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Paediatric HIV Guidelines

Summary – HIV Pathways

Referral from other hospital as admission to Pinckney ward or PICU according to clinical status

Attending ward due to acute illness as a known patient with 24/7 access to Pinckney ward

An unwell child suspected to be HIV infected should be seen by PID team

Out of hours phone call/queries to the on call paediatric registrar regarding HIV care, can be discussed via switch with 24/7 PID PID consultant on call.

Parents/others to contact the ward nurses or HIV specialist nurses that the child needs medical review. During day time PID registrar, out of hours the paediatric registrar need to be informed and review the child timely according clinical needs.

Follow up according to needs in either clinic, ward or via admission.

Attended Pinckney ward but found critically ill

Crash call, stabilise on PICU.

Conversaion with GP or referral of well child with suspected or known HIV from other hospitals

Referral letter fax to 02087253262 and phone call during day time to specialist nurses tel 0208725 3613

Follow up in HIV clinic or as ward attender on Pinckney ward

Paediatric HIV guide for Pinckney guidelines. Authors: Katja Doerholt, Sheila Donaghy, Sharon Storey, Caroline Campbell, Michelle Webber.
Approved Jan 2014
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Paediatric HIV Guidelines

Pathway of Paediatric HIV services at St George’s Hospital (SGH)

This document covers referral pathways for children with HIV infection who are under follow up at St George’s NHS trust.

Pathways
This section covers what route is likely to be most appropriate for patients presenting with possible or known HIV infection.

Newly diagnosed children

- Children/adolescents may present to SGH or are diagnosed in other hospitals in the South west. Children that are acutely unwell will get transferred to Pinckney ward or PICU depending on clinical need.
- Children that are clinically well and being referred with suspected HIV or already diagnosed from primary or secondary care, will be seen within 2 weeks in clinic or on Pinckney ward as a ward attender.

Children adolescents already in follow up with HIV infection at SGH

- If children are becoming unwell, they have 24/7 access to Pinckney ward. The parents are aware and have information/phone numbers made available.

Resources
There are several mechanisms for obtaining advice for queries in regards to HIV but also all other infectious diseases patients.

- Advice can be sought from Sheila and Sharon, specialist HIV nurses on 3613.
- For medical questions PID consultant on call via switch board (24/7) or PID registrar during the day time bleep 7140

Any problems that arise can be discussed with either Katja Doerholt or Sheila Donaghy. All contact details can be found on page 6.
Introduction to existing guidelines

This is a short summary of the existing guidelines in paediatric HIV (some local to St. George’s Hospital, national ones and some European wide guidelines). It also informs you on websites with support information in regards to the care of HIV infected children. The end of the chapter contains all information in relation to our local pathways and contacts of professionals looking after children with HIV infection.

Scale of the HIV epidemic among children in the UK and globally

In the UK a total of 1,835 children were reported to Collaborative HIV Paediatric Study (CHIPS, http://www.chipscohort.ac.uk) by the end of March 2013, comprising virtually all of those receiving HIV-related care in the UK and Ireland from 2006 onwards. Half the children known to be HIV positive are followed up in London.

According to statistics released from UNAIDS (World AIDS Day Report, www.unaids.org/.../2012/gr2012/JC2434_WorldAIDSDay_results_en.pdf ) 34 million people are infected with HIV-1 of which about half are aware of their diagnosis. There were more than 700 000 fewer new HIV infections globally in 2011 than in 2001. 2.5 million children and adult were infected in 2011 with the UNAIDS aim of zero new HIV infections being still far away in the future. However Africa has cut AIDS-related deaths by one third in the past six years. Concern is that the access to treatment is worse for children than for adults and still many children are without access to antiretroviral therapy. Less than one third of children requiring treatment are currently receiving antiretroviral therapy in sub-Saharan Africa. Worldwide 40% of all new adult HIV infection are due to new infections in young people account for 40% of all new adult infections. Every day, more than 2400 young people become infected with HIV with 5 million young people living with HIV.

HIV infections in children dropped by 43% from 2003 to 2011. The majority of the decrease in the last 2 years were due to reduction in transmission from mother to child due to access to antiretroviral therapy for pregnant mothers. In sub-Saharan Africa 59% of pregnant mothers received antiretroviral therapy during pregnancy and delivery in 2011. Vertical transmission is the primary means by which infants become infected with HIV either in utero, during delivery or by breast-feeding. At the end of 2011 around 3.3 million children (<15 years) were infected with HIV globally.
Prevention of mother-to-child-transmission (MTCT) of HIV and specific UK guidelines for MTCT

With the improved uptake of antenatal HIV testing, identification of infected women during pregnancy has dramatically improved with >90% being tested throughout the UK. Our local testing is very successful with very few women refusing HIV testing at St. George’s Hospital. Those that have opted out will be seen by our specialist midwife, Michael Bird. MTCT of HIV has been dramatically reduced by providing antiretroviral therapy (ART) to mother antenatally, during delivery and to the baby postnatally; by avoidance of breast-feeding and delivery by elective caesarean section (ELCS) if maternal viral load is still detectable. The main risk factors is maternal HIV viral load (VL) with a higher VL increasing the risk. Other risk factors include advanced maternal HIV disease, vaginal delivery (if detectable viral load), prolonged rupture of membranes (>4 hours); premature delivery (<36/40); breastfeeding, chorioamnionitis, placental abruption and foetal scalp monitoring.

Our local neonatal unit management is described in chapter 6.6 of the http://stginet/Units%20and%20Departments/Children%20Womens/Neonatology/Neonatal%20Unit.aspx and antenatal guidelines on infections in pregnancy are chapter 29 in the maternity guidelines and http://stginet/Units%20and%20Departments/Maternity/Maternity%20Guidelines.aspx are available on the intranet.


Babies born to HIV infected mothers will be followed up in our Mother and Baby clinic.
Clinical notes and treatment guidelines for HIV infected children at St. George’s Hospital

Notes

All children under follow up in our paediatric HIV clinic have a front sheet in the notes which highlights previous severe infection including AIDS events and the past history of their antiretroviral therapy. Their antiretroviral therapy prescription is usually the second sheet at the front of the notes in a plastic sleeve. There is also a sheet labelled “Diagnosis disclosure” which will tell you what the child knows about their illness. The notes are kept in the HIV specialist nurses office which is opposite the playroom; the code to the door is kept in the communication book on Pinckney ward.

Management of clinical illness

The Pinckney manual on the intranet provides information on investigation, diagnosis and management of children with HIV and immune compromise. It also has guidelines for children returning from travel abroad as many of the children with HIV are travelling to countries, which exposes them to tropical diseases. The Pinckney guidelines can be found on the intranet page on principle care of the immune compromised.


Anti-Retroviral Treatment

There are European guidelines for paediatric HIV which are written by the Paediatric Network for the treatment of AIDS (PENTA) and are available on the CHIVA link below. Information on diagnosis, testing, immunisations are available on Children’s HIV Association (CHIVA) website (http://www.chiva.org.uk). Both guidelines and resources as well as support material are available at http://www.chiva.org.uk/professionals/health/guidelines/index.html.

A big part of therapy is work around adherence to antiretroviral therapy (ART) in order to have viral load suppression and to avoid the development of resistance with subsequent failure of therapy. This is particularly important with limited antiretrovirals available particularly in children.

Drug Interactions

To check and drug interactions with the child’s antiretroviral therapy please either contact Courtyard Clinic pharmacy 020 8725 1803 or use http://www.hiv-druginteractions.org

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Testing


“Any infant/child/young person thought to be at significant risk of HIV infection, including all those with parents or siblings who are HIV-infected, should be tested. It is in the best interest of the infant /child/young person to be tested in these circumstances although this only needs to be undertaken urgently in infants who are at risk of rapid disease progression.

Who to consider for HIV testing

• infants and children whatever their age where the mother has HIV, or may have died of an HIV-associated condition
• infants born to mothers known to have HIV in pregnancy
• infants born to mothers who have refused an HIV test in pregnancy
• infants and children who are presented for fostering/adoption where there is any risk of blood-borne infections
• infants and children newly arrived in the UK from high-prevalence areas (they may be unaccompanied minors)
• infants and children with signs and symptoms consistent with an HIV diagnosis
• infants and children being screened for a congenital immunodeficiency
• infants and children in circumstances of post-exposure prophylaxis
• infants and children in cases where there has been sexual abuse

For a child over 18 months old an HIV antibody test (clotted specimen) is adequate. If the child has recently been exposed to HIV, further testing at least 3 months after the exposure will be necessary.
For children with accidental needle stick injury, the risk is generally very low in particular if the needle is old. http://www.chiva.org.uk/professionals/health/guidelines/pep/young-pep-ref.html.

In babies, testing for HIV is more complex. A baby born to a mother who has HIV will have maternal antibodies, which may still be in their blood until 18 months of age. The test required is an RNA Polymerase Chain Reaction (PCR) (EDTA specimen) and can be done in-house in virology laboratory. The testing of babies born to positive mothers is done at 0-2 days old, 6 weeks and 3 months old. An HIV antibody test will be done at 18 months of age. All follow up of babies being born to an HIV positive mother occurs in the Family Clinic for follow up.
CONTACT DETAILS

Paediatric Infectious Diseases Office: 0208 725 3262 Fax: 0208 725 1208

Consultants
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(CNS Paediatric HIV)

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(Dietician)
David Odgen 1803
HIV Pharmacist
Caroline Campbell 0659
(Psychologist)
Youné Ng 0208 725 3262 youne.ng@stgeorges.nhs.uk
(PID Secretary)

Paediatric Infectious Diseases Unit Ward – Pinckney Ward 5th Floor Lanesborough Wing

Extensions
Pinckney: 2082/2083 PICU: 1932
NICU: 1936
Pinckney ward office: 1168

Urgent (or non-urgent) contact: - To bleep anyone, you need to dial 88 followed by the bleep you require and add your extension afterwards. Or contact the switchboard for the PID consultant on call at St George's Hospital 0208 672 1255.

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