Perinatally HIV–exposed infants worksheet

Mission Statement: The use of maternal highly active antiretroviral therapy during pregnancy, maternal IV zidovudine during labor, and zidovudine therapy to the neonate until 6 weeks of age has been shown to decrease the risk of HIV transmission from mother to child from ~25% to 1-2%.

- Please contact Stephanie Fahner, RN at 317-274-7260 to initiate a referral to the Ryan White Center for Pediatric Infectious Disease at Riley Hospital for perinatally HIV-exposed infants soon after birth.
- Infant should be seen in our clinic at 2 weeks of age if possible or no later than 4 weeks of age.
- Please FAX infant’s medical records including pregnancy, birth history, and laboratories to 317-278-0860

I. Follow-up HIV testing as recommended by the Centers for Disease Control and Prevention:

- At birth: CBC with diff and platelets
  HIV-1 DNA PCR
  NOTE: (to be obtained in the nursery of local hospital by referring physician)

- At 2 weeks of age: HIV-1 RNA
  Ultrasensitive Quantitative PCR

- At 4 weeks of age: HIV-1 RNA
  Ultrasensitive Quantitative PCR

- At 4 months of age: HIV-1 RNA Ultrasensitive Quantitative PCR
  NOTE: (will be obtained at Riley hospital in conjunction with medical visit)

- At 18 months of age: HIV ELISA to document loss of maternal antibody (seroreversion)
  NOTE: (this test can be obtained locally to obviate the need for travel to Indianapolis)

Test Interpretation:

Infant with NEGATIVE HIV-1 DNA-PCR at birth indicates infant infection was not detected at the time of the test. This test is more indicative of in utero infection and does not rule out infection that is acquired at the time of delivery.

Infant with POSITIVE HIV-1 DNA-PCR at birth is presumed to be infected but needs repeat testing for confirmation. In this situation, please call (800) 622-4989 and ask to speak to the Pediatric Infectious Disease staff physician on call for guidance.

NOTE: Based on CDC guidelines, if the PCR at 2 weeks and 4 weeks are both negative, the chance of HIV infection is low enough (<5%) to eliminate the need for prophylactic trimethoprim/sulfamethoxazole. HIV infection can only be definitively excluded if an infant’s HIV RNA PCR is negative at 4 weeks and 4 months of age.

II. Antiretroviral medications:

- All HIV-exposed infants must start on Zidovudine (AZT) within 6-12 hours of birth.
  - IF mother is known to have AZT resistance or other HIV drug resistance mutations, please contact us for additional antiretroviral drug recommendations.
  - Zidovudine suspension (10mg/1ml) should be dosed at 4 mg/kg per dose orally (or 1.5mg/kg per dose given IV) every six hours for 6 weeks for term neonates (≥35 weeks gestation).
  - For neonates <35 weeks but >30 weeks, 4 mg/kg per dose given orally every 12 hours (or 1.5mg/kg per dose given IV) advanced to every 8 hours at 2 weeks of age.
  - For neonates <30 weeks, 4 mg/kg per dose given orally every 12 hours (or 1.5mg/kg per dose given IV), advanced to every 8 hours at 4 weeks of age.