Editorial

HIV INFECTION AND OBSTETRIC PRACTICE

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MJAFI 1994; 50 : 02-03

KEY WORDS : HIV infection in Obstetrics & Gynaecology

First HIV seropositive individual in India was identified in 1986 among the prostitutes of Madras city. Since then the surveillance has revealed progressive increase in prevalence rate of seropositivity from 0.2% in 1986 to 0.7% in 1992. Upto 31 Oct 1992, out of a total of 242 AIDS cases in India, 55 were females [1]. The number of AIDS cases in women is increasing and by the year 2000 A.D. it is estimated that the annual number of fresh AIDS cases in women and men will be equal [2]. Most of the women don't know that they are infected and HIV infection does not reduce fertility. The increasing incidence of HIV infection among women will result in a corresponding increase in the number of babies acquiring the infection from their mothers, as 20 to 50% infected pregnant women will pass the virus to their off-springs [3], before, during or shortly after birth, by transplacental passage of virus, exposure to infectious maternal blood and vaginal secretions during labour, or breast feeding [4].

We still don't know why some of the children will be infected while many of them will not be. Almost all the infected infants will succumb to the disease by the age of 5 years and of the uninfected 75% are likely to be orphaned by 5 years of age. It is important that the baby's risk of HIV infection through breast feeding be weighed against its risk of dying of other causes, if breast feeding is denied. Therefore, where the primary causes of infant death are infectious diseases and malnutrition, infants who are not breast fed

run a particularly high risk of dying from these conditions and breast feeding should remain the standard advice to HIV infected women [3].

Pregnancy outcome for both mother and baby is not significantly different between HIV positive and matched HIV negative women [5]. The Obstetric management of HIV seropositive women is not much different from sero-negative women. Pregnancy does not affect the course of HIV infection in the asymptomatic individual but women with AIDS are at risk of severe opportunistic infection whilst pregnant [6]. Whether these women will benefit from antiretroviral therapy is controversial but foetal malformation, excess prematurity or foetal toxicity have not yet been attributed to the use of this drug [7].

If a women of reproductive age gets infected with HIV, she should be advised for prevention of pregnancy or if she gets pregnant, she should be informed that her baby has a chance of being infected and should be given medical, social and psychological support for her decision to either carry or terminate the pregnancy. When an infected pregnant woman desires an induced abortion, or sterilisation as a means of permanent contraception or has to be delivered, the obstetrician is at a greater risk of exposure to infected blood and amniotic fluid entering through exposed skin or mucous membranes.

Therefore it is imperative that surgeon should take precautions against HIV infection even if the patient is sero-negative because

the patient may be incubating the virus and antiHIV antibodies may not have appeared yet in her blood. Adequate precautions e.g. protective head-wear, water-proof gowns, double latex gloves, avoiding penetration of skin by sharp instruments by being cautious and no-touch suturing techniques, should be observed. In case skin is cut or punctured the wound should be bled and washed with surgical soap or 70% isopropyl alcohol. A 6-week course of azidothymidine (AZT) within one hour of exposure should be considered. The affected individual should undergo HIV testing at 3,6 and 12 months [4].

All seropositive women should have the benefits of counselling and health education. Option regarding contraceptive care, use of azidothymidine (AZT), medical termination of pregnancy, provision of appropriate antenatal, intrapartum and postnatal care should be explained and appropriate care provided. All prophylactic and curative therapeutic procedures including elective and emergency surgery should be made available to all sero-positive women. Though there is a need to take up screening of all pregnant

women, it is impossible at present. However, HIV testing should be undertaken in high risk groups. Under the existing circumstances most asymptomatic sero-positive mothers will remain undetected.

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