BHIVA guidelines and breastfeeding in the UK- the current picture

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Background

- The current HIV **vertical transmission (VT) rate is 0.28% (95% CI 0.08%, 0.71%)** among births to diagnosed women living with HIV (WLHIV) in the UK in 2015-16
- The British HIV Association (BHIVA) **recommends formula-feeding infants born to WLHIV, eliminating postnatal transmission**, but also states that virologically-suppressed treated women with good adherence choosing to breastfeed may be **clinically supported** to do so
- Guidelines on diagnostics for breastfed infants and maternal viral load monitoring reflect this, but **little is known about current clinical practices**. Data are lacking on breastfeeding by WLHIV in resource-rich settings
- The Integrated Screening Outcomes Surveillance Service (ISOSS) is placed to collect this **data in the UK on a population level**

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Methods

- The **Integrated Screening Outcomes Surveillance Service (ISOSS)** is part of Public Health England's Infectious Diseases in Pregnancy Screening Programme (IDPS)
- Reporting to ISOSS is part of the NHS IDPS service specification. ISOSS builds on the well-established National Surveillance of HIV in Pregnancy & Childhood (NSHPC) to collect data on all screened for infections in pregnancy (HIV, syphilis and Hepatitis B) and their outcomes.
- **All pregnancies to women living with HIV, their children and any children diagnosed with HIV (<16yrs age) are reported**
- Running for 30 years the NSHPC (now ISOSS) holds data on over 25,000 pregnancies and their children
- Data on supported breastfeeding (in accordance with BHIVA guidelines) has been collected since 2012, enhanced surveillance has been carried out since August 2018.

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BHIVA feeding guidelines

BHIVA 2018 guidelines for management of supported breastfeeding (BF) include:

- **Mother and infant should be reviewed monthly in clinic for HIV RNA viral load testing during, and for 2 months after stopping BF**
- **Maternal cART (rather than infant pre-exposure prophylaxis) is advised to minimise HIV transmission and safeguard mothers' health**
- **Infant HIV antibody testing for seroreversion should be checked at age 18–24 months**
- **BF for as short a time as possible, exclusively for the first 6 months, and cease if:**
  - **signs of breast infection/mastitis**
  - **mother or infant has gastrointestinal symptoms**
  - **blip in maternal viral load**

www.bhiva.org/pregnancy-guidelines

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BHIVA statement on management of a pregnant woman living with HIV and infant testing during Coronavirus (COVID-19)

Advice from the British HIV Association (BHIVA)

Wednesday 25 March 2020

Management of a woman living with HIV while pregnant during COVID-19

Monitoring by HIV physicians may be reduced based on clinician assessment of HIV treatment and its efficacy but with a minimum of one initial contact/bloods (virtual or in person), one second trimester contact (virtual or in person) and one final visit in person at 36/40 for bloods and confirmation of the birth plan. Should further support be required antenatally and/or postnatally, virtual follow-up by phone is encouraged.

Breastfeeding should be discouraged as it requires monthly maternal and infant viral load follow-up for the duration of the breastfeeding period and for 2 months post-cessation of breastfeeding.

during, and

IV

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Methods

Enhanced surveillance is now part of the secure online collection for maternity and paediatric respondents and **covers all cases of planned/supported breastfeeding.**

Questions include:

- Reasons for wanting to breastfeed
- Whether the woman's partner and GP knew her HIV status
- Duration of breastfeeding
- Whether any mixed feeding occurred before 6 months of age
- Details of maternal and infant test results during breastfeeding
- Maternal cART during breastfeeding
- Infant confirmatory antibody tests (18-24mths)

We describe cases reported to ISOSS by March 2020

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Results

Among 9133 livebirth deliveries to HIV diagnosed women 2012-2020:

- **151/9133 (1.8%)** were reported as **supported to breastfeed**
- **20/151** were women who were supported to breastfeed more than one infant

- **95%** (143/151) were pregnancies to women **diagnosed before pregnancy**
- **85%** (129/151) were pregnancies to women **born abroad (majority from Sub-Saharan Africa)**

- Median age at delivery was 35yrs (IQR: 31,40)

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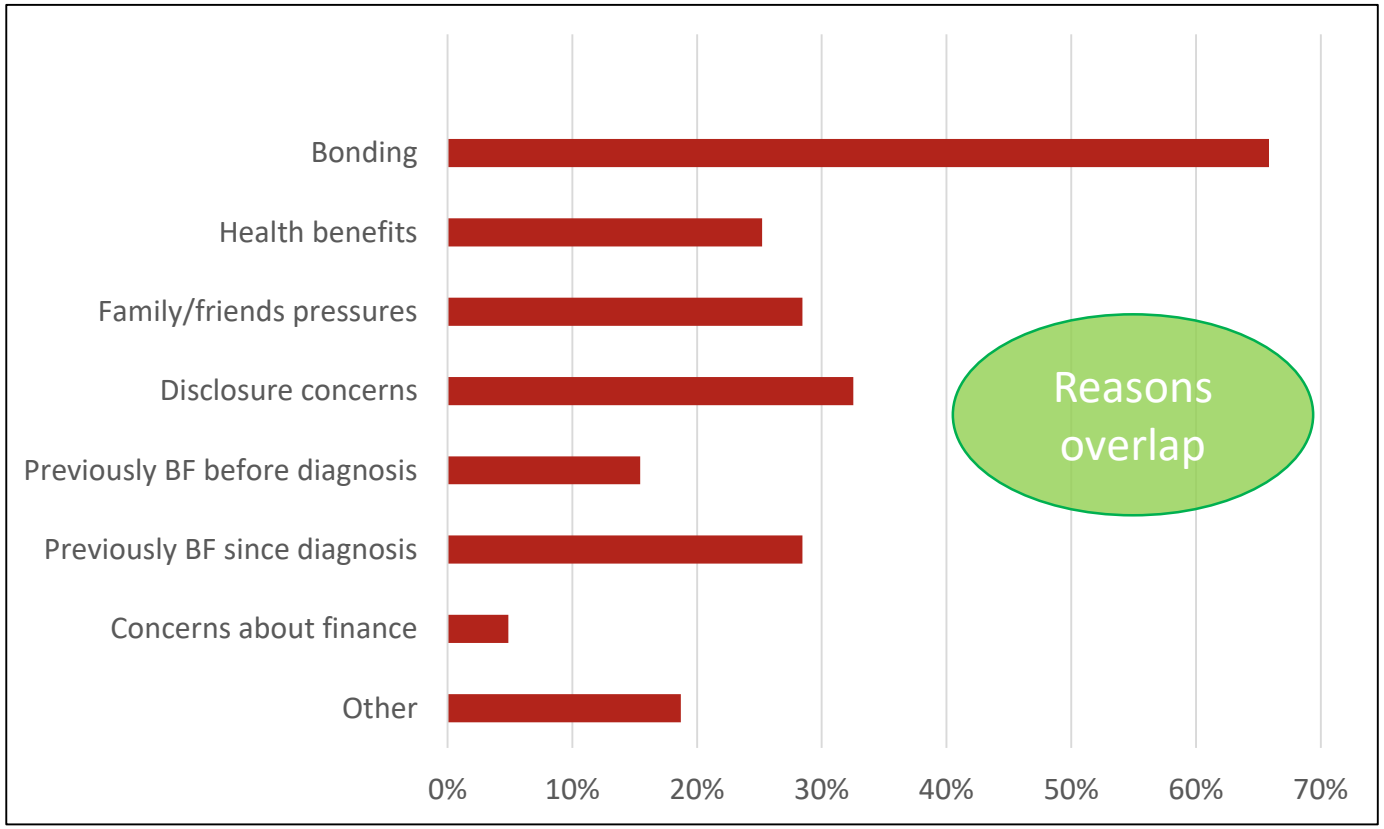
Results

Reported reasons for breastfeeding (n=123)



Partners were unaware of maternal HIV status in 22/123

7/22 both unaware

GPs were unaware in 12/123

Problems with attendance for monthly VL testing reported in 28/127

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Duration

Breastfeeding was reported to have stopped in 120/151, 6/151 not known (lost to follow-up)

Wide range of duration: ranged from 1 day- 2 years

Median duration: 7wk (IQR: 3, 16)

Variety of reasons for stopping/starting formula included:

- part of a plan to stop (51)
- mastitis (3)
- viral load rebound (7)
- travel/testing burden (1)

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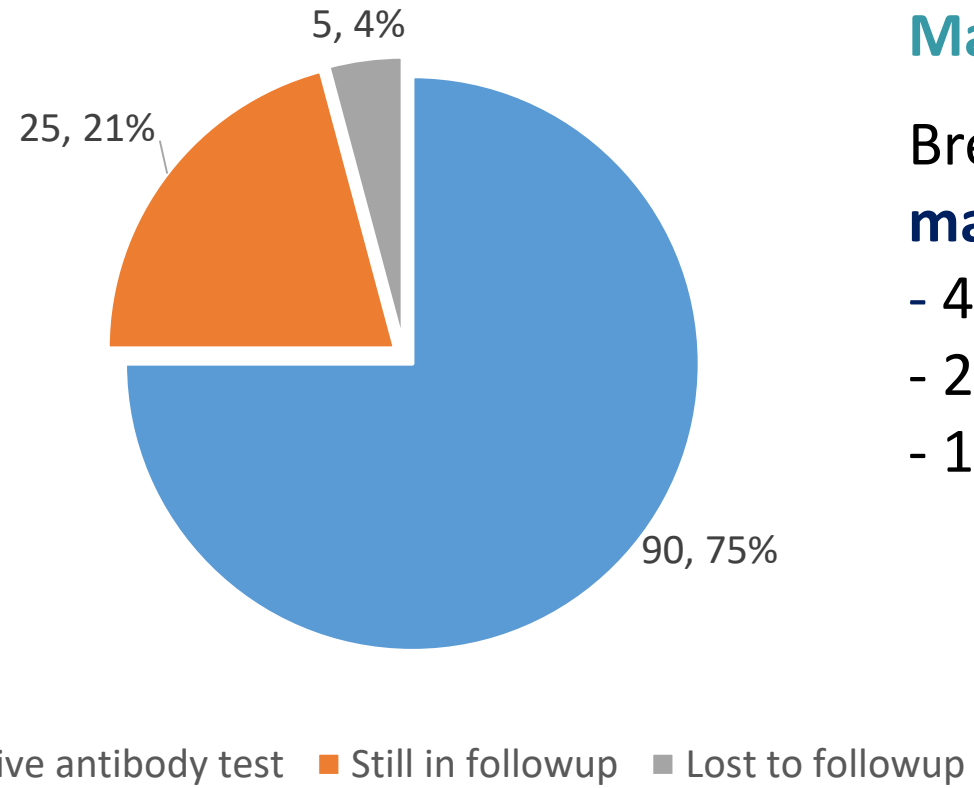
Current status

Among the 120 infants where breastfeeding had stopped..

Infant follow-up



Maternal viral load blips:

Breastfeeding reported to have **stopped owing to maternal VL rebound in 7/120:**

- 4/7 discharged uninfected
- 2/7 still in follow-up
- 1/7 lost to follow-up

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Conclusions

Numbers remain small and cases to date have been diverse particularly regarding duration and attendance for monthly testing.

Ongoing monitoring is essential, including early identification of VL blips and establishment of infection status post-breastfeeding cessation.

Our results highlight the importance of an MDT approach and an awareness of the BHIVA guidelines including the 'Safer Triangle’.

Although results show no VTs among supported BF cases so far, in the 2015-16 VTs reported there was one postnatal transmission likely due to covert BF breastfeeding by a woman who was undetectable throughout pregnancy.

ISOSS is uniquely placed to continue monitoring the national picture and assess the impact of COVID on clinical care.

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Integrated Screening Outcomes Surveillance Service (ISOSS)

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