Antiretroviral Timing in Pregnancy Is Tricky

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SAN FRANCISCO — The optimal time to initiate antiretroviral therapy during pregnancy depends on a balance of factors, Dr. Deborah Cohan said at a meeting on HIV management sponsored by the University of California, San Francisco.

The primary goal is viral suppression by the third trimester to minimize the chances of HIV transmission to the fetus. At least one study shows that the median time to viral suppression is about 50 days in pregnant women, although 10% fail to achieve total suppression within 6.5 months.

"In the United States we tend to start antiretrovirals between 12 and 14 weeks or beyond," said Dr. Cohan of the University of California, San Francisco. Many women "feel pretty bad in the first trimester, and the last thing we want is for them to … attribute their nausea and vomiting to the antiretrovirals."

Women who have morning sickness may vomit up some of their medication, and that can create worries about whether and how to redose. Fortunately, the weight of the evidence is that transmission does not occur in the first trimester, so antiretroviral therapy may not be crucial during that time.

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There are some situations, however, in which antiretroviral therapy would be appropriate during the first trimester. For example, if the woman is continuing her preconception regimen, and the regimen includes only nonteratogenic medications that are well tolerated, it need not be discontinued.

First-trimester antiretrovirals also are indicated in patients who need them immediately for their own health.

For women who fail to tolerate their preconception regimen during the first trimester despite the use of antiemetics, the recommendation is to discontinue all medications at once. The one exception is if the patient is on a regimen containing nonnucleoside reverse transcription inhibitors. In that case, discontinuation should be staggered.

The principles of determining a proper antiretroviral regimen are similar in pregnant and nonpregnant women, except for one major consideration: Is this for her own health, and is it going to be a long-term regimen, or is it strictly chemoprophylaxis to prevent transmission?

If it's strictly chemoprophylaxis, less potent regimens may be acceptable. These could include triple nucleoside reverse transcriptase inhibitors. "Triple nukes really have fallen out of favor in terms of chronic use in adults," Dr. Cohan said. "In this setting it may be appropriate. If someone comes to you with a CD4 count of 600 [cells/mm^3] and a baseline viral load of 3,000 [copies/mL], and she's going to be on antiretrovirals for 5 months and she really would like to reduce her pill burden, Trizivir [abacavir, lamivudine, and zidovudine] may be a good option."

Nelfinavir, a less potent protease inhibitor that has fallen out of favor, also is an option. It tends to be quite well tolerated in pregnancy, and in fact can counter the constipation that pregnant women frequently experience.

Another question concerns whether antiretroviral therapy is needed in pregnant women with viral loads less than 1,000 cells/mL. One as yet unpublished study of more than 1,200 woman-infant pairs determined the transmission rate to be 9.8% among women with low viral loads who don't get antiretroviral therapy, compared with 1.0% for women who do, yielding a highly significant odds ratio of 0.10.

Finally, there's the question of what one should do for women who are unlikely to comply with an antiretroviral regimen because of their life circumstances. Another unpublished study looked at the cost-effectiveness of directly observed therapy, which requires keeping women in the hospital during the third trimester. This resulted in a greatly reduced transmission rate and a cost saving of $3,200 per pregnancy.

Dr. Cohan routinely orders directly observed therapy for women in difficult circumstances. ■