HIVE SOAP Note for Prenatal Care of HIV-negative Women with Sex Partners Living with HIV

S:

Patient

HPI:

[ ] ID: __ yo G_P_ at __+__ by __, here for prenatal care.
[ ] New/recent symptoms (screen for symptoms of acute HIV infection)
[ ] Prenatal ROS (VB, LOF, UC, FM, dysuria)
[ ] Most recent HIV test (date/result/type of assay):

PMHx/POBHx

[ ] Reproductive hx: G_P_, pregnancy outcomes, delivery route, custody
[ ] Hx STIs (including HSV)
[ ] Last pap/HPV (date/result)
[ ] HBV, HCV status
[ ] HAV, HBV vax

SHx

[ ] Housing, employment, education
[ ] Home/family structure
[ ] IPV screen [ ] 1st Trimester [ ] 2nd Trimester [ ] 3rd Trimester
[ ] Depression screen
[ ] Substance use screen: Tobacco/ETOH/Drugs & route, needle sharing
[ ] 2nd hand smoke exposure
[ ] Food insecurity/nutrition screen

Sexual hx

[ ] Frequency of sex, mode (vaginal/anal/oral)
[ ] Condom use
[ ] Assess eligibility for PEP (recent known viremic exposure or other high risk exposure within last 72 hour window). Last condomless sex with HIV+ partner? Known recent viremia in partner? Other high risk exposure?
[ ] Past or current PEP or PrEP use
[ ] Other sex partners
[ ] Sex work screen

Partner hx

[ ] Confirm partner in primary care and PCP contact information:
    [ ] If partner is not currently in care, refer to Family HIV Clinic
[ ] Sign ROI for viewing partner's medical records to coordinate care with partner's provider, confirm lab adherence, lab results
[ ] Invite partner to participate in patient's prenatal visits to help with engagement in couple's care plan if patient comfortable with partner's presence at visits
[ ] Partner HIV hx:
    [ ] Confirm partner's current ARV regimen, history of resistance
    [ ] Date of dx, h/o OIs
    [ ] Last VL, duration of VL suppression
        [ ] Viremic: (date):
        [ ] Undetectable since: (date)
    [ ] Partner sexual hx: discuss # partners current and past, sex practices, h/o STIs including HSV
[ ] Partner HBV and HCV status
[ ] Fathered other children? HIV testing of other partners/children
[ ] Partner substance use (incl tobacco) screen, housing security, mental health screen

O:
[ ] BP, weight gain, Udip
[ ] Fundal height, fetal heart rate
[ ] Focused exam as indicated by subjective

A/P:
HIV Prevention
1. Patient education
[ ] HIV Risk Reduction Counseling for serodifferent couples: There is overall low risk of HIV transmission if the partner living with HIV has consistently undetectable viral load (VL). However, there is a high risk of perinatal HIV transmission if the mother seroconverts during pregnancy or breastfeeding. For that reason, we recommend frequent partner monitoring throughout the pregnancy and breastfeeding (if applicable) and discussing other options for further risk reduction.
[ ] Discuss HIV natural history, transmission, warning signs of acute viral syndrome.
[ ] Discuss "Treatment as Prevention"
    [ ] Highly effective when in mutually monogamous relationship: there has never been a documented case of male-to-female HIV transmission if the HIV+ partner has an undetectable VL.
    [ ] Discuss frequent partner monitoring during pregnancy and breastfeeding: monthly VL
    [ ] Discuss importance of partner antiretroviral adherence and maintenance of undetectable VL
[ ] Discuss option of female and male condom use throughout pregnancy
[ ] Discuss eligibility and option of PEP and PrEP (see below)
[ ] Offer support resources, HIVE website, patient handouts.
[ ] Refer to PROMEN resources/online resources

2. PEP (Post-Exposure Prophylaxis)
[ ] Assess current eligibility for PEP (recent known viremic exposure or other high risk exposure within last 72 hour window), and continue to counsel at future visits going forward about PEP as an ongoing option in the setting of inadequate PrEP, condom breakage with viremic partner, or other high risk situation.
[ ] Discuss starting PEP immediately if clinically indicated, offer patient education, discuss risks and benefits, counsel re: anticipatory guidance. Refer to PEP guidelines: https://stacks.cdc.gov/view/cdc/38856, seek consultation with PEPline if more provider guidance needed.
[ ] Consider bridging from PEP directly to PrEP after 28-day PEP course has been completed if patient remains at ongoing risk
[ ] If patient elects to take PEP, enroll patient in Antiretroviral Pregnancy Registry (APR): http://www.apregistry.com/

3. PrEP (Pre-Exposure Prophylaxis)
[ ] Discuss option of PrEP and review "Is PrEP right for me?" patient handout.
[ ] Refer to "SFGH Family Health Center PrEP Essentials Pocket Card" for provider guidance on PrEP initiation, prescribing, adherence counseling, side effects, ongoing lab monitoring: http://www.hiveonline.org/prep_implementation/prep_essentials_pocket_card.pdf
[ ] Discuss risks and benefits of taking Truvada during pregnancy
    [ ] Risks include: Possible slightly decreased infant head circumference [Siberry, *AIDS,* 2012]; possible increased risk of preterm birth in PROMISE study with AZT or TDF among HIV+ compared to HIV-neg women not on ARVs, though results confounded by use of other antiretroviral agents. [Fowler, CROI, 2016]
    [ ] There is no evidence of teratogenicity in humans, and Truvada has been used safely during pregnancy by many women with HIV and/or hepatitis B virus [AIDSinfo Clinical Guidelines, 2015]. When used as PrEP for safer conception until pregnancy was diagnosed, Truvada was not associated with any statistically significant differences in pregnancy incidence, birth outcomes, or infant growth [Mugo, *JAMA*, 2014]. Tenofovir appeared to be associated with an increased risk of preterm birth among pregnant women with HIV, though these women lived in sub-Saharan Africa and were also taking other antiretrovirals (Kaletra) that may have been the reason for increased preterm birth [PROMISE study]. Contrary to 2 studies that found no difference in postnatal growth in infants born to women with HIV who took Tenofovir during pregnancy compared to infants born to women with

HIV not on Tenofovir, one study found that the Tenofovir-exposed infants had decreased head circumference at 1 year of age, though the actual difference was small and not clinically significant [Siberry, *AIDS*, 2012]. No difference in bone mineral density among HIV-uninfected babies exposed to in-utero TDF

[ ] Refer to APR Interim Report (6/2015): http://www.apregistry.com/forms/interim_report.pdf

[ ] If patient elects to take PrEP, enroll patient in Antiretroviral Pregnancy Registry (APR): http://www.apregistry.com/

4. Lab monitoring

[ ] HIV-negative female patient monitoring

[ ] Check HIV Ab/Ag at least once per trimester (consider more frequently/monthly if risk factors present) and at presentation to L&D; low threshold to send HIV viral load (VL) for acute viral syndrome

[ ] HBsAg, HBsAb (vaccinate prn), HCV Ab

[ ] CT/GC/RPR testing in 1st and 3rd trimesters and prn as clinically indicated, if risk factors present. If patient engages in oral or anal sex, screen for pharyngeal and rectal CT/GC as well as vaginal/cervical.

[ ] **If taking PrEP:** [ ] Cr and U/A q 3-6 months

[ ] HIV-positive partner monitoring:

[ ] Adherence counseling

[ ] Check partner VL monthly (during pregnancy and breastfeeding)

[ ] CT/GC/RPR while partner pregnant, once minimum, and during post-partum period; more often as clinically indicated by risk factors.

Routine Prenatal Care

#Fetal Wellbeing:

[ ] 1st tri genetic screen: Offer at 10+0 to 13+6 weeks

[ ] NT US: 11+2 to 14+2 weeks

[ ] 2nd tri genetic screen: 15+0 to 20+0 weeks

[ ] Anatomy scan 18-20 weeks

[ ] cell-free DNA if 35+ yr old

#Prenatal labs:

[ ] 1st tri labs: Hct, Hg electrophoresis, HIV, RPR, HbsAg, Rubella, GC/CT (If patient engages in oral or anal sex, screen for pharyngeal and rectal CT/GC as well as vaginal/cervical.)

[ ] Blood type, Antibody screen

[ ] HCV Ab if partner is HCV+ or if risk factors for HCV

[ ] HAV Ab, HBsAb as appropriate

[ ] VZV titer as appropriate

[ ] Last cervical pap

[ ] TB screen

[ ] 3rd tri labs: GLT, CBC, RPR, GC/CT (If patient engages in oral or anal sex, screen for pharyngeal and rectal CT/GC as well as vaginal/cervical.)

[ ] GBS 36 weeks

[ ] Confirm cephalic starting at 36 weeks

#Vaccinations:

[ ] Flu vax: offer when available.

[ ] Tdap 28+ weeks

[ ] Hep B

[ ] Hep A

#BMI:

[ ] Maternal BMI

[ ] Nutrition/exercise counseling

[ ] Discuss recommended weight gain during pregnancy

#MOC:
[ ] Discuss 18+ month child spacing and assess patient's family planning goals
[ ] Discuss birth control options 2nd-3rd tri

#MOD:
[ ] Discuss anticipated vaginal delivery
[ ] Coordinate plan of care with L&D as patient approaches EDD

#MOF:
[ ] Assess risk of antepartum transmission and discuss breastfeeding vs. formula-feeding options

Intrapartum Management
[ ] Confirm partner in primary care and with recent undetectable VL. Date of last VL:
[ ] Assess risk of recent maternal seroconversion: Confirm HIV Ab/Ag negative at presentation to L&D. HIGH risk if: 1) partner with known viremia, 2) partner not monitored and couple not using condoms or PrEP consistently, 3) couple not mutually monogamous, or 4) unknown maternal HIV status.
[ ] Assess for symptoms of acute HIV
[ ] Discuss patient's risk assessment, intrapartum and postpartum plan with L&D and pediatrics teams

Postpartum Management and Follow-up
1. Plan for Infant Follow-Up:
[ ] Coordinate follow-up at Family HIV Clinic for patient and infant

2. HIV Prevention During Breastfeeding:
Patient Education:
- Please refer to "Breastfeeding Protocol for HIV- mothers if Father of Baby is HIV+" regarding counseling around breastfeeding http://www.hiveonline.org/providers/breastfeeding_protocol_mothers_partner_positive.pdf

- In general, it is safe and recommended for HIV- women to breastfeed; however, there is a high risk of postpartum perinatal transmission via breast milk should the mother seroconvert while breastfeeding. For that reason, we recommend continued surveillance of the mother to ensure she remains HIV negative while breastfeeding and of the HIV+ partner to ensure he remains virally suppressed.
[ ] Discuss continued male and female condom use if applicable
[ ] Coordinate follow-up at Family HIV Clinic for patient and infant

3. PEP
[ ] Continue to counsel about PEP as an option in the event of high risk exposure in the setting of poor PrEP adherence , condom breakage with viremic partner, or other high-risk exposure.

5. PrEP:
[ ] If on PrEP, discuss continuing vs. stopping during breastfeeding, discussion about safety of TDF/FTC in breastfeeding women with HBV

6. Lab monitoring:
[ ] If breastfeeding, continue to follow partner VL monthly
[ ] If breastfeeding, continue to check patient HIV Ab/Ag q3 months or more frequently as indicated
[ ] If taking PrEP: [ ] Cr and U/A q 3-6 months [ ] syphilis/CT/GC q 6 months

Need help?
HIVE Online resources for providers: http://www.hiveonline.org/for-providers/
UCSF National Clinician Consultation Center: http://nccc.ucsf.edu/

- PrEPline: (855)-448-7737
- PEPline: (888) 448-4911
- Perinatal Hotline: (888) 448-8765

Please PrEP Me: http://PleasePrEPMe.org

References:

1. Siberry et al. Safety of tenofovir use during pregnancy: early growth outcomes in HIV-exposed uninfected infants. *AIDS.* 2012; 26(9): 1151-1159.
2. Fowler et al. PROMISE: efficacy and safety of 2 strategies to prevent perinatal HIV transmission. Forthcoming presentation at CROI, Feb 2016, session O-2, abstract 31LB.
3. AIDSinfo Clinical Guidelines. 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. Last updated: August 6, 2015. https://aidsinfo.nih.gov/contentfiles/lvguidelines/glchunk/glchunk_197.pdf.
4. Mugo et al. Pregnancy incidence and outcomes among women receiving preexposureprophylaxis for HIV prevention: a randomized clinical trial. *JAMA.* 2014; 312(4): 362-371.

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