

Pocket Guide to HIV/AIDS Treatment

Prepared by: The AIDS Education and Training Centers, National Resource Center
A Project of the HIV/AIDS Bureau, Health Resources and Services Administration

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Regional AIDS Education and Training Centers

Delta Region AETC: (504) 568-3855

Florida AETC: (813) 974-4430

Great Lakes to Tennessee Valley AETC: (313) 962-2000

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Mountain-Plains AETC: (303) 315-2516

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Warmline: 1-800-933-3413

References for the Pocket Guide to HIV/AIDS Treatment:

- The Guidelines for the Use of Antiretroviral Agents in HIV-Infected Adults and Adolescents living document (January 28,2000). The HIV/AIDS Treatment Information Service (ATIS): <http://hivatis.org>.
- 1999 USPHS/IDSAGuidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus. Draft May 14, 1999. Published by The HIV/AIDS Treatment Information Service (ATIS): www.hivatis.org
- Guidelines for the Use of Antiretroviral Agents in Pediatric HIVInfection: January 2000. Published by The HIV/AIDS Treatment Information Service (ATIS): <http://hivatis.org>.
- Public Health Service Task Force Recommendations for the Use of Antiretroviral Drugs in Pregnant Women Infected with HIV-1 for Maternal Health and for Reducing Perinatal HIV-1 Transmission in the United States. The Living Document: February 25, 2000. Published by The HIV/AIDS Treatment Information Service (ATIS): <http://hivatis.org>

Abbreviations Used in this Pocket Guide to HIV/AIDS Treatment

(06/2000)

Drug Abbreviations

ABC: Abacavir (Ziagen)
APV: Amprenavir (Agenerase)
AZT: Zidovudine (Retrovir)
ddl: Didanosine (Videx)
d4T: Stavudine (Zerit)
ddC: Zalcitabine (Hivid)
DLV: Delavirdine (Rescriptor)
EFV: Efavirenz (Sustiva)
FTV: Fortovase
HU: Hydroxyurea
INH: Isoniazid
IDV: Indinavir (Crixivan)
IVIg: Intravenous immune globulin
NFV: Nelfinavir (Viracept)
NVP: Nevirapine (Viramune)
RBT: Rifabutin
RTV: Ritonavir (Norvir)
SQV: Saquinavir
3TC: Lamivudine (Eпив)
TMP-SMX: Trimethoprim sulfamethoxazole
VZIG: Varicella zoster immune globulin

Miscellaneous Abbreviations

ART: Antiretroviral Therapy
HAART: Highly Active Antiretroviral Therapy
IV: Intravenous
IM: Intramuscular
NNRTI: Non-nucleoside reverse transcriptase inhibitor
PI: Protease Inhibitor
VL: Viral Load
bid: twice per day
biw: twice per week
hs: bedtime (hour of sleep)
mo: month
po: by mouth
q: every
qd: daily
qid: four times per day
qm: monthly
qod: every other day
qw: every week
tid: three times per day
tiw: three times per week

Adult Guidelines

1. When to Start:

- Acute HIV
 - Symptomatic HIV
 - CD4 count <500 cells/mm³ *or* viral burden >10,000 c/ml* (bDNA) or >20,000 (RT-PCR)
- * Strength of recommendation depends on patient readiness, probability of adherence, and prognosis based on CD4 count and HIV load.

2. What to Start With:

- **Preferred:** EFV, IDV, NFV *or* RTV + SQV *plus* AZT + 3TC, AZT + ddI, d4T+ 3TC, *or* d4T + ddI
- **Alternatives to pair with 2 NRTIs:** ABC, APV, DLV, NVP, RTV, FTV(Fortovase), FTV+ NFV
- **Alternative NRTIs:** ddI + 3TC, AZT+ddC
- **Inadequate data for recommendation:** HU, RTV + IDV, RTV + NFV, RTV + APV
- **Avoid:** INV(Invirase) except with RTV, AZT + d4T, ddC + 3TC, ddC +d4T, ddC + ddI

3. Monitoring Therapy

- Viral load at baseline (x2) and 4-8 wks after initiating therapy or new regimen, then every 3 – 6 months
- CD4 count at baseline and then every 3 - 6 months
- Consider: HAART– Fasting glucose, lipid profile (triglyceride, cholesterol, LDL, HDL) at baseline, 3 – 4 months, then prn depending on changes in regimen, baseline values and risk

4. Considerations for Changing Therapy

- Less than 0.5 – 0.75 log₁₀ c/ml reduction in plasma HIV RNA by 4 weeks following initiation of therapy, or less than 1 log₁₀ reduction by 8 weeks
- Failure to suppress plasma HIV RNA to undetectable levels within 4 – 6 months of initiating therapy or repeated detection of virus after initial suppression to undetectable levels
- Persistently declining CD4⁺ cell count, as measured on at least two separate occasions (optional)

Adult Guidelines

5. Recommendations for Resistance Testing

- Virologic failure: Failure to achieve or sustain a VL <1000 c/ml after >16-24 weeks of treatment
- Acute HIV infection
- **Not recommended:** Chronic HIV infection in treatment naïve patient; after discontinuation of treatment (for >2 weeks); plasma viral load <1000 c/ml

6. Methods to Achieve Readiness to Start HAART & Maintain Adherence

Patient-related:

- Negotiate a plan that the patient understands and to which s/he commits
- Take time needed, > 2 visits, to ensure readiness before 1st prescription
- Recruit family, friends, peer and community support
- Use memory aids - timers, pagers, written schedule
- Plan ahead - keep extra meds in key locations, obtain refills
- Use missed doses as opportunities to prevent future misses
- Active drug and alcohol use and mental illness predict poor adherence; race, sex, age, educational level, income, and past drug use do not.

Physician-related:

- Educate patient re: goals of therapy, pills, food, and side effects
- Assess adherence potential before HAART; monitor at each visit
- Ensure access off-hours, weekends for questions or problems
- Utilize full health care team; ensure med refills at pharmacy
- Consider impact of new diagnoses and events on adherence

Regimen-related:

- Simplify regimen re: dose frequency, pill burden, and food requirements
- Inform patient and anticipate side effects

Health team-related:

- Provide training updates on adherence for all team members
- Educate volunteers, patient community representatives

Adult Table 1. Antiretroviral Agents (most common and/or important toxicities are in italics)
(06/2000)

Drug Name	Form	Usual Dose	Renal Failure CrCl 10-50	<10	Liver Failure	Toxicity (main toxicity – italics)	Monitor
Abacavir (ABC, Ziagen)	300 mg tab	300 mg bid	Standard		Usual	<i>Hypersensitivity</i> - fever, rash, GI/ respiratory sx	Warn
Didanosine (Videx; ddi)	25, 50, 100, 150, 200 mg tab 100, 167, 25 mg powder	Wt >60 kg: * tabs - 400 mg qd or 200 mg bid powder - 250 bid. Wt <60 kg: tabs - 250 mg qd or 125 mg bid; powder -167 bid	200-400 mg qd	100 mg qd	Reduce?	GI intolerance <i>Pancreatitis</i> <i>Peripheral neuropathy</i>	Amylase? Foot pain
Lamivudine (Epivir; 3TC)	150 mg tab	150 mg bid	150 mg qd	50 mg qd	Usual	Nil	
Stavudine (Zerit; d4T)	15, 20, 30, 40 mg cap	Wt >60 kg: 40 mg bid Wt <60 kg: 30 mg bid	15 – 20 mg bid	15 – 20 mg qd	Usual	<i>Peripheral neuropathy</i>	Foot pain
Zalcitabine (Hivid; ddC)	0.375, 0.75 mg tab	0.75 mg tid	0.75 mg bid	0.75 mg qd	Usual	<i>Peripheral neuropathy</i> Stomatitis	Foot pain
Zidovudine (Retrovir, AZT)	100, 300 mg cap	300 mg bid 200 mg tid	300 mg bid	300 mg qd	200 mg bid	GI intolerance, asthenia <i>Anemia, neutropenia</i>	CBC
Combivir	AZT300 mg + 3TC 150 mg	1 bid	Avoid	Avoid	Usual	AZT side effects	CBC
Delavirdine (DLV, Rescriptor)	100, 200 mg tabs	400 mg tid	Standard		Reduce?	<i>Rash</i>	None **
Efavirenz *** (EFV, Sustiva)	50, 100, 200 mg tabs	600 mg hs *	Standard		Reduce?	<i>CNS toxicity</i> Rash	None **
Nevirapine (NVP, Viramune)	200 mg tabs	200 mg qd x14 days 200 mg bid	Standard		Reduce?	<i>Rash</i>	None **

* Food effect: ddI- take $\geq 1/2$ hr before and ≥ 1 hr after meal. Efavirenz – avoid taking with high fat meal. Indinavir – take ≥ 1 hr before and ≥ 2 hrs after meal. Nelfinavir, ritonavir, saquinavir – take with meals.

** Monitor lipodystrophy with PIs and possibly for NNRTIs; fasting triglycerides, cholesterol, LDL, HDL and glucose at baseline and q 3-6 months

***Contraindicated in pregnancy. The contraindication with amprenavir applies to the oral solution which contains large quantities of propylene glycol

Adult Table 1, continued. Antiretroviral Agents (most common and/or important toxicities are in italics)

(06/2000)

Drug Name	Form	Usual Dose	Renal Failure CrCl 10-50	<10	Liver Failure	Toxicity (main toxicity – italics)	Monitor
Hydroxyurea*** (HU)	500 mg caps	500 mg bid or 1000 mg qd	Avoid		Usual	GI intolerance Marrow suppression	CBC
Amprenavir*** (APV, Agenerase)	50, 150 mg caps	1200 mg bid	Standard		300 – 450 mg bid	GI intolerance	Lipid profile **
Indinavir (IDV, Crixivan)	200 mg caps	800 mg q 8h *	Standard		600 mg q 8h	GI intolerance <i>Nephrolithiasis</i>	Lipid profile ** Urinalysis
Nelfinavir (NFV, Viracept)	250 mg tabs	1250 mg bid or 750 mg tid *	Standard		Reduce?	<i>Diarrhea</i>	Lipid profile **
Ritonavir (RTV, Norvir)	100 mg caps	600 mg bid	Standard		Reduce?	<i>GI intolerance</i>	Lipid profile **
Saquinavir(SQV) Fortovase (FTV)	200 mg caps	FTV – 1200 mg tid	Standard		Reduce?	<i>GI intolerance</i>	Lipid profile **
Invirase (INV)	200 mg caps	IND – 400 mg bid + RTV					

* Food effect: ddI- take $\geq 1/2$ hr before and ≥ 1 hr after meal. Efavirenz – avoid taking with high fat meal. Indinavir – take ≥ 1 hr before and ≥ 2 hrs after meal. Nelfinavir, ritonavir, saquinavir – take with meals.

** Monitor lipodystrophy with PIs and possibly for NNRTIs; fasting triglycerides, cholesterol, LDL, HDL and glucose at baseline and q 3-6 months

***Contraindicated in pregnancy. The contraindication with amprenavir applies to the oral solution which contains large quantities of propylene glycol

Adult Table 2. Combination Therapy

(06/2000)

	RTV	SQV**	NFV	APV	IDV
IDV	RTV400 bid+ IDV400 bid or RTV100-200 bid+ IDV800 bid	ND	NFV1250 bid+ IDV1200 bid	APVstandard+ IDVstandard	-----
RTV	-----	SQV400 bid+ RTV400 bid	NFV500-750 bid+ RTV400 bid	RTV100-200 bid+ APV600 bid (?)*	-----
SQV**	-----	-----	NFVstandard+ SQV800 tid or NFV1250 bid SQV800 bid*	ND	ND
NFV	-----	-----	-----	ND	-----
NVP	RTVstandard+ NVPstandard	Avoid	NFVstandard+ NVPstandard	ND	IDV1000 tid+ NVPstandard
DLV	ND	SQV800 tid+ DLV standard	ND	ND	IDV600 tid+ DLV standard
EFV	RTV500-600 bid+ EFVstandard	Avoid	NFVstandard+ EFVstandard	APV- 1200 tid + EFV600 hs APV- 1200 bid + RTV200 bid + EFV600 hs	IDV1000 tid EFVstandard

Doses are in mg ND = No data

* Added by authors to update DHHS guidelines

**SQV should be with Fortovase except in combination with RTV when either Invirase or Fortovase are acceptable

Adult Table 3. Drug Interactions: Contraindicated Combinations**(06/2000)**

Class	Agent	ART Agents	Alternatives
Ca++ channel blocker	Bepidil	RTV, APV	-----
Lipid lowering	Simvastatin	All PIs, DLV	Atorvastatin, pravastatin, flurastatin, cerivastatin
	Lovastatin		
Tuberculosis	Rifampin	All PIs, DLV	Use rifabutin*
	Rifabutin	NVP, DLV, SQV	Rifabutin dose adjustment*
Antihistamine	Astemizole	All PIs, DLV, EFV	Loridine, fexofenadine or cetirizine
	Terfenadine		
GI	Cisapride	All PIs, DLV, EFV	-----
	H2 blockers	DLV	
Neuroleptic	Clozapine	RTV	-----
Psychotropic	Midazolam	All PIs, DLV, EFV	Temazepam or lorazepam
	Triazolam		
Ergot alkaloids	Ergotamine	All PIs, DLV, EFV	-----
Herbs	St. John's Wort	All PIs & NNRTIs	Alternative antidepressants

* Rifabutin: RBT150 mg/d + IDV1200 mg q 8h; RBT150 mg/d + NFV1000 mg tid;
 RBT150 mg/d + APV1200 mg bid; RBTmg qod + RTV600 mg bid; RBT450 mg/d + EFV600 mg/d

Produced by the AETC National Resource Center, a program of HRSA.

Adult Table 4. Drug Interactions: Combinations Requiring Dose Modifications**(06/2000)**

Class	Agent	ART
Antifungal	Ketoconazole	IDV– IDV600 mg tid
		RTV– Ketoconazole \leq 200 mg /d
		NVP– Not recommended
Oral contraceptives	-----	Alternative method – RTV, NFV, APV, EFV
		No data – SQV, NVP, DLV
Anticonvulsants	Phenobarbital Phenytoin Carbamazepine	All PIs and NNRTIs – Monitor levels of anticonvulsant
Methadone	-----	RTV, NVP, EFV– May cause withdrawal; monitor methadone levels or symptoms
		Other PIs and NNRTIs – no data; may need ddI dose increase.
Antibiotics	Clarithromycin	RTV, DLV – Decrease clarithromycin dose in renal failure.
		EFV– Use alternative to clarithromycin.
Miscellaneous	Theophylline	RTV– Monitor theophylline levels
	Warfarin	EFV– Monitor patient
	Sildenafil	All PIs and DLV – \leq 25 mg/ 48 hrs
	Desipramine	RTV– Reduce desipramine dose

Adult Table 5. National Cholesterol Education Program: Indications for Dietary or Drug Therapy for Hyperlipidemia**(06/2000)**

	Threshold for diet Rx		Threshold for drug Rx	
	Cholesterol	LDL	Cholesterol	LDL
0 – Risks*	> 240 mg/dL	< 160 mg/dL	> 275 mg/dL	< 190 mg/dL
≥ 2 Risks*	> 200 mg/dL	< 130 mg/dL	> 240 mg/dL	< 160 mg/dL
Cardiovascular disease	> 160 mg/dL	< 100 mg/dL	> 200 mg/dL	< 130 mg/dL

* Risks: Age (men >45 years; women post-menopausal); hypertension, smoking, diabetes mellitus, hx of cardiovascular disease in first degree relatives (<55 years for men and <65 years for women), or serum cholesterol <35 mg/dL.

Adult Table 6. Resistance Mutations – Adapted from Hirsch et al, *JAMA* (2000) 283: 2417

(06/2000)

Drug	Primary	Secondary
Nucleosides and Nucleotides		
AZT	70, 215	41, 67, 210, 219
3TC	44, 118, 184	
ddC	65, 69, 74, 184 (limited clinical data)	
ddI	74	65, 184
d4T	75 (selected in <i>vitro</i> , rarely seen in patients)	
ABC	65, 74, 184	41, 67, 70, 115, 210, 215, 219
Multinucleoside Resistance –A*	151	62, 75, 77, 116
Multinucleoside Resistance-B*	69 (insertion)	41, 62, 67, 70, 210, 215, 219
Non-nucleoside Reverse Transcriptase Inhibitors		
NVP	103, 106, 108, 181, 188, 190	100
DLV	103, 181	236
EFV	103, 188, 190	100, 108, 225
Protease Inhibitors		
IDV	46, 82 (usually selected in combination with other mutations)	10, 20, 24, 32, 36, 54, 71, 73, 77, 84, 90
NFV	30, 90	10, 36, 46, 71, 77, 82, 84, 88
RTV	82	20, 32, 33, 36, 46, 54, 71, 77, 84, 90
SQV	48, 90	10, 54, 71, 73, 77, 82, 84
APV	50, 84	10, 32, 46, 47, 54

Primary - usually develop first; associated with decreased drug binding

Secondary - also contributes to drug resistance; may affect drug binding in *vitro* less than primary mutations

Adult Table 7. Performance Indicators: Essential Care Processes Linked to other Desirable Processes or Outcomes***(06/2000)**

Performance Indicator	Expectation	Reporting
HAART	Discussion of HAART with chart documentation for patients with CD4 <350	Number with CD4 <350 with discussion documented/Number with CD4 < 350
PCP prophylaxis	PCP prophylaxis prescribed for patients with current CD4 <200	Number with CD4 <200 given PCP prophylaxis/Number with CD4 <200
MAC prophylaxis	Offer clarithromycin or azithromycin prophylaxis within 2 mos. of CD4 <50	Number with CD4 <50 given MAC prophylaxis/Number with CD4 <50
TB prophylaxis	PPD with first evaluation and x-ray for positives (unless prior positive PPD)	Number with PPD at any time/Number HIV-infected patients followed
Cervical carcinoma	PAP smears x 2 in first year, then annual	Number of women with > 1 PAP per year/Number of women followed
Laboratory monitoring	VL: q 3 – 4 mos. CD4 < 350: q 3 – 4 mos. > 350: q 6 – 7 mos.	Number with VL and CD4 measurements at designated intervals/Number with > 1 visit in prior 6 mos.
Pneumococcal vaccine	Deleted due to decreased strength of recommendation	
Toxoplasmosis serology	Deleted because PCP prophylaxis will usually prevent toxoplasmosis	

* 1999 USPHS/IDSA Guidelines for the Prevention of Opportunistic Infections in Persons Infected with Human Immunodeficiency Virus
[H Masur, et al. CID 2000; 30, supplement: S1]

Adult Table 8. 1999 USPHS / IDSA Guidelines for Prevention of Opportunistic Infections

(06/2000)

Pathogen	Indication	First Choice	Alternatives	Comment	
Strongly Recommended					
<i>P. carinii</i>	CD4 < 200 Thrush FUO	TMP-SMX 1 DS/d TMP-SMX 1 SS/d	Dapsone 100 mg/d Dapsone 50 mg/d + pyrimethamine 50 mg/ wk + leukovorin 25 mg/ wk Dapsone 200 mg + pyrimethamine 75 mg + leukovorin 25 mg/wk Aerosol pentamidine 300 mg/ mo Atovaquone 1500 mg/d TMP-SMX 1 DS 3x /wk	Immune reconstitution: • Primary prophylaxis* CD4 > 200 for >3 mos. • Secondary prophylaxis (prior PCP): CD4 > 200 for 3 mos. **	
Tuberculosis	PPD \geq 5mm and/or history of untreated positive PPD; contact with active case	Rifampin 600mg/d + pyrazinamide 20mg/kg x 2 mo INH 300 mg/d + pyridoxine 50mg/d x 9 mos DOT- INH 900 mg + pyridoxine 100 mg 2x/wk x 9 mos	Rifabutin 300mg/d + pyrazinamide 20mg/kg/d x 2 mo Rifampin 600mg/d x 4 mo	Rifabutin dose with PI	
				PI	RBT
				APV1200 mg bid	150 mg/d
				IDV1200 mg q 8h	150 mg/d
				NPV1000 mg tid	150 mg/d
				RTV standard	150 qod
				EFV600 mg hs	450 mg/d
Toxoplasmosis	+ anti-toxoplasma IgG and CD4 < 100	TMP- SMX 1 DS qd	TMP- SMX 1 SS qd Dapsone + pyrimethamine + leukovorin (see PCP)	Immune reconstitution: • Primary prophylaxis* CD4 > 100 for > 3 mos. • Secondary prophylaxis* continue prophylaxis	

* USPHS/ IDSA Recommendation with immune reconstitution

** USPHS/ IDSA recommendation is to continue prophylaxis because data were considered inadequate to support discontinuation. Subsequent data supports discontinuation when indicated criteria are met.

***Relenza and oseltamivir were released after recommendations were completed. These drugs are effective for prophylaxis but are not FDA- approved for prophylaxis.

Adult Table 8, continued. 1999 USPHS / IDSA Guidelines for Prevention of Opportunistic Infections

(06/2000)

Pathogen	Indication	First Choice	Alternatives	Comment
Strongly Recommended				
<i>Mycobacterium avium</i> complex	CD4 < 50	Azithromycin 1200 mg/wk Clarithromycin 500mg bid	Rifabutin 300 mg/d Azithromycin 1200 mg / wk + rifabutin 300 mg/d	Immune reconstitution: • Primary prophylaxis * CD4 > 100 for > 3 mo and HIV viral suppression ** • Secondary prophylaxis: continue prophylaxis
Varicella	Chickenpox / shingles exposure + susceptible (no history of disease and varicella seronegative)	VZIG 5 vials (6.25 ml) IM ≤ 96 h post exposure		

Generally Recommended

<i>S. pneumoniae</i>	All Patients	Pneumovax		Immune reconstitution: consider reimmunization if CD4 increases to > 200
Hepatitis B	Susceptible- (anti – HBC negative)	HBV vaccine series		
Influenza	All Patients	Influenza vaccine	Rimantidine 100 mg bid Amantadine 100 mg bid	Relenza*** Oseltamivir***
Hepatitis A	Susceptible- (anti HAV neg) and anti HCV positive	Hepatitis A vaccine series	None	

* USPHS/ IDSA Recommendation with immune reconstitution

** USPHS/ IDSA recommendation is to continue prophylaxis because data were considered inadequate to support discontinuation. Subsequent data supports discontinuation when indicated criteria are met.

***Relenza and oseltamivir were released after recommendations were completed. These drugs are effective for prophylaxis but are not FDA- approved for prophylaxis.

Pregnancy Table 1.

(06/2000)

Antiretroviral Drugs in Pregnant Women: ACTG 076 Protocol**Antepartum:** AZT100 5 x /d (or 300 bid or 200 tid) Wk 14 until delivery**Intrapartum:** AZTIV2 mg/kg first hr. then 1 mg/kg/hr until delivery**Postpartum:** (infant): AZT syrup 2 mg/kg q 6h (or 1.5 mg/kg q 6h IV) x 6 wks**Pregnancy Table 2. Drugs:**

(06/2000)

FDAPregnancy Category				
Drug	Class (FDA)	Placental Passage	Animal Carcinogenicity	Animal Teratogenicity
AZT	C	Yes*	Positive	Positive
ddC	C	Yes	Positive	Positive
ddI	B	Yes*	Negative	Negative
d4T	C	Yes	No Data	Negative
3TC	C	Yes*	Negative	Negative
ABC	C	Yes	No Data	Positive
NVP	C	Yes*	No Data	Negative
DLV	C	No Data	No Data	Positive
EFV**	C	Yes	No Data	Positive
IDV	C	Yes	No Data	Negative
RTV	B	Yes	No Data	Negative
SQV	B	Minimal	No Data	Negative
NFV	B	No Data	No Data	Negative
APV**	C	No Data	No Data	Negative

* Placenta passage in humans; others tested in rodents or primates only or not tested

**Contraindicated in pregnancy: EFV and APV oral solution

Pregnancy Table 3.**(06/2000)**

Adverse Drug Reactions	Risk for Perinatal HIV Transmission	Post Partum Risk:
Common ADRs with antiretroviral agents in pregnancy are anemia, nausea & vomiting, amniotransferase elevation and hyperglycemia.	Viral load (most significant), lack of AZT, cigarette smoking, illicit drug use, unprotected sex with multiple partners.	Breast feeding- not recommended in U.S.

Antiretroviral Pregnancy Registry: 1410 Commonwealth Dr., Wilmington NC 28403, TEL: 800-258-4263, Fax 800-800-1052

Pregnancy Table 4. Clinical Scenarios**(06/2000)**

Untreated Pregnant Patient	Standard clinical, immunologic and virologic evaluation. Standard antiretroviral regimen including the three part 076 protocol AZTregimen; avoid AZT+ d4T. Consider delaying ART to 10-12 wks gestation
Treated Pregnant Patient	Continue therapy, but 1) consider discontinuation during 1st trimester 2) include AZT if tolerated
Untreated & Presents in Labor	1) NVP200 mg po onset labor + single 2 mg/kg po to infant at 48 hrs; <i>OR</i> 2) AZT+ 3TC; <i>OR</i> 3) 076 protocol with AZT intrapartum + infant components; <i>OR</i> 4) NVP + AZT as described in 1 and 3.
Untreated Mother Post Delivery	6 week neonatal AZT component of ACTG 076 (and evaluation of mother).