Birth weight >2 kg:
- 1st dose within 48 hrs of birth

If supplemental testing is required, a > 1% risk of acute HIV infection is demonstrated. Recent data have demonstrated a negative HIV screen at the start of pregnancy and confirmatory viral load testing should be performed. If supplemental testing is performed prior to delivery, the risk of perinatal transmission is reduced by 50%, and therefore HIV antibody testing should be deferred to the neonatal period (initiated as soon after delivery as possible).

For infants with a negative HIV DNA PCR and negative HIV antibody on the initial panel, HIV DNA PCR should be performed at one month of life. HIV DNA PCR should be repeated at 6 months of age to definitively test for infection. Antiretroviral treatment is recommended as soon as possible prior to delivery and should continue through one month of life.

References:

Evidence-Based Treatment of HIV-Exposed Infants: 1 Drug, 2 Drugs, or CART

Interest in the use of combination antiretroviral (cART) prophylaxis for high-risk HIV-exposed infants was heightened after initial reports of a “functional cure” of an infant in 2013. The “Mississippi baby” was born in 2010 to a mother diagnosed with HIV infection during labor. The infant received zidovudine, lamivudine, and nevirapine at the age of 30 hours; nevirapine was replaced by ritonavir-boosted lopinavir for treatment of HIV infection at seven days of life. Treatment continued through the age of 18 months and it was self-discontinued by the mother. In October 2013, the doctors caring for the infant reported that at 30 months (twelve months after ART had stopped), the infant was in the child to be few below detectable levels. Interest in the case was intense among the scientific community and the case was widely reported as a “cure” in the media. On July 10, 2014, however, it was reported that the child had detectable levels of HIV and whether the worldwide study of multi-drug infant ARV prophylaxis planned by the National Institutes of Health will be conducted remains uncertain.5

While viral remission was achieved for 27 months without treatment in the child in this case, viral rebound after the prolonged period of remission supported the hypothesis that left untreated, HIV infections are re-seeded from viral DNA carried in dormant cells. Researchers must now work to better understand what enabled the child to remain without HIV treatment for over two years while maintaining an undetectable viral load and without evident impact on immunological markers of infection.

The use of combination antiretroviral (CAR) prophylaxis for HIV-exposed infants considered at high risk for HIV infection appears to be increasing in the United States and in Europe.6 7 However, continued on next page