FIVE THINGS TO KNOW ABOUT ...

Intrapartum care of the HIV-positive woman

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1 The number of HIV-positive women in Canada is rising

In 2011, 71 300 Canadians were HIV positive, and 16 600 were women. This number increased from 14 740 women in 2008. In 2009, 177 infants were born to HIV-positive mothers.[1] It is important that all HIV-positive women receive access to women-specific HIV/AIDS services.[2]

2 Intrapartum pharmacotherapy is part of the strategy to reduce perinatal transmission

HIV-positive women should be given highly active antiretroviral therapy (HAART) during pregnancy and during labour.[3,4] In recent American guidelines, intravenous zidovudine treatment is no longer recommended during labour for women with a viral load below 400 copies/mL.[3] In Canada, such treatment continues to be recommended for all women in labour and before cesarean delivery.[4]

3 HIV-positive women with an undetectable viral load can be encouraged to pursue a vaginal delivery

It is important to discuss mode of delivery and to assess viral loads in late pregnancy.[3,4] The likelihood of perinatal transmission in women with an undetectable viral load is 0.1%–1.2%,[2] and women can be supported to pursue a vaginal delivery, with cesarean delivery for obstetric indications only. See Box 1 for indications for elective cesarean delivery.

Box 1: Indications for elective cesarean delivery in HIV-positive women at 38 weeks' gestation[3]

- No antepartum antiretroviral therapy
- Prior antiretroviral monotherapy
- Detectable viral load above 1000 copies/mL
- No prenatal care
- Patient request for cesarean delivery

4 Invasive intrapartum procedures should be minimized

To minimize the theoretical risk of perinatal transmission from exposure to maternal blood, invasive procedures (e.g., the use of fetal scalp electrodes, fetal scalp blood gas sampling, intrauterine pressure catheters and instrumental delivery) should be avoided when possible.[2]

5 A longer duration of ruptured membranes can be safe in HIV-positive women with undetectable viral loads

In 2001, a meta-analysis of data from 15 prospective cohort studies showed a 2% increased risk of perinatal transmission for every hour of ruptured membranes. Based on this, a shorter duration of ruptured membranes was recommended for HIV-positive women. However, many of the women in those studies had unknown viral loads, and many did not receive HAART. Thus, the results have limited applicability to the current era, in which most pregnant HIV-positive women are taking HAART and have undetectable viral loads.[5] A recent Canadian study found no instances of perinatal transmission among women with a viral load below 1000 copies/mL, irrespective of the duration of ruptured membranes.[6]

A physician resources list is available in Appendix 1 (www.cmaj.ca/lookup/suppl/doi:10.1503/cmaj.131062/-/DC1).

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Competing interests: None declared.

This article has been peer reviewed.

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***CMAJ* 2014. DOI:10.1503/cmaj.131062**

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