2012 UPDATED GUIDELINES FOR MANAGEMENT OF BABIES BORN TO HIV-INFECTED WOMEN
(and women who are at high risk but have not been tested yet)

Maternal HIV-related Care:
The care of HIV-infected, pregnant women should ideally be provided by an expert in adult HIV care in conjunction with an expert in perinatal care. The goal needs to be to maximally control maternal HIV disease to minimize the risk of vertical transmission. Details about treatment for women are in "Recommendations for Use of Antiretroviral Drugs in Pregnant, HIV-1 Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV-1 Transmission in the United States" and can be found at http://www.aidsinfo.nih.gov/contentfiles/lvguidelines/perinatalgl.pdf. Detailed information about the mother's antiretroviral therapy prior to and during the pregnancy and about her response to that therapy is essential to management of the baby. Women whose disease is suboptimally controlled should be given IV zidovudine (AZT) during labor. Some women may carry HIV that is resistant to many of the available antiretroviral agents. Infants born to these women may need dramatic modifications of their care and should be discussed with an expert in pediatric HIV disease. Breastfeeding confers an additional 15% risk of transmission and is strongly discouraged in the United States. C-section may confer added protection for the infant if mother’s latest viral load is >1,000 copies/mL.

Women at high risk but not recently tested or with undocumented results:
These women should be approached for consent and testing using a rapid HIV test. Details about rapid testing, consent, interventions, and follow-up (and in pregnancy) can be found at http://www.cdc.gov/std/treatment/2010/hiv.htm

Babies whose mothers have poorly-controlled disease or AZT-resistant virus may need combinations of anti-retroviral drugs to prevent HIV transmission and should be discussed with an expert in HIV in children.

STANDARD DOSING OF ZIDOVUDINE (AZT) FOR INFANTS BORN TO HIV-INFECTED WOMEN:

<table>
<thead>
<tr>
<th>GEST. AGE</th>
<th>ORAL DOSING (start within 6-12 hrs of birth)</th>
<th>INTRAVENOUS DOSING (if unable to tolerate PO)</th>
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<tbody>
<tr>
<td>≥ 35 wks GA at birth</td>
<td>4 mg/kg/dose PO q12h for 6 weeks</td>
<td>3 mg/kg/dose IV q12h for 6 weeks</td>
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<tr>
<td>≥ 30-35 wks GA at birth</td>
<td>2 mg/kg/dose PO q12h for first 14 days, THEN increase to 3 mg/kg/dose PO q12h for remainder of 6 weeks</td>
<td>1.5 mg/kg/dose IV q12h for first 14 days, THEN increase to 2.3 mg/kg/dose IV q12h for remainder of 6 weeks</td>
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<tr>
<td>&lt; 30 wks GA at birth</td>
<td>2 mg/kg/dose PO q12h for first 4 weeks, THEN increase to 3 mg/kg/dose PO q12h for remainder of 6 weeks</td>
<td>1.5 mg/kg/dose IV q12h for first 4 weeks, THEN increase to 2.3 mg/kg/dose IV q12h for remainder of 6 weeks</td>
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Liquid AZT has a high osmolarity and should be diluted into or given concurrently with formula feedings. AZT dose should be gradually increased with baby’s weight. Please discharge baby with a 200 mL supply of AZT (10 mg/mL) which should last for 6 weeks. Many pharmacies do not carry the syrup and Medi-Cal doesn’t reimburse sufficiently, so be sure that mother has access to a pharmacy that has and will dispense liquid AZT (try Children’s Clinic Pharmacy, 510-428-3166). If the baby cannot take medication or is not being fed yet, AZT can be also be given IV (doses listed above).

TESTING CONSENT ISSUES:
Consent to test should be obtained on the standard forms for the hospital where the baby will be delivered and the form should indicate permission to reveal the test results to the primary care physician as well as to Dr. Ann Petru at Children’s Hospital & Research Center Oakland (CHRCO). California laws about not requiring signatures only apply to teens and adults; you still need mom’s consent to test and to release info to CHRCO.

For babies who are not going to be released to their mothers: Please ask a perinatal social worker to obtain MATERNAL consent for follow-up testing and care of the infant at CHRCO BEFORE mother is discharged. This process can be initiated as soon as it is clear that the baby will not be discharged to mother. In order for babies going to foster care to have a proper evaluation and testing at CHRCO, maternal or court consent is needed. Court consent often takes weeks to obtain and can delay follow-up HIV PCR testing and potentially delay diagnosis and treatment of HIV infection.

Mother’s signature is needed on three separate forms: (1) the standard CHRCO consent for HIV testing, (2) consent for release of maternal and newborn records, and (3) consent for referral to CCS --- California Children’s Services.
Proof that a baby is not infected requires at least 2 HIV PCR tests, one of which has to be done at/after 4 weeks and the
with the team who will care for the infant. This is important for future management and for legal reasons.

at lower risk can be tested starting at 2 weeks of age. Ideally, testing should be done as follows:

Beyond 6 weeks of age:

For infants whose mothers report HIV infection, but for whom there is no written documentation, please also send an HIV-
1,2 antibody (red top tube) from the infant to confirm maternal infection. Information about mother’s HIV status (her viral
loads and CD4 counts during pregnancy and any information about her drug resistance pattern) needs to be shared
with the team who will care for the infant. This is important for future management and for legal reasons.

Proof that a baby is not infected requires at least 2 HIV PCR tests, one of which has to be done at/after 4 weeks and the
second at/after 4 months of age. Newborn infants at high risk should first be tested in the first 48 hours after birth; those
at lower risk can be tested starting at 2 weeks of age. Ideally, testing should be done as follows:

Low risk infants (mom’s disease is well controlled): 2 weeks, 4-6 weeks, and after 4 months.
High risk infants (mom’s disease is poorly controlled): First 48 hours, 2 weeks, 4-6 weeks, and after 4 months.

Beyond 6 weeks of age:

Prophylaxis against Pneumocystis jiroveci pneumonia (PCP) is not indicated for infants who have at least 2 negative
studies by the time they are 4-6 weeks of age. Only children with a positive PCR test should be placed on PCP
prophylaxis with TMP-SMX (75 mg/M2/dose BID TIW), which is usually 2.5 mL PO BID on Sat/Sun/Mondays in term
infants. Alternative schedules and drugs are available. Those infants found to have any POSITIVE HIV DNA or RNA
PCR studies are presumed to have HIV and need more aggressive management in the Pediatric Infectious Disease clinic.

Referral: Please call whenever an infant is expected to be or is born to an HIV-infected mother. Many of the women are known at CHRCO and our information may be critical in the infant’s management. We can and will help to remind pediatricians about critical issues in the care of these challenging infants.

Please make a direct referral of all HIV-exposed infants to the Pediatric HIV/AIDS Program at Children's Hospital &
Research Center Oakland prior to the infant’s discharge. Most babies are seen at 2 weeks of age in the “Hope Clinic”.
Referrals should be made to one of the staff at (510) 428-3336 or, on weekends/holidays, ask for the ID physician on call at (510)428-3000.

Medical Staff at Children's Hospital & Research Center Oakland, Pediatric Infectious Diseases Division:

Ann Petru, M.D., Director of Pediatric AIDS/HIV Program and Co-Director ID Division 510-428-3337
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    A. Desiree LaBeaud, MD, & Shamim Islam, MD, Associate Physicians 510-428-3336
Pediatric ID Fellows are available by phone and may cover on weekends 510-428-3000

Staff in the Pediatric AIDS/HIV Program:

Katherine Eng, P.N.P., Hope Clinic Coordinator 510-428-3885 x 4294
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Last Updated: 8/31/2012