



Tuesday, January 17, 2012 | 3:00 – 4:30pm

ALL PARTICIPANTS MUST CALL THE CONFERENCE LINE

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TO MUTE PRESS *6, TO UNMUTE PRESS #6

<<DO NOT PLACE PHONE ON HOLD>>

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CODE: 97443049856

www.FCAETC.org/ECHO



Agenda/Session Format

- **Welcome and Introductions**
 - 5 minutes
- **Overview of Important Points**
 - 5 minutes
- **Brief Didactic Presentation**
 - 10 minutes
- **Case Presentation(s)**
 - 1 hour
- **Question/Answer Session**
 - 10 minutes

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Welcome and Introductions

www.FCAETC.org/ECHO



Do's and Don'ts in Video Conferencing

Do's	Don'ts
Do be courteous to other participants	Don't make distracting sounds
Do speak clearly	Don't shout
Do keep body movements minimal	Don't make distracting movements
Do move and gesture slowly and naturally	Don't interrupt other speakers
Do maintain eye contact by looking into the camera	Don't carry on side conversations
Do dress appropriately	Don't wear "noisy" jewelry
Do make the session animated	Don't cover the microphone
Do be yourself and have fun!	Don't chew gum

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How to Ask Questions



The best way to get the attention of the speaker is to use the **“Raise Hand”** feature.

The speaker will be made aware that you have a comment or question.

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Future Meetings

- Frequency of sessions
- Estimated to last 1.5 hours
- Upcoming meeting dates will be posted at:
www.FCAETC.org/ECHO

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Continuing Education Disclosure

- **The activity planners do not have any financial relationships with commercial entities to disclose.**
- **This speaker has no financial relationships with commercial entities to disclose.**
- **The speaker will not discuss any off-label use or investigational product during the program.**

This slide set has been peer-reviewed to ensure that there are no conflicts of interest represented in the presentation.

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Continuing Education

Continuing Medical Education

This activity has been planned and implemented in accordance with the Essentials Areas and Policies of the Accreditation Council for Continuing Medical Education through the joint sponsorship of the Florida AHEC Network and the Florida/Caribbean AIDS Education and Training Center.

The Florida AHEC Network is accredited by the Florida Medical Association to provide continuing medical education for physicians.

The Florida AHEC Network designates this live activity for a maximum of **1.0** AMA PRA Category 1 Credits™. Each physician should claim credit commensurate with the extent of their participation in the activity.

Continuing Education

Suwannee River Area Health Education Center, Inc., is a Florida Board of Nursing approved provider of continuing nursing education (CE Broker Provider ID #50-1922); a Florida Board of Clinical Social Work, Marriage and Family Therapy, and Mental Health Counseling approved provider of continuing education (BAP #50-1922), and a Florida Board of Pharmacy approved provider of continuing education (BAP #1922). This program meets the requirements for up to **1.0** contact hours.



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**HIV PERINATAL CLINIC:
Management of HIV-Exposed Infants**

Saniyyah Mahmoudi, MSN, ARNP

Director of Education

University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES)
Jacksonville, FL

Faculty/Training Coordinator

F/C AETC

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Special Thanks To:

Ayesha Mirza, MD

Assistant Professor and Medical Director

University of Florida Center for HIV/AIDS Research, Education and Service (UF CARES)
Jacksonville, FL

Faculty

F/C AETC

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Perinatal Guidelines

- **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. September 14, 2011; pp 1-207.**
- **Available at**
<http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>.

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ABOUT US
The Florida/Caribbean AIDS Education and Training Center provides state-of-the-art HIV education, consultation, and resource materials to health care providers in Florida, Puerto Rico and the US Virgin Islands.

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EDITORS
Jeffrey Beal, MD, AAHIVS
239-839-4645
aetbeal@embarqmail.com

Joanne J. Orrick, PharmD, AAHIVE
813-974-6002
jorrick@usf.edu

Lois Hall, ARNP
813-974-5447
loishall@usf.edu

MANAGING EDITOR
Pamela Gatches-Fort, BA
813-974-2983
pgatches@usf.edu

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Update: Recommendations for Use of Antiretroviral Drugs in Pregnant HIV-1-Infected Women for Maternal Health and Interventions to Reduce Perinatal HIV Transmission in the U.S.

Released: September 14, 2011

Jorge Lujan-Zilberman, M.D.
Associate Professor of Pediatrics, Division of Infectious Diseases
Department of Pediatrics, University of South Florida College of Medicine

It is well known that antiretroviral (ARV) drugs reduce perinatal transmission by multiple mechanisms, including lowering maternal antepartum viral load (VL) and providing infant pre- and post-exposure prophylaxis. To prevent perinatal transmission of HIV a combination of antepartum, intrapartum, and infant ARV prophylaxis is recommended (AI). Key changes made to update the May 24, 2010 version of the perinatal guidelines are summarized in this HIV CareLink. Clinicians are encouraged to view the full guidelines at <http://www.aidsinfo.nih.gov/guidelines/GuidelineDetail.aspx?GuidelineID=9&ClassID=2>.



Neonatal Care of Infants Exposed to HIV Born to an HIV Positive Mother

Purpose: To provide guidelines for the care of an infant born to an HIV infected mother.

Policy: Infants born to HIV infected mothers will be cared for in the same manner as all other infants with special attention given to body secretions and not breaking the infant's skin barrier. Breastfeeding of these infants is contraindicated.

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Neonatal Care of Infants Exposed to HIV Born to an HIV Positive Mother (Cont')

Procedure:

- Avoid procedures that disrupt the infant's skin barrier whenever possible (fetal scalp monitoring/pH sampling).
- Clean skin/bathe with chlorhexidine soap and water before invasive procedures.
- Administer eye prophylaxis once maternal body fluids are wiped from the eyes.
- Administer first dose of hepatitis B vaccine before discharge.
- If infant is high risk for HIV infection due to inadequate maternal treatment during pregnancy and intrapartum period, contact PEDS ID in your area for consult regarding additional medications (such as nevirapine [NVP]) for the infant along with 6 weeks of zidovudine (ZDV).
- All HIV exposed infants- Start ZDV as soon as possible after birth, preferably within 6-12 hours of birth (dose according to infant's gestation and ability to take PO). Infant to have ZDV for a total of 6 weeks.

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Neonatal Care of Infants Exposed to HIV Born to an HIV Positive Mother (Cont')

Gestation	Zidovudine Dosing	
≥35 Weeks	4 mg/ kg/dose PO BID 1.5 mg/ kg/ dose IV q 6 hrs	
<35 to >30 Weeks	2 mg/kg/dose PO q 12 hrs (or 1.5 mg/kg/dose IV) q 12 hrs, then advanced to every 8 hrs at 2 weeks of age	
<30 Weeks	2 mg/kg/dose PO (or 1.5 mg/kg/dose IV) q12 hrs, then advanced to every 8 hrs at 4 weeks of age	
Two drug regimen in special circumstances	Order to be determined by Pediatric HIV specialist	Regimen for infants ≥ 35 weeks
2-drug regimen: ZDV + NVP	<ul style="list-style-type: none"> ZDV: 4 mg/kg given orally twice daily 	Birth through 6 weeks
	<ul style="list-style-type: none"> NVP: <i>Birth weight 1.5–2 kg:</i> 8 mg per dose given orally <i>Birth weight >2 kg:</i> 12 mg per dose given orally 	3 doses in the first week of life <ul style="list-style-type: none"> 1st dose within 48 hrs of birth (birth–48 hrs) 2nd dose 48 hrs after 1st 3rd dose 96 hrs after 2nd

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Neonatal Care of Infants Exposed to HIV Born to an HIV Positive Mother (Cont')

- **Order labs: CBC with differential, Urine CMV, Urine DOA, HIV DNA PCR**
- **Order: Caregiver of infant to have meds in hand at time of discharge (put this as an order).**
- **Nutrition: Infant must be formula fed. Absolute contraindication to breast feeding.**
- **Consults: Pediatric Infectious Diseases**

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STANDARD OF CARE VISIT SCHEDULE HIV EXPOSED INFANTS/PEDIATRIC PATIENTS

AGE/VISIT	LAB	CLINICAL
BIRTH	HIV DNA PCR URINE CMV CBC	<p>NEWBORN CONSULT START ZDV soon after birth & within 6-12 hours of delivery. Give ZDV prophylaxis for a total of 6 weeks.</p> <p><u>Infants born > 35 weeks gestation:</u> ZDV dose 4mg/kg PO BID</p> <p><u>Infants born <35 to >30 Weeks gestation:</u> 2 mg per kg body weight per dose PO every 12 hours, advance to every 8 hours at 2 weeks of age</p> <p><u>Infants born <30 Weeks gestation:</u> 2 mg per kg body weight per dose PO every 12 hours, advance to every 8 hours at 4 weeks of age.</p> <p>Case Management Intake Give hepatitis B vaccine #1</p>
5 days to 1 WEEK of age	HIV DNA PCR if not done at birth	<p>1st visit to outpatient clinic Confirm ZDV dosing Primary Care Services includes checking for jaundice, gaining back birth weight</p>

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STANDARD OF CARE VISIT SCHEDULE HIV EXPOSED INFANTS/PEDIATRIC PATIENTS (Cont')

AGE/VISIT	LAB	CLINICAL
2 weeks (≥ 14 days)	HIV DNA PCR #1 (age 14 to 21 days test) CBC	<p>Confirm ZDV dosing. Primary Care Services include checking weight, check if anemic due to ZDV.</p>
4-5 weeks of age	HIV DNA PCR #2 (age 1-2 months test)	<p>If birth and DNA PCR #1 are negative, check DNA PCR #2, Stop ZDV after completing 6 weeks,</p>
2 MONTHS		<p>If baby has two negative HIV DNA PCRs at ≥2 weeks and ≥4 weeks of age then HIV infection can be presumptively excluded and PCP prophylaxis with Septra/Bactrim can be omitted.</p> <p>*If no results HIV DNA PCRs at ≥2 weeks and ≥ 4 weeks of age, then start Septra/Bactrim 75mg/m² BID every Mon/Tues/Wed (or any three consecutive days) . Primary Care: vaccinations (Pediarix, HIB, Prevnar and Rotarix) Check Growth and Development.</p>
4 MONTHS	HIV DNA PCR # 3 (age 4-6 months test)	<p>*If two negative DNA PCRs with one at ≥ 1month and one at ≥ 4 months of age, then may discontinue Septra/Bactrim Primary Care: vaccinations (Pentacel, Prevnar and Rotarix)</p>

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STANDARD OF CARE VISIT SCHEDULE HIV EXPOSED INFANTS/PEDIATRIC PATIENTS (Cont')

AGE/VISIT	LAB	CLINICAL
6 MONTHS		Primary Care: vaccinations (Pediatrix, HIB, Prevnar) Check Growth and Development
9 MONTHS		Primary Care: well child Check Growth and Development
12 MONTHS	PPD	Primary care: vaccinations (MMR, VZV, HIB, Prevnar, <i>hepatitis A #1</i>) Check Growth and Development
15 MONTHS		Check Growth and Development Primary Care: vaccination (DTaP)
18 MONTHS	Elisa/WB Lead Level	Pre/Post Test Counseling Discharge from clinic if negative, unless patient will be followed for primary care Check Growth and Development Primary Care: vaccination (<i>hepatitis A #2</i>)

Each institution can adopt its own vaccination schedule. *Hepatitis A* can be given at 15 months and then at the 2 year visit. Please note that if using Rotateq instead of Rotarix then give additional Rotavirus vaccine dose at 6 months of age

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LPV/r Dosing in Pregnancy

- PK studies suggest dose increase to 600mg/150mg bid in 2nd and 3rd trimester, especially in PI-experienced patients
- If standard dosing used, monitor for virologic response; consider TDM if available

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. September 14, 2011; pp 1-207.
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Atazanavir (ATV) Dosing in Pregnancy

- **ATV 400 mg + RTV 100 mg:**
 - Some experts recommend increased dose for all women in 2nd and 3rd trimester

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. September 14, 2011; pp 1-207. <http://aidsinfo.nih.gov/ContentFiles/PerinatalGL.pdf>.

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Case Presentation Form


www.FCAETC.org/ECHO

Perinatal Case Presentation Form

**F/C AETC Project ECHO™
Perinatal HIV Prevention Clinic
Initial Case Presentation**

Please fax to 866-499-2041 For Puerto Rico and U.S. Virgin Islands: 813-464-8036

Case to Discuss:							Presentation Date:	
							Topic:	
							Clinician:	
							Phone:	
							E-mail:	
General Information:	Age	Gr/Para	Date of HIV Dx	Meds	Most Recent CD4	Most Recent Viral Load	Funding Source	
Prenatal History:								
Medical History:								
Psycho/Social History:								
Current Meds (including doses)								


Perinatal HIV Prevention Community
www.USFCenter.org/Perinatal



Why should I present patient cases during the F/C AETC Project ECHO™ clinic?

- Co-manage your patients with experts in the field
- Increase your capacity to treat HIV patients
- Join a supportive network of your peers (or “community of practice”)
- Learn best practice guidelines
- Save your patient gas, mileage, and time
- Earn CE/CME credits (available for free on a limited basis)

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Case Presentation

www.FCAETC.org/ECHO



Case Presentation FCECHO0007

Age/Race: 33/African-American

Gr/Para: 1/0

Date of HIV Dx: 05/2011

Funding Source: Medicaid

Most Recent CD4: 691

Most Recent Viral Load: 36

Med HX: Morbid obesity w/ BMI 38 (class 3), syphilis w/ Tx X3 (2011), + chlamydia (2011), fibroids, and anemia.

Psycho-Social HX: Non Disclosure to _____; occasionally missed prenatal appts (2 in 11/2011)

Prenatal HX:

- Labs: Viral Load 1072 (07/11)
- Initial medications:
Lopinavir/ritonavir (Kaletra®) 2 TAB PO BID, Zidovudine/lamivudine (Combivir®) 1 TAB PO BID, and Ondansetron (Zofran®) 10mg TID (nausea)
- 1st Prenatal Care (08/11) at 21 wks gestation at this service
- Labs: Viral Load 38 (08/11)
- Stopped Lopinavir/ritonavir and Zidovudine/lamivudine (08/11)
- Labs: Viral Load 1117 (09/11)
- Current Medications: Zidovudine/lamivudine/abacavir (Trizivir®) PO BID (10/11), Prenatal Vitamins PO daily
- Labs: Viral Load 36 (12/11)
- Delivery by C/S (12/11), 40 wks, at outlying community hospital
- ????AZT – Pt. did not disclose RT + on L/D

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Question & Answer Session

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Reminders

- Please complete your session evaluation survey:
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- Completion of the registration survey and the evaluation survey are required to obtain CE/CME credits
- Any questions regarding this presentation please e-mail: echo@FCAETC.org

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