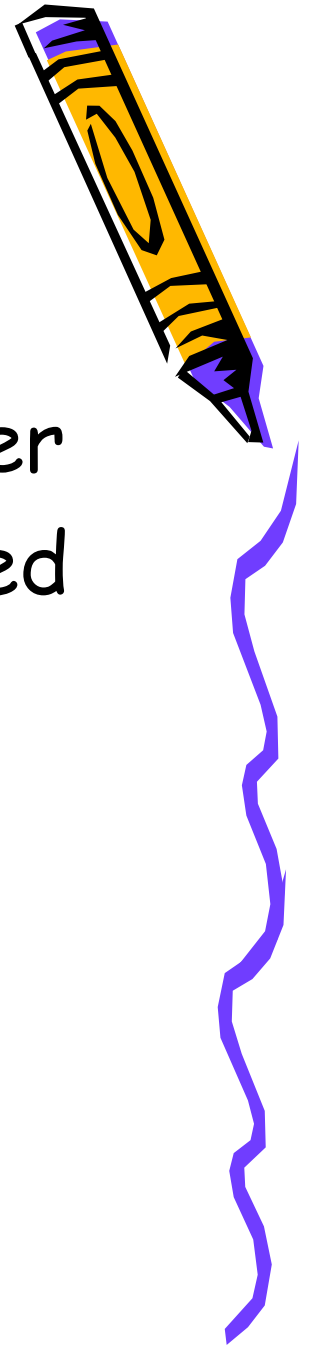
Women on ARV b4 pregnancy

- Review medication - if on EFV, change to NVP
- Anomaly scan for all women at 18 - 22 weeks
- EFV exposure in 1st trimester - counsel + scan. If normal - reassuring; cont surveillance



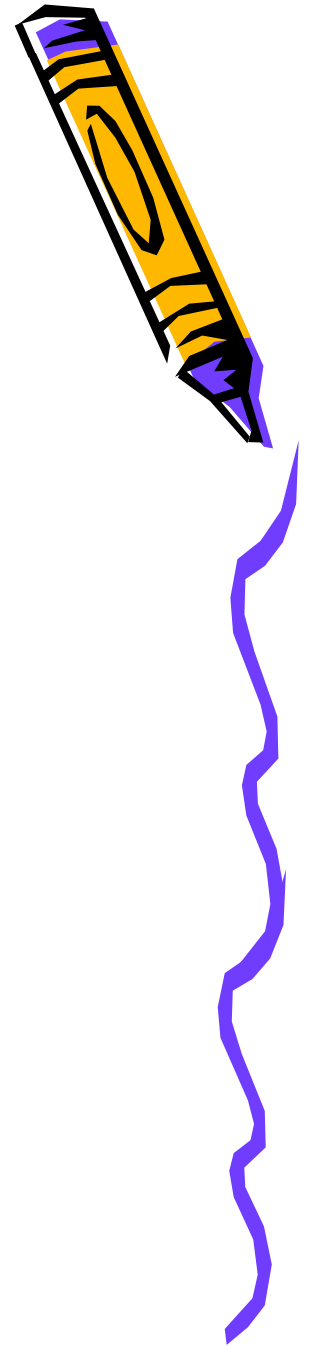
Pt on ARV (cont)

- Avoid cotrimoxazole in 1st trimester
- NVP + Rifampicin: possible enhanced hepatotoxicity; bio-availability of NVP also reduced
- **DO NOT STOP THERAPY IN 1ST TRIMESTER**



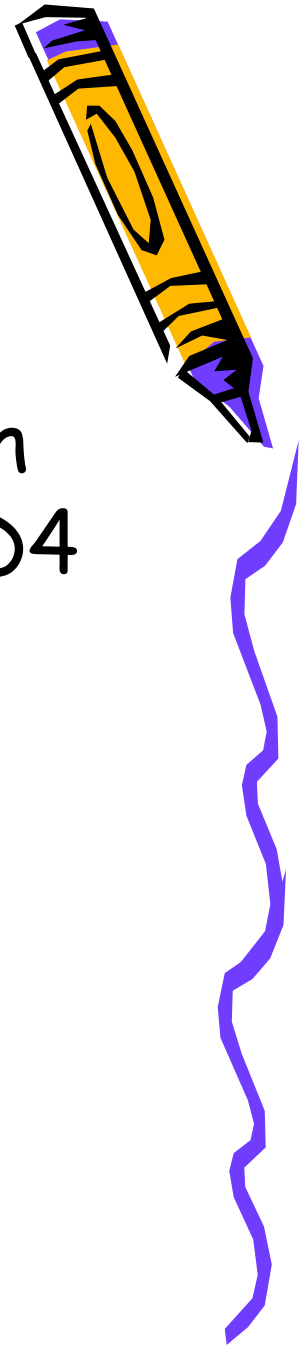
Unbooked women

- If in **early labour** - VCT, and if infected - Std pmtct
- **Advanced labour** - counsel in immediate post delivery period, if indicated - NVP to baby
- **All women- reassess need for ARV postdelivery**



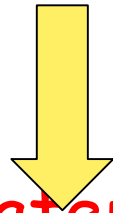
ARV / TB / Pregnancy

- Start TB therapy first, follow with ARV after 2 months - except if CD4 $< 50/\text{mm}^3$ or xtrapulmonary TB (2w lag)
- Caution with NVP + Rifampicin



Conclusion

- Pregnancy NB entry point into the ARV programme
- NB step: clinical exam of patient / CD4 - identify the 5 - 10%



- Reduction in maternal deaths, and benefit in pmtct

