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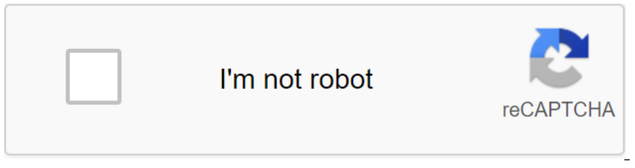

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These changes are highlighted in yellow in the pdf version of the guidelines. The main changes to the section are below. On 14 April 2020, the Group changed the term HIV empiric therapy to the intended HIV therapy in this section and in all guidelines consistent with the terminology used by the World Health Organization. The group recommends pur supposed HIV therapy for infants at higher risk of acquiring perinatal HIV. To be clear, the term multi-drug prevention of ARVs has been changed to two-drug ARV prevention. Table 6. Neonatal antiretroviral management, depending on the risk of HIV infection in newborns and Table 7. Antiretroviral recommendations for neonatal dosing have been revised to clarify THE regimens and the duration and dosing of ARVs used for suspected HIV therapy. The two-drug regimen used in NICHD-HPTN 040/PACTG 1043 for children at higher risk of HIV infection is no longer included in Tables 6 and 7; This regimen is described in the text, not, see section two of the antiretroviral prevention drugs. On January 17, 2020, the Group added new subsections on potential adverse growth and metabolic and neurodevelopmental outcomes in the uterine exposure to HIV and antiretroviral drugs. 24 December 2019 In a number of sections, the Group for the Treatment of Pregnant Women with HIV infection and the Prevention of Perinatal Transmission (Group) emphasizes the importance of patient counselling and recommends that informed decisions be made regarding the use of dolutegravir (DTG) and other antiretroviral (ARV) drugs for pregnant women or those trying to become pregnant (AIII). A counselling guide was added to summarize the content to be discussed with patients; See Annex D: Dolutegravir Consulting Guide for Health Care Providers. The group also recommends that physicians discuss with patients future reproductive plans and timing, as well as the risks and benefits of conceiving specific ARVs and contraceptives to prevent unwanted pregnancies (AIIs). In addition to recommendations for HIV re-testing in the third trimester, re-testing for HIV at another time during pregnancy should be considered when clinically indicated. For example, retesting should be performed when a woman presents with symptoms that suggestive sexually transmitted (STIs), (STIs), a woman presents a confirmed diagnosis of STIs, or when a woman presents with symptoms that are consistent with acute HIV infection. The team updated recommendations on the use of DTH in pregnant women and women trying to conceive, based on data available as of August 2019. Restrictions on the use of DTG during the first trimester and in women who are trying to get pregnant have been removed. DTG is currently the preferred drug ARVs throughout pregnancy and an alternative drug ARVs for women who are trying to get pregnant. The team weighed not only updated data on the risk of neural tube defects (NTDs) associated with DTH from Botswana, but also the important lack of comparable data on the risk of NTDs when using DTG in other settings, as well as what is known about the risk of NTD and other adverse pregnancy outcomes, such as preterm birth, with other preferred and alternative ARV drugs and combinations. The following sections of the guidelines now include an update on the use of DTG: The use of antiretroviral therapy (ART) to achieve sustained viral suppression prevents HIV transmission to sexual partners. With this in mind, the recommendation for couples with different HIV statuses who are trying to conceive no longer limits sexual intercourse to peak fertility when a partner with HIV has achieved sustained viral suppression. Sexual intercourse without a condom allows conception with virtually no risk of sexual transmission to a partner without HIV in this situation. The team has also reorganized and updated recommendations that provide recommendations if the HIV partner has not achieved viral suppression or has had an inconsistent commitment, or where their viral suppression status is unknown. A table with information on the effectiveness of pre-exposure prophylaxis has been revised and transferred to Annex C: Clinical Trial Efficiency Data for Daily, Oral Tenofovir Disoproxil Fumarate/Emtricitabine as Pre-Exposure Prophylaxis Prevention. The recommendations associated with DTH have been updated (see updates on recommendations for the use of antiretroviral drugs during pregnancy below), and a new subsection has been added with data on the link between other integrative filament inhibitors (INST) and birth defects. This section also includes the latest data on elevated levels of microcephaly in HIV-infected but uninfected children exposed to utero-efavirens. This section has been revised and reorganized to focus on data on preterm birth, fetal growth, miscarriage and stillbirth, which have been published since 2015. This section also looks at data on hypertensive pregnancy and maternal HIV. please refer to the archival versions of this section. The Team updated the definitions of preferred and alternative categories of ARVs recommended use during pregnancy and in women who are trying to get pregnant. Based on available data, the Panel currently recommends DTG as the preferred ARV drug for pregnant women, regardless of trimester (AII), and an alternative drug ARVs for women who are trying to conceive (AIII). The group stresses the importance of advising and making informed decisions about all ARV schemes for people with HIV (AIII). Folic acid is known to prevent NTDs in the general population. All pregnant women and women who might become pregnant should take at least 400 micrograms of folic acid daily (AI). There is no established link between the use of DTG and metabolic disorders of folic acid, nor is there evidence that folic acid supplements prevent DTG-associated NTDs. Recommendations in this section have been updated in accordance with updates on recommendations for the use of antiretroviral drugs during pregnancy, Table 4 and Table 5. When pregnant women receiving DTG are currently receiving care during pregnancy, providers should advise these women on the risks and benefits of continuing DTG or switching to another ARV (AIII) regimen. In most cases, the Panel recommends the continuation of DTG (AIII). There are no data on the use of two-drug circuits during pregnancy (e.g., DTH plus lamivudin, DTH plus rippiurin); Women who are present to care for one of these modes should switch modes or add additional ARVs agents to these modes. After reviewing the full history of the woman's treatment and the results of the drug test, the doctor may consider using INSTI as part of a new regimen for a pregnant woman who is experiencing a virological failure on an arV regimen that does not contain INSTI. The Panel's recommendations have been updated to clarify that women who are not immune to the hepatitis B virus (VVD) should receive a HV vaccine. In accordance with the recommendations of the Society of Maternal and Fetal Medicine and the American College of Obstetricians and Gynecologists, the Panel recommends repeating screening of the hepatitis C virus (HCV) later in pregnancy for women who are initially screened negative for HCV but who have persistent or new risk factors for HCV (e.g. new or ongoing injections or intranasal substance use) (AIII). DTG is now recommended for the treatment of HIV-2 mono-infection in pregnant women, regardless of trimester, and in women who are trying to get pregnant (AIII). As with HIV-1, the Panel recommends that physicians consider contracting ERV/HIV-2 when choosing an ARV regimen for HIV-2 (AI). DTG plus tenofovir dysoprossil fumarate (TDF) plus emtricitabine (FTC) is the preferred arV regime for and nursing women with acute HIV, regardless of trimester (AII). It can also be initiated by RAL,1 plus TDF plus FTC or regimen, which includes a protease inhibitor with an increase in ritonavir (AIII). Breastfeeding is not recommended for women with HIV, HIV, Symptoms associated with breast enlargement can be very unpleasant for a few days after childbirth and childbirth. The team added a new lactation braking subsection, which aims to manage symptoms associated with breast augmentation; this includes the use of cabergolin to suppress the production of breast milk. In considering the risk of perinatal HIV transmission and the choice of appropriate ARVs for newborns with perinatal EXPOSURE to HIV, the Group currently defines maternal viral infection suppression as HIV RNA level in zlt;50 copies/ml. The new subsection summarizes the choice between empirical HIV therapy and multiple drug prevention of ARV for newborns with perinatal HIV infection. The team also explained that nevirapine (NVP) can be replaced by lopinavir/ritonavir when children receiving experiential HIV therapy reach postmenstrual ≥42 weeks and postpartum age ≥14 days; NVP can be replaced by an RAL at any age. The Panel's recommendation that all newborns exposed to HIV should receive appropriate POST-birth ARVs as soon as possible is currently included in the list of recommendations under this section. Table 8: The use of antiretroviral drugs in pregnant women with HIV infection: Pharmacokinetic and toxic data on human pregnancy and recommendations for use during pregnancy and other sections in Annex B were supplemented with new data for each drug, including new formulations and combinations of fixed-dose pills. Older ARVs that the Panel does not recommend for pregnant women or women who are trying to conceive due to unacceptable toxicity, low virological efficacy, high pill load, pharmacological problems and/or limited data on use during pregnancy have been moved to a new section in Annex B called Archive Drugs; data on these drugs will no longer be reviewed by the Panel. Drugs that have been moved to this section include amprenavir, delavirdine, didanosine, enfuvirtide, phosamprenavir, indinavir, nelfinavir, sacvinavir, statudine, cycranavier and zalcitabine. The text and references to all the guidelines have been updated to include new data and publications where appropriate. 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Sexual intercourse without a condom allows conception with virtually no risk of sexual transmission to a partner without HIV in this situation. The team has also reorganized and updated recommendations that provide recommendations if the HIV partner has not achieved viral suppression or has had an inconsistent commitment, or where their viral suppression status is unknown. A table with information on the effectiveness of pre-exposure prophylaxis has been revised and transferred to Annex C: Clinical Trial Efficiency Data for Daily, Oral Tenofovir Disoproxil Fumarate/Emtricitabine as Pre-Exposure Prophylaxis Prevention. The recommendations associated with DTH have been updated (see updates on recommendations for the use of antiretroviral drugs during pregnancy below), and a new subsection has been added with data on the link between other integrative filament inhibitors (INST) and birth defects. 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