Table 4 Clinical Scenarios

Scenarios					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother	Mode of Delivery	Grade (Table 1)
1) Woman does not need treatment for own health (asymptomatic good CD4) **Low VL**	> 200 / > 21%	< 10,000	Naive	< 32 weeks	AZT mono 076 regimen (BD dosing) commence late 2nd / early 3rd trimester, but before 32 weeks[a]	AZT mono 076 regimen IV at delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	Stop therapy after delivery	PLCS at 38 weeks	MOD –A ART – A for prevention of transmission
2) Woman does not need treatment for own health (asymptomatic good CD4) **high VL**	> 200 / > 21%	> 10,000	Naive	< 32 weeks	"START" suggest: inc AZT by 076 regimen + 3TC+ PI / NNRTI[b] Commence late 2nd trimester	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	If stopping therapy after delivery, give consideration to timing of stopping NVP in relation to NRTI's, eg 3-5 days prior	PLCS at 38 weeks	MOD – A ART - C for prevention of transmission
3) Woman needs treatment for own health	< 200 / < 21% (200 – 350 but steep slope of decline) (200 – 350)	Any Any High	Naïve	< 32 weeks	"HAART" suggest: inc AZT by 076 regimen + 3TC+ PI / NNRTI[b] Defer until after 1st trimester, if possible	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	AZT mono 076 regimen (BD dosing) for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A ART – A for maternal health. C for prevention of transmission
4) Woman presents pregnant on effective ART	Any	< 50	On effective "HAART"	Any time	Continue:[c]	If on AZT, 076 regimen IV at delivery[d] + Oral doses of other ART as usual pre-delivery	Mono-therapy component of the mother's regimen: e.g. AZT, 3TC, D4T for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A ART - A for maternal health. C for prevention of transmission

Table 4 Clinical Scenarios

Scenarios					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother	Mode of Delivery	Grade
5A) On non-suppressive ART	Any	VL > 1000 resistance test VL = 50-1000 monitor closely for trend, if ↑ resistance test	May be multiple drug classes exposed	< 32 weeks	With resistance data Consider change to best option[e] Seek expert advice	If on AZT, 076 regimen IV at delivery[d] + Oral doses of other drugs in ART as usual pre-delivery	Mono-therapy component of the mother's regimen to which no resistance for 4-6 weeks	Continue maternal regimen after delivery. Make sure no doses missed around delivery time	PLCS at 38 weeks	MOD – A ART - B for maternal health. C for prevention of transmission
5B) Failing therapy in late pregnancy		>1000		>37 weeks	Select best combination from therapy history Seek expert advice.			**Seek expert advice.**	PLCS at 38 weeks	
6) Late presentation, but before delivery	CD4 < 200 + any / no VL CD4 > 200 + VL > 10,000 NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	> 32 weeks, but before delivery. Time to get CD4, but maybe not VL	"START" suggest: inc AZT by 076 regimen + 3TC+ NVP[f] Commence ASAP	AZT 076 regimen IV at delivery + Oral doses of other ART as usual pre-delivery	If > 4 wks maternal Rx: AZT mono. If < 4 wks maternal Rx especially if BL VL high: Triple ART[g]	Continue maternal regimen after delivery until get CD4 + VL. Ideally, do not stop ART until VL < 50	PLCS at 38 weeks	MOD – A ART - C for prevention of transmission

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Scenarios					Recommendations					
Clinical	CD 4 Count	Viral load	Treatment history	Gestation at presentation	Antiretroviral Therapy Ante-partum	Intra-partum	Post-partum Infant	Post-partum Mother	Mode of Delivery	Grade
7) Presents in labour – membranes intact	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	In labour Any gestation **intact membranes**	----------	AZT 076 regimen IV at delivery + Oral doses of NVP + 3TC	Triple ART[g,h]	If labour stops continue "START". If delivered -continue maternal ART until get CD4 + VL. Ideally, do not stop ART until VL < 50	32 wks – term If labour progresses consider CS < 32 wks IV antibiotics, tocolysis, steriods. If labour progresses consider CS	MOD – D ART - C for prevention of transmission
8) Presents with rupture of membranes, +/- labour	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	In labour Any gestation No labour Any gestation	----------	IV AZT 076 regimen + Oral doses of NVP + 3TC	Triple ART[g,h]	Continue maternal "START" until get CD4 + VL. Ideally, do not stop ART until VL < 50	If labour progresses consider SVD + antibiotics No labour CS[i] + antibiotics	MOD – D ART - C for prevention of transmission
9) Presents after delivery	Unknown NB take blood for base line CD4, VL and resistance prior to any ART		Naïve (usually)	After delivery	----------	----------	Triple ART*[g,h] Start ASAP, less likely to be effective if > 48hrs after delivery	Assess maternal need for ART	----------	ART - C

Resistance testing should be carried out in women failing therapy. Also consider resistance testing in ART naïve mothers.

Closely monitored / actively managed vaginal delivery may be considered in women with VL < 50.

"START"Short term combination anti-retroviral therapy

"HAART" Highly active anti-retroviral therapy

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a An alternative to regimen 1) would be to use regimen 2) "START" for women with "good CD4, low VL, ART naïve".

b When choosing the PI / NNRTI, consider the short-term toxicities of NVP (rash, hepatitis), & short term / long term toxicities of e.g. NEL (diarrhoea, lipid derangement's etc)

c If AZT unexposed, consider changing one NRTI to AZT after 1st trimester. Substitute EFAV with another drug, if presents in 1st trimester.

d If not on AZT, not necessary to give IV AZT infusion in labour, as long as all regular doses given at correct times. It may be contra-indicated to give AZT if D4T is part of the regimen.

e When changing treatment consider the following: VL trend; absolute VL; potential toxicities; available drug choices; At stable low viraemia e.g. < 5,000 it may be possible to continue current treatment regimen

f Use NVP in preference because of rapid anti-viral effect and high transplacental concentrations

g See table 5 for appropriate infant doses of AZT, 3TC, NVP for 4-6 weeks of treatment

h Premature or sick infants may not tolerate oral therapy, only available IV preparation is AZT. See table **XXX** for appropriate infant doses.

i If there is extreme prematurity with rupture of membranes, a period of conservative management with steroids, antibiotics and "START", may be more appropriate for the infant. Seek expert advice.