Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Pathway

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EXCLUSION CRITERIA

- Potentially exposed person with existing HIV infection
- Neonates (postnatal age < 4 weeks)

GUIDELINE INCLUSION CRITERIA

High-risk encounters with exposure < 72 hours of presentation: (1)
Anal, vaginal, percutaneous or oral exposure to possible or definite HIV infected blood, semen, or genital fluids (2) (3)

(1) Timing
PEP is most effective if started as soon as possible, ideally within 24 hours

(2) Low risk
Saliva, vomit, feces, and percutaneous needle-sticks; consider contacting ID prior to starting HIV PEP for these exposures

(3) Possible or definite HIV exposures
High risk for being HIV+ includes persons who inject drugs, engage in male-male sex, or have multiple sex partners. Sexual assaults with multiple assailants or significant trauma to vaginal or anal mucosa are also considered high risk

Order Labs:

- HIV 1/2 Ag/Ab
- Complete blood count with differential
- Comprehensive metabolic panel
- Hepatitis B surface antigen
- Hepatitis B surface antibody
- Hepatitis B core antibody
- Hepatitis C antibody
- Pregnancy Test (child bearing age, (ie pubertal)

Additional labs in cases of sexual assault:

- Rapid plasma reagin (RPR)
- Gonorrhea
- Chlamydia

Patient/family Consent to treatment?

NO → Contact ID for further steps

Yes

Initiate 3-drug regimen for 28 days

Infants 4 weeks to < 2 years old:

- Lamivudine (oral solution 10 mg/mL)
  - 4 mg/kg/dose BID (max 150 mg/dose)
- Zidovudine (oral solution 10 mg/mL)
  - 4-8 kg: 12 mg/kg/dose BID
  - 9-29 kg: 9 mg/kg/dose BID
  - ≥ 30 kg: 300 mg/dose BID
- Kaletra [Lopinavir/Ritonavir] (oral solution 400 mg-100 mg/5mL):
  - ≤ 12 mo: 16 mg/kg/dose BID
  - > 12 mo: weight based dosing
    - < 15 kg: 12 mg/kg/dose BID
    - 15-40 kg: 10 mg/kg/dose BID
    - > 40 kg: 400 mg BID
  - *If > 10 kg and can chew, can substitute Kaletra with Raltegravir*

≥ 2 years old AND < 35 kg OR
≥ 2 years old AND CANNOT swallow tablets

- Tenofovir (powder for suspension)
  - 8 mg/kg (max 300 mg) PO once daily
- Emtricitabine (oral solution 10 mg/5 ml)
  - 6 mg/kg (max 240 mg) PO once daily
- Raltegravir (chewable tablets 100 mg)
  - 11-13 kg: 75 mg PO BID
  - 14-19 kg: 100 mg PO BID
  - 20-27 kg: 150 mg PO BID
  - 28-39 kg: 200 mg PO BID
  - 40 kg or > 12 yo: 300 mg PO BID

≥ 2 years old AND
≥ 35 kg AND CAN swallow tablets:

- Truvada (Tenofovir 300 mg & Emtricitabine 200 mg): 1 tablet once daily
- Dolutegravir: 50 mg once daily

Post-Exposure Management for Hepatitis B Virus

Post-exposure monitoring and follow-up

Monitoring and follow-up are necessary even if PEP is not used

! ALERT
Contact Pharmacy for renal dosing recommendations for patients with estimated CrCl ≤ 59 ml/min

dell children's Ascension

Last Updated November 2024

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Indications

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PEP INDICATIONS: PEP prophylaxis should be initiated as soon as possible, ideally within 1 to 4 hours and no more than 72 hours after the exposure. If the exposure occurred more than 72 hours before presentation, PEP is unlikely to be effective in reducing transmission. Even if PEP is not initiated, testing and follow up are still indicated.

PEP is recommended in several instances regardless of the HIV status, however sources considered to be of a higher risk for HIV include those with a history of multiple sexual partners, needle-sharing behavior, trading sex for money or drugs, men who have sex with men, and those with a sexually transmitted disease.

Consideration of PEP According to the Type of Risk Exposure	

SUBSTANTIAL Risk for HIV Acquisition
 	
PEP Should Be Recommended
	• Source of body fluids is known to be HIV-positive and the reported exposure presents a substantial risk for transmission
	  ○ Receptive anal intercourse
	  ○ Needle sharing during injection drug use
	  ○ Percutaneous needle stick injuries†
	  ○ Human bites with skin break (visible blood)
	  ○ Blood transfusion

Case-by-Case Evaluation for PEP
 	
Assess for factors that increase risk for HIV acquisition and discuss risks/benefits with patient/caregiver before recommending initiation of PEP
	• HIV infection of the source of the body fluids is unknown and the reported exposure presents a substantial risk for transmission if the source did have HIV infection
	  ○ Insertive anal intercourse
	  ○ Insertive penile-vaginal intercourse.
	  ○ Oral-vaginal contact (receptive and insertive).
	  ○ Oral-anal contact (receptive and insertive).
	  ○ Receptive penile-oral contact with or without ejaculation.
	  ○ Insertive penile-oral contact with or without ejaculation.

	Factors that increase risk: • Source of exposure is known to be from a group with a high prevalence of HIV infection (i.e. man who has sex with men, person who injects drugs who shares needles or other equipment). • An oral mucosa that is not intact (e.g., oral lesions, gingivitis, wounds). • Blood exposure — it is important to note that blood exposure can be minimal and therefore not recognized by the exposed person. If the exposed person reports frank blood exposure, PEP would be indicated. • Presence of genital ulcer disease or other sexually transmitted infections.
Negligible Risk for HIV Acquisition **PEP IS Not Recommended**	• Kissing (unless mucosal not intact). • Oral-to-oral contact without mucosal damage (mouth-to-mouth resuscitation). • Human bites without breaking the skin (not involving blood). • Exposure to solid-bore needles (used for tattoo or diabetes lancets) or sharps not in recent contact with blood. • Mutual masturbation without skin breakdown or blood exposure. • Care sought > 72 hours after potential exposure.

† No HIV infections have occurred from percutaneous needle stick injuries, however concern exist that syringes discarded by people who inject drugs might pose a substantial risk. However, such injuries typically involve small-bore needles that contain only limited amounts of blood, and the infectiousness of any virus present might be low. The decision to offer PEP should be made on a case-by-case basis.

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Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Exposure Risk

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Risk of HIV acquisition depends on the characteristic of the exposure and it is important to understand risk of transmission when first evaluating the pediatric patient. This information can be used by physicians and parents to decide if use of PEP would be beneficial. Risk of HIV transmission is summarized below. Providers should consider three main factors when determining if PEP is indicated 1) whether the exposure source is known to have HIV infection 2) to which potentially infected body fluid(s) the patient was exposed, and 3) the exposure site or surface.

Exposure type	Rate for HIV acquisition per 10,000 exposures
Parenteral	
Blood transfusion	9,250
Needle sharing during injection drug use	63
Percutaneous (needlestick)	23
Sexual	
Receptive anal intercourse	138
Receptive penile-vaginal intercourse	8
Insertive anal intercourse	11
Insertive penile-vaginal intercourse	4
Receptive oral intercourse	Low
Insertive oral intercourse	Low
Other[b]	
Biting	Negligible
Spitting	Negligible
Throwing body fluids (including semen or saliva)	Negligible
Sharing sex toys	Negligible

Source: http://www.cdc.gov/hiv/policies/law/risk.html

[a] Factors that may increase the risk of HIV transmission include sexually transmitted diseases, acute and late-stage HIV infection, and high viral load. Factors that may decrease the risk include condom use, male circumcision, antiretroviral treatment, and preexposure prophylaxis. None of these factors are accounted for in the estimates presented in the table.

[b] HIV transmission through these exposure routes is technically possible but unlikely and not well documented.

Prior to initiation of antiretroviral (ARV) therapy the following topics should be discussed with the family/child/adolescent/guardian. Suggested scripting for conversations with patients.
The significance and timing of the exposure in relationship to the potential risk of HIV transmission. PEP prophylaxis should be initiated as soon as possible, ideally within 1 to 4 hours and no more than 72 hours after the exposure. If the exposure occurred more than 72 hours before presentation, PEP is unlikely to be beneficial in reducing transmission.
Assess readiness and likeliness of adherence for the family/caregiver(s) to administer and/or child/adolescent to take ARV, which includes 2-3 drugs for 28 days.
The importance of clinical and laboratory follow-up with appropriate providers, even if PEP is not initiated, testing and follow-up are still indicated.
The potential risks and benefits of ARV for PEP, including the high likelihood of **common side effects occurring**.
Contact provider immediately if experience the following signs and symptoms - fever, generalized lymphadenopathy, pharyngitis, rash - which may indicate acute HIV infection.

PEP REGIMENS

The choice of PEP in the pediatric population is influenced by availability of pediatric formulations, reported side effects/toxicity, and cost. No strong evidence exists, based on randomized clinical trials that any specific combination of antiretroviral medication is optimal for PEP and these regimens are based on expert opinion and experience with antiretroviral combinations that demonstrate maximal suppression of viral replication and medication tolerance/adherence.

Age Group	Preferred Medication
4 weeks (postnatal age ≥ 28 days, postmenstrual age ≥ 42 weeks) to < 2 years	A 3 drug regimen consisting of zidovudine, lamivudine, and lopinavir/ritonavir
≥ 2 years old AND <35 kg OR ≥ 2 years AND CANNOT swallow tablets	A 3 drug regimen consisting of tenofovir, emtricitabine, and raltegravir
≥ 2 years old AND ≥ 35 kg AND CAN swallow tablets	A 3 drug regimen consisting of tenofovir, emtricitabine, and dolutegravir

If the source of exposure is known to be HIV infected, consider ID consultation to guide medication selection for PEP. Medications should be made available to the patient in sufficient supply to complete a course of prophylaxis which is 28 days. Providers may consider an alternative regimen if the patients is unable to tolerate or there is concern for toxicity, however strongly recommend consultation with an experienced HIV/ Infectious Diseases provider when considering alternatives.

Additional information can be accessed online in the Pediatric ARV Guidelines Appendix A: Pediatric Antiretroviral Drug Information accessible at https://clinicalinfo.hiv.gov/en/guidelines/pediatric-arv/overview-0?view=full

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Regimens

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Infants 4 weeks to < 2 years old

For dosing recommendations for postnatal age < 4 weeks and weight < 10 kg strongly recommend consultation with an experienced HIV/Infectious Diseases provider.

Medication	Dosage Forms	Dose	Considerations
Lamivudine (3TC - Epivir)	**10 mg/mL oral solution** (preferred) 150 mg tablet (scored) 300 mg tablet	4 mg/kg (max: 150 mg) twice daily	**Administration:** -Without regard to food -Solution strawberry-banana flavor and contains 6% volume/ volume alcohol and 3 gram sugar **Adverse effects:** Headache, nausea **Dosage adjustment required in renal insufficiency**
Lopinavir/ritonavir (RTV - Kaletra)	**80/20 mg/mL oral solution** (preferred) 100 mg lopinavir/25 mg ritonavir tablet 200 mg lopinavir/50 mg ritonavir tablet	***Dose based on Lopinavir component** **Infants < 12 months old:** 300 mg/m2/dose BID (or 16 mg/kg/dose BID) **> 12 months old** < 15 kg: 12 mg/kg/dose BID 15-40 kg: 10 mg/kg/dose BID > 40 kg: 400 mg BID	**Administration:** -Oral solution: high-fat meal -Tablets: without regard to food **Adverse Effects:** nausea, vomiting, diarrhea, fatigue, headache, rash, QT interval prolongation, elevated transaminases **Potential for CYP3A4 drug interactions**
Zidovudine (ZDV; AZT - Retrovir)	**10mg/mL syrup** (preferred) 100 mg capsule 300 mg tablet	**Infants and children aged ≥35 weeks post-conception and at least 4 weeks post-delivery:** 4 to < 9 kg: 12 mg/kg/dose twice daily 9 to < 30 kg: 9 mg/kg/dose twice daily ≥ 30 kg: 300 mg twice daily	**Administration:** -Without regard to food -Solution strawberry flavor and contains sodium benzoate **Adverse effects:** Nausea, vomiting, headache, insomnia, and fatigue. anemia and neutropenia **Dosage adjustment required in renal insufficiency**

¥ All recommended medications must be taken together at the same time

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Regimens

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≥ 2 years old AND < 35 kg
OR
≥ 2 years old AND CANNOT swallow tablets

Medication	Dosage Forms	Dose	Considerations
Tenofovir disproxil fumarate (TDF - Viread) ***Also available as compnent of fixed-dose combination, Truvada (200 mg emtricitabine + 300 mg TDF)**	40 mg/gram powder 150 mg tablet 200 mg tablet 250 mg tablet 300 mg tablet	**Children aged > 2 years (powder):** 8 mg/kg once daily (max 300 mg daily) *1 scoop = 40 mg (round to nearest 1/2 scoop) **Children aged > 2 years (tablet):** 17-21 kg: 150 mg once daily 22 to 27 kg: 200 mg once daily 28 to 34 kg: 250 mg once daily ≥ 35 kg: 300 mg once daily (consider fixed dose combo Truvada)	**Administration:** -tablet may be crushed and dissolved in water, grape juice, or orange juice **Adverse effects:** nausea, diarrhea, vomiting, flatulence, osteomalacia and reduced bone density, renal toxicity, lactic acidosis **Contraindications:** Nephrotoxicity; should not be administered to persons with acute or chronic kidney injury or those with eCrCl < 60 ml/min Dosage adjustment or alternative regimen required in renal insufficiency
Emtricitabine (FTC - Emtriva) ***Also available as component of fixed-dose combination, Truvada (200 mg FTC + 300 mg TDF)**	10 mg/mL oral solution 200 mg capsule	**Children > 2 years (solution):** 6 mg/kg/dose once daily (max 240 mg) **Children > 2 years (capsule):** > 33 kg: 200 mg once daily (consider fixed dose combo Truvada)	**Administration:** -Without regard to food -Solution cotton candy flavor **Adverse effects:** headache, insomnia, diarrhea, nausea, rash, hyperpigmentation/skin discoloration on palms and/or soles, neutropenia, lactic acidosis **Warnings:** Hepatitis exacerbations in HBV-coinfected patients; hepatic function tests should be closely monitored when regimen is stopped **Contraindications:** Do not administer with lamivudine
Raltegravir (RAL - Isentress)	Chewable tablet: 25 mg or 100 mg 400 mg film-coated tablet	**Children > 2 years (chewable tablets):** 11-13 kg: 75 mg twice daily 14-19 kg: 100 mg twice daily 20-27 kg: 150 mg twice daily 28-39 kg: 200 mg twice daily ≥ 40 kg: 300 mg twice daily	**Administration:** - Give dose 2 hours before or a 6 hours after cation-containing medications or products (aluminum, magnesium, etc.) -Chewable tablets: orange-banana flavored, contains phenylalanine -Chewable tablets: May be crushed and dissolved in 5 mL of liquid. Must be taken within 30 minutes **Adverse effects:** insomnia, nausea, diarrhea, fatigue, headache, dizziness, itching, skin and hypersensitivity reactions **Potential drug interactions w/ UGT1A1 metabolizers**

¥ All recommended medications must be taken together at the same time

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Regimens

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Age ≥ 2 years old AND ≥ 35 kg AND CAN swallow tablets

Medication	Dosage Forms	Dose	Considerations
Truvada (FTC + TDF)	Fixed-dose tablet (200 mg FTC + 300 mg TDF)	**1 tablet once daily**	**Administration:** -Take without regard to food -May split tablets and/or crush and stir into water, grapefruit juice, or orange juice *see previous table for individual components warnings/side effects
Dolutegravir (DTG - Tivicay)	50 mg Tablet	**1 tablet once daily**	**Administration:** -Take without regard to food -Take 2 hours before and 6 hours after taking cation-containing antacids or laxatives, sucralfate, oral iron supplements, oral calcium supplements, or buffered medications -Tablet may be crushed and added to small amount of semisolid food or liquid to be consumed immediately **Adverse effects**: insomnia, headache, hypersensitivity reactions including rash, constitutional symptoms and organ dysfunction **Drug Interactions:** UGT1A1 and CYP3A substrate

¥ *All recommended medications must be taken together at the same time*

Post Exposure Management for Hepatitis B Virus (HBV)

Transmission of HBV occurs at a rate of 23-62% during needle stick injury between health care personnel and HBV-positive sources and it can survive on environmental surfaces at room temperature for at least 7 days. Immune status against Hepatitis B after a needle stick in the community should be evaluated.

Post Exposure Management for Hepatitis B Virus (HBV)			
	Source		
Exposed person	**HBsAG (-)**	**HBsAG (+)**	**Unknown**
Unimmunized **Not completed 3-dose series**	Vaccinate	Vaccinate + HBIG	Vaccinate + HBIG
Previously immunized **Known nonresponder**	No treatment	Vaccinate + HBIG 1-2 doses	Vaccinate + HBIG If high-risk source
Previously immunized **Known responder** **(anti-HBs ≥ 10 mIU/mL)**	No treatment		
Previously immunized **anti-HBs level unkown**	No treatment	Test anti-HBs If < 10 mIU/mL then Vaccinate + HBIG	
Abbreviations:			
HBsAG: Hepatitis B surface antigens			
HBIG: Hepatitis B immune globulin			
anti-HBs: Hepatitis B surface antibodies			
Treatment notes:			
Vaccine series should be started as soon as possible after exposure preferably within 24 hours and then completed using age-appropriate dose and schedule.			
HBIG dose = 0.06 mL/kg IM			

Monitoring after Exposure and initiation of PEP

The exposed child should follow-up with an Infectious Diseases provider within 5 days after the exposure to review the medication regimen, assess adherence, and address any other needed follow up counseling or monitoring. Patients should be encouraged to continue to follow-up over the next several weeks to months so the provider can continue to closely monitor for medication-induced toxicities, continue HIV testing after exposure, assess adherence, and continue to provide support. If the source of exposure is known consider testing the source for HIV. If source of the exposure is confirmed to be HIV negative and there is no evidence of acute retroviral syndrome, PEP may be discontinued. Further follow up, with an HIV/Infectious Diseases provider, as indicated below is recommended:

Monitoring After Exposure and Initiation of PEP				
	Baseline	**4-6 weeks after exposure**	**3 months after exposure**	**6 months after exposure**
Clinic Visit*	✓	✓	✓	✓
HIV 1/2 Ag/Ab*	✓	✓	✓	✓
CBC with diff	✓	✓	✓	
CMP	✓	✓		
Hepatitis B surface antigen*	✓			✓
Hepatitis B surface antibody*	✓			✓
Hepatitis B surface core antibody	✓			✓
Hepatitis C antibody*	✓			✓
For all persons with exposure during sexual encounter				
Syphilis serology (RPR)*	✓	✓		✓
Gonorrhea‡	✓	✓	✓	
Chlamydia‡	✓	✓	✓	
Pregnancy Test†	✓	✓	✓	
Recommend all patients follow-up with an Infectious Diseases provider within 5 days after exposure				
*Recommended even if PEP is declined				
‡Gonorrhea and Chlamydia testing is indicated at 4-6 weeks if the patient is symptomatic or no presumptive treatment at baseline. If the patient tested positive for either disease at baseline testing				
†Recommended for females with a self-reported history of meses and/or other signs of puberty				

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis References

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BACKGROUND

Potential HIV exposures in children occur most often by accident (e.g., needle sticks in the community, fights, or playground incidents resulting in bleeding by an HIV-infected child) or by sexual abuse or assaults.

HIV post-exposure prophylaxis (PEP) is the use of antiretroviral drugs, after a single high risk event to prevent viral replication or attachment.

The following guideline is based on the 2016 Centers for Disease Control and Prevention (CDC) non-occupational exposure to HIV guidelines, 2003 statement concerning pediatric PEP from the American Academy of Pediatrics, the New York Department of Health recommendations for pediatric PEP, and a systematic review in choices of antiretroviral drugs for PEP for children.[1-4]

The objective of this guideline is to help medical providers to identify and offer PEP to pediatric patients with potential HIV exposures.

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Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Summary

Evidence Based Outcome Center

EBOC Project Owner: Dr. Marisol Fernandez, MD

Approved by the HIV Post Exposure Prophylaxis Evidence-Based Outcomes Center

Next Full Review: November 2028

Algorithm Revision History	
June 20, 2016	Date Approved
January 10, 2019	Last Revision
October 2024	Review of Literature specifically the 2016 CDC Guidelines for PEP after nonoccupational exposure to HIV and 2023 New York State Department of Health AIDS Institute PEP Guidelines. Changes to PEP Regimens: Change in Age group classification with major change coming from the patient's ability to swallow tablets. Simplified Dosing Tables within new classifications Updates to nPEP Algorithm to accommodate the new age/tablet swallowing ability classifications.

2024 EBOC Project Team (update/Review):

Marisol Fernandez, MD
Alec Wesolowski, PharmD
Cynthia McCune, PharmD
Katherine Snyder, MD
Melissa Cossey, MD
Thanhhao Ngo, PharmD
Claire Bundick, PharmD
Sheryl Yanger, MD
Carmen Garudo, EBOC PM

EBOC Leadership Committee:

Lynsey Vaughan, MD
Tory Myer, MD
Meena Iyer, MD
Melissa Cossey, MD
Nilda Garcia, MD
Sarmistha Hauger, MD
Patty Click, DNP
Sheryl Yanger, MD
Amanda Puro, MD

Pediatric Non-occupational (Community) Post-Exposure HIV Prophylaxis Conversation Script

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Suggested scripting for conversation about non-occupational and victims of sexual assault pediatric post exposure HIV prophylaxis

1) The significance and timing of the exposure in relationship to the potential risk of HIV transmission.
   - If reported exposure source is known to have HIV:
     - "It has been reported that the person that your child was exposed to is known to be HIV positive. Because it has been less than 72 hours since the exposure, we have the opportunity to treat your child with medications for HIV to reduce any chance that your child becomes HIV positive. The risk of transmission of HIV is small, but the consequences are significant, so it is highly recommended that your child receive this treatment."
   - If reported exposure source is unknown or his/her HIV status is unknown:
     - "It is possible that someone can have HIV and not appear to have symptoms, and it is also possible that, while you may feel that you know a person, you may not know everything about them, so we may not know the HIV status of the person your child was exposed to. Because it has been less than 72 hours since the reported exposure, you may choose for your child to receive medications to reduce the chance that your child becomes HIV positive. I can help you make this decision. Since we do not know whether your child was, in fact, exposed to the HIV virus, we will need to weigh this possible risk of not receiving the treatment with the pros and cons of receiving the treatment. I am going to explain to you what will be required if you decide to start the treatment for your child, so that you can make an informed decision."

2) Assess readiness and likeliness of adherence for the family/caregiver(s) to administer and/or child/adolescent to take antiretroviral therapy which includes 2-3 drugs for 28 days. Education on adherence is of the upmost importance.
   - "Post-exposure prophylaxis treatment requires 2-3 medications taken for 28 days. It is absolutely critical that your child not miss any doses and that they continue the treatment for the full 28 days. If your child has been exposed to the HIV virus, missing doses or not completing the treatment could increase the chance that your child will become positive, and the virus could develop resistance to the medications we are using to treat it."

3) The importance of clinical and laboratory follow up with appropriate providers, even if post-exposure prophylaxis is not initiated, testing and follow-up are still indicated.
   - "If you decide not to begin the treatment, it is still very important that your child continues to be tested for sexually transmitted infections until 3-6 months from the exposure. I will provide you instructions for when you will need follow-up and what will happen at each visit. Even if your child tests negative at today's visit, there is still a small chance that they could become positive at a later date, because the test may not detect the infection in the early stages. If you decide to begin the treatment, it is even more important to have good follow-up with a physician, not only to continue the testing, but to monitor for tolerance and side effects of the medications and identify other medical needs that may arise. You must be committed to attend these follow-up visits if you decide to start the medication."

4) The potential risks and benefits of antiretroviral therapy for post-exposure prophylaxis, including the high likelihood of common side effects occurring.
   - "Post-exposure prophylaxis treatment reduces the chance that your child becomes HIV positive, however it is not 100% effective and it can cause side effects that can cause your child to feel unwell. It is important that you know the side effects will be worse when your child first starts taking the medications but the side effects will likely go away over time. It is possible your child may experience upset stomach, vomiting, diarrhea, and/or trouble sleeping while taking the medications. Your doctor may be able to give your child additional medications to help with these side effects."

5) Contact provider immediately if experience the following signs and symptoms – fever, generalized lymphadenopathy, pharyngitis, rash – which may indicate acute HIV infection.
   - "Even if your child tests negative at today's visit, there is still a small chance that they could become positive at a later date, because the test may not detect the infection in the early stages. If your child starts to feel like they have the flu or has a fever, rash, sore throat, body rash, or swollen glands that lasts for several days to weeks please let your doctor know. These signs may indicate early HIV infection and your child needs to be seen by a doctor so more testing can be done. If given post-exposure prophylaxis today watch for these signs during the 28 days of prophylaxis and up to a month after it is finished."