Neonatal HIV Exposure Clinical Guideline

This guideline is intended to ensure appropriate and timely treatment of newborns at risk for HIV infection, following the current recommendations from the AAP, CDC, ACOG, and NIH at the time of publication. Please refer to www.aidsinfo.nih.gov/ for the most up to date treatment options. Please direct any questions regarding this guideline to the Pediatric Infectious Diseases Service.

HIV unknown mother

- Contact covering obstetrician as soon as possible to obtain a rapid HIV antibody screen.
- If mother refuses testing, obtain rapid HIV antibody test on infant.
- If the mother or infant is antibody positive, contact the PCP and Pediatric ID service. Infant antiretroviral therapy should be initiated as soon as possible and the mother advised not to breastfeed pending results of confirmatory HIV antibody testing.

Infants born to known HIV Positive Mothers

Post exposure antiretroviral (ARV) prophylaxis significantly decreases the rate of perinatal acquisition of HIV disease. All HIV exposed infants require initial laboratory evaluation and initiation of ARV therapy, so the PCP should be notified immediately. Infectious Disease should be consulted but do not delay initial management. In most case the ID service is aware of these infants prior to delivery. The National Perinatal HIV hotline (1-888-448-8765) provides free clinical consultation on all aspects of perinatal HIV. This guideline is intended for initial management of the newborn, please consult Pediatric Infectious Disease for follow up management.

In L&D, invasive procedures should be carefully considered for infant. If possible, Vitamin K and Hep B should not be given until after the baby is bathed and/or the site of injection is well cleansed. Eye care should be done after eyes are cleansed.

- Initiate treatment as soon as possible, within 6-12 hours of delivery.
- Infant is not to breastfeed. Bottle feed only.
- Initial laboratory evaluation: CBC with differential, AST, ALT, HIV DNA PCR (whole blood in purple top tube, 2ml required) Do not delay treatment if unable to obtain.

Did mother have antiretroviral therapy during pregnancy?

Yes

Infants ≥ 35 weeks:
Zidovudine (AZT) 4mg/kg/dose PO q12 hours
(3 mg/kg/dose IV q12 hours if unable to take PO)
Infants <35 weeks- ≥ 30 weeks:
Zidovudine (AZT) 2mg/kg/dose PO q12hrs for 2 weeks, then 3 mg/kg/dose after 14 days. (1.5mg/kg/dose IV q12 hours if unable to take PO then 2.3 mg/kg/dose after 14 days)
Infants <30 weeks:
Check Harriet Lane or www.aidsinfo.nih.gov/
Prior to discharge PCP must verify outpatient pharmacy has liquid AZT

No

Two Drug Regimen: Ziduvidine and Nevirapine
Zidovudine- same as recommended for those infants whose mother received antiretroviral therapy.
Nevirapine-Birth weight >2kg: 12 mg/dose PO
1.5-2kg: 8 mg per dose PO
3 doses in the first week of life:
1st dose within 48 hours of birth
2nd dose 48 hours after 1st dose
3rd does 96 hours after 2nd dose
Prior to discharge PCP must verify outpatient pharmacy has liquid AZT

Algorithms are not intended to replace providers' clinical judgment or to establish a single protocol. Some clinical situations may not be adequately addressed in this guideline. Clinicians should document management variations or plans of care as indicated. *Last revised Oct 2014*

References 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. Sep. 14, 2011; pp 1-207. Available at http://aidsinfo.nih.gov/contentfiles/PerinatalGL.pdf.

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