SCENARIO

Maternal Medicine- Intrapartum HIV

LEARNING OBJECTIVES

To be aware of the management of unbooked women with an unknown HIV status
Be able to counsel women on potential new diagnosis of HIV
To liaise with multidisciplinary team regarding management of untreated women with HIV in labour
Discuss mode of delivery in case of untreated HIV
Initiate medical management
Arrange Postnatal management and follow up

EQUIPMENT LIST

Labour ward bed
Blood bottles/request forms
Phone
IVC/venepuncture kit
BP/pulse oximeter
USS

PERSONNEL

MINIMUM:
ROLES:
Patient
Midwife
Obstetrician
Paediatrician
GUM/ID (voice /facilitator)

FACULTY

MINIMUM: 2
Facilitator
Debrief Lead

TIME REQUIRMENTS
TOTAL 50 minutes

Set up: 10 mins
Pre Brief: 5 mins
Simulation: 15mins
Debrief: 20mins

INFORMATION TO CANDIDATE

PATIENT DETAILS

Name: Halima Sanyang
Age: 22
Weight/BMI: 54kg/ 20

Phx: nil
Allergies: nil

SCENARIO BACKGROUND

Location: Labour Ward

Situation:

Halima has been referred to labour ward from A&E where she presented with intermittent abdominal pain. On examination she was found to have a gravida uterus. The pregnancy has been concealed and Halima has not accessed any antenatal care. She gives a history of being sexually assaulted in Gambia before travelling to the UK seeking asylum. She speaks little English and the use of a phone interpreter has been required. The midwife has performed an initial assessment. Her observations are normal, FH 135bpm, SFH 39cm. She is contracting 4/10, there is no history of rupture of membranes. Vaginal examination: 3cm dilated fully effaced, cephalic presentation PP-1.

Task:

The midwife has suggested she take some booking bloods but would like you to review the patient in case she requires any additional investigations.

RCOG CURRICULUM MAPPING

Module 9 Maternal Medicine
HIV
Module 10 Management of Delivery
Evaluate clinical risk
ATSM
Advanced antenatal practice 2: Infections in pregnancy
Advanced Labour ward 12: Medical disorders on LW
Maternal Medicine 16: Medical disorders on LW

INFORMATION FOR ROLEPLAYERS

BACKGROUND

Your name is Halima Sanyang. You are 22 years old. You are originally from Gambia but have fled with your sister to the UK to seek asylum. Your English is limited and you require a phone interpreter. Before leaving Gambia you were raped by an accompanying asylum seeker. You didn't realise you were pregnant until arriving in the UK 2 months ago. You have been too scared to tell anybody and have not accessed any medical care. You are usually well, with no regular medications or allergies. You have never had any surgery. You have never been pregnant before. You do not recall when your last period was.

You started with severe pains last night. You have felt the baby moving. Your sister has forced you to come to see a doctor.

RESPONSES / QUESTIONS

You have had no bleeding or watery discharge.
Pain started five hours ago, getting much worse.
What does HIV infection mean for me and my baby?
What is the chance of my baby getting HIV?
Can I have a normal delivery?
Can I breast feed?
Can I stop the medications once baby is born?
Will my baby need any medications?

INFORMATION TO FACILITATOR

SCENARIO DIRECTION

Trainee to take a brief and focused history.
Recognition of concealed pregnancy and high risk of HIV.
Trainee to request booking bloods (FBC, blood group/ antibodies, HBV/HCV serology, syphilis, rubella, HIV, Haemoglobinopathy screen) aware not all results immediate
AND point of care test (POCT) for HIV- urgent discussion with microbiology/virology
Inform Paediatricians – unbooked presentation in labour

USS presentation by most experienced practitioner available- presentation, placental site, number of fetus, gross abnormality, approximate gestation

Social Services- check child protection registry

POCT +ve, highly reactive:
Trainee to discuss results with patient
Inform obstetric consultant
Urgently inform Infectious Disease /GUM consultant
Inform paediatricians

Send confirmatory HIV-1 serology, resistance screen (can be sent at a later date), CD4 count and viral load (will not get immediate results)

SCENARIO DIRECTION (cont.)

Halima is now 4 cm dilated and contracting well- Requires initiation of preventative maternal to child transmission treatment (PMTCT)

1. dose of nevirapine 200mg (consider double dose of tenofovir if believe baby to be premature and may not be able to swallow antiretrovirals [ARVs])
2. fixed dose oral zidovudine with lamivudine and raltegravir (HAART)
3. continuous IV infusion of zidovudine for the duration of labour /delivery (2mg/kg over one hour then 1mg/kg until cord is clamped. Dilute with 500mls 5% dextrose)

Discussion of mode of delivery:
Emergency Lower Segment caesarean section at least 2 hours post nevirapine as delivery not imminent

Postnatal:
HIV Physician follow up
Carbergoline - avoidance of breast feeding (16% transmission in 2 years)
Post partum- in accordance with BHIVA adult guidelines, ARVs to be continued for all HIV patients, decision by ID consultant

Baby requires:
HIV pro-viral DNA PCR, FBC, U&E, LFTS and triple therapy (Zidovudine and lamivudine 4 weeks and nevirapine for 2 weeks)
BCG: given 12-14 weeks when exclusively formal fed infant confirmed uninfected with HIV
Further HIV testing 6 weeks, 12weeks and 12-18 months for proof of negativity.

SCENARIO DEBRIEF

TOPICS TO DISCUSS

Risk factors for HIV infection

Diagnostic tests available for HIV

Mode of delivery in HIV patients: refer to

www.bhiva.org/documents/guidelines/pregnancy

Importance of MDT involvement

Risk of Mother to child transmission (MTCT):

1993 25.6%

2000-2006 1.2% <1% ART within 14days

2007-2011 0.57%

Risk reduction strategies

REFERENCES

British HIV Association guidelines for the management of HIV infection in pregnant women 2012 (2014 Interim review) HIV medicine(2014) 15Suppl. 4), 1-77

HIV in pregnancy Jessop wing Maternity Services Clinical Practice Guideline 2014)