

Recommendations for HIV Postexposure Prophylaxis (PEP)

New York State Department of Health AIDS Institute recommendations for PEP following occupational exposure and sexual assault are based on careful review of available studies and constitute the considered opinion of expert HIV clinicians. To access the complete guidelines, visit the NYSDOH HIV Guidelines Website at www.hivguidelines.org.

PEP Following Occupational Exposure in Healthcare Workers (HCW)

- A. Manage exposure incident.** Clean exposure site with soap and water; flush mucous membranes with water.
- B. Assess severity of exposure.** PEP (HAART) is recommended for all significant risk exposures.

Table 1: Assessing Significant Risk for PEP

Type of Exposure	Source Material	Prophylaxis
Percutaneous OR Mucocutaneous OR Non-intact skin	Blood or visibly bloody fluid or potentially infectious fluid* AND source patient is potentially HIV infected	Recommended
Mucocutaneous	Other body fluids	Not Recommended

* Semen, vaginal secretions, synovial, pleural, peritoneal, pericardial, cerebrospinal, and amniotic fluids

C. Evaluate source patient

If source patient is known:

- **Do not delay initiation of PEP** to determine HIV status of the source.
- **Seek voluntary HIV testing of source** with informed consent as soon as possible after exposure. Rapid testing can determine HIV status of the source patient within 30 minutes of testing. A positive rapid test requires a confirmatory test.
- **Evaluate for evidence of other bloodborne diseases** (HBV, HCV).
- **Discontinue therapy** if the source is found with certainty not to be infected with HIV.

If source patient is unknown:

- **Base** treatment on assessment of bloodborne disease risk and type of exposure (Table 1).

D. Counsel/treat the healthcare worker.

- **Discuss significance of exposure;** provide scientifically accurate information about the known risks of seroconversion and transmission.
- **Inform HCW of the need for baseline and follow-up HIV testing.**
- **Encourage confidential testing** at 1, 3, and 6 months post-exposure, even if PEP is declined, to assess HIV status.
- **Educate HCW to immediately report symptoms** (lymphadenopathy, rash, sore throat, flu-like symptoms) suggestive of acute HIV seroconversion.
- **Counsel HCW about the need for risk reduction measures** until testing rules out HIV infection:
 - Avoid sex or use a male latex condom or a female condom during sex.
 - Postpone pregnancy; consult HIV Specialist if HCW is already pregnant.
 - Refrain from blood, organ, or sperm donation; breast-feeding.

- E. Record in HCW's confidential medical record:** date and time of exposure; details of procedure leading to exposure including protective equipment used; the type, severity, and amount of fluid to which HCW was exposed; exposure source details (i.e., bloodborne diseases, ARV regimen, ARV resistance); postexposure management, including HCW's PEP treatment decision. OSHA requirements can be found at <http://www.osha-slc.gov/SLTC/bloodborne pathogens/index.html>.

F. Prophylaxis for HIV exposure

- **Initiate prophylaxis as soon as possible**, ideally within 2 hours, and **no later than 36 hours postexposure** (PEP regimens on reverse side).
- **Treatment for 4 weeks** with all drugs is recommended.
- **Review** regimen and circumstances of the exposure **with an HIV Specialist** within 72 hours of beginning PEP.
- **Inform the HCW** about potential drug toxicity and the importance of adherence to therapy.
- **Re-evaluate HCW within 72 hours after exposure.**
- **Monitor HCW weekly** while on PEP regimen for adherence, symptoms of HIV seroconversion, side effects, and emotional status.

PEP Following Sexual Assault

A. Recommending PEP (PEP regimens on reverse side):

- **Evaluate survivors of sexual assault** in a healthcare setting with access to all appropriate medical resources.
- **Recommend PEP when significant exposure occurs**, as defined by direct contact of the vagina, anus, or mouth with the semen or blood of the perpetrator with or without physical injury, tissue damage, or presence of blood at the site of the assault.
- **Recommend PEP based on the nature of the exposure**, and not the likelihood of HIV infection in the assailant.

- **Offer PEP as soon as possible following exposure**, ideally within 2 hours and **not more than 36 hours after exposure.**
- **If the survivor is too distraught to engage in a discussion about PEP**, offer a first dose of medication and re-open the discussion about treatment initiation at a follow-up visit within the next 24 hours.
- **Involve the rape crisis counselor** in the discussion about HIV PEP.
- **Discontinue therapy** if the perpetrator is found with certainty not to be infected with HIV.

B. HIV Testing of the Survivor:

- **Obtain blood for baseline HIV serologic testing** before initiating PEP. Do not wait for results to start PEP. Refusal to undergo baseline testing should not preclude initiation of therapy.
- **Perform repeat HIV serologic testing** at 1, 3, and 6 months post-exposure to confirm or exclude HIV infection.

C. When PEP is Initiated:

- **Schedule a follow-up visit within 24 hours** after treatment initiation to evaluate initial tolerance of drugs and reinforce the need for regimen adherence.
- **Arrange follow-up care** to monitor treatment and subsequent diagnostic HIV testing.
- **Educate the patient** to immediately report symptoms (lymphadenopathy, rash, sore throat, flu-like symptoms) suggestive of acute HIV seroconversion. Instruct the patient to seek immediate medical care from an HIV Specialist if signs or symptoms occur.
- **Ensure that medications are available** to the patient in sufficient supply to complete a full course of PEP treatment. Various payment methods may be available, including Medicaid, Medicare, expanded Crime Victims Compensation or third party-payer reimbursement. For forms or victim assistance program information, visit the Crime Victims Board website at www.cvb.state.ny.us

D. Medical Care and Follow-Up:

- **Make referrals to or consult with an HIV Specialist.**
- **Discuss the follow-up care plan** with the rape crisis counselor or outreach worker if patient consents.
- **Screen and treat for HBV, HCV, and STDs** as per NYSDOH protocol for the management of sexual assault survivors. For other recommendations, refer to the CDC 2002 Guidelines for Treatment of Sexually Transmitted Disease, *MMWR* May 10, 2002 located at www.cdc.gov/STD/treatment/.
- **Counsel patient regarding the need for risk reduction measures** to be taken until HIV, HBV, HCV, and STD infection are ruled out:
 - Avoid sex or use a male latex condom or a female condom during sex.
 - Postpone pregnancy; consult HIV Specialist if survivor is pregnant.
 - Refrain from blood, organ or sperm donation; breast-feeding.

HIV PEP Regimen Following Occupational Exposure or Sexual Assault*†

**Zidovudine‡ 300 mg po bid + lamivudine 150 mg po bid (or Combivir 1 bid)§
PLUS
Tenofovir 300 mg po qd ||**

Notes:

* When the source is known to be HIV infected, past and current ARV therapy experience, viral load data, and genotypic or phenotypic resistance data (if available) may indicate the use of an alternative PEP regimen. Consult an HIV Specialist.

† **NNRTIs should be considered as an alternative only when 1) the HCW or sexual assault survivor cannot tolerate either tenofovir, nefinavir, or lopinavir/ritonavir (co-formulated as Kaletra), or 2) when exposure has occurred from a patient/source with known drug-resistant HIV that is sensitive to the NNRTIs.**

Nevirapine should be considered an alternative only when NRTIs or PIs are not an option. Consultation with an HIV Specialist is strongly recommended. If the individual decides to take nevirapine after a review of the risks and benefits, serum liver enzymes should be carefully monitored at baseline, weeks 2 and 4, or at any time the patient reports significant constitutional complaints, such as fever, rash, anorexia, or abdominal pain. The dosage for nevirapine is 200 mg po daily for the first 2 weeks, followed by 200 mg bid for the remaining 2 weeks. Use of efavirenz should only be considered in men and women not capable of bearing children because it has been associated with teratogenicity. Efavirenz dosage is 600 mg po qhs.

‡ If the patient is intolerant to zidovudine, stavudine 40 mg po bid may be substituted (if patient is <60 kg, 30 mg po bid should be given).

§ The dosing interval of lamivudine should be adjusted in patients with baseline creatinine clearance <50 mL/min. Because Combivir is a fixed-dose combination that cannot be adjusted, zidovudine 300 mg twice daily should be combined with lamivudine (dose adjusted for creatinine clearance).

|| The dosing interval of tenofovir should be adjusted in patients with baseline creatinine clearance <50 mL/min.

For detailed dose adjustment recommendations, please refer to the HIV Prophylaxis Following Occupational Exposure chapter at www.hivguidelines.org.

Resources

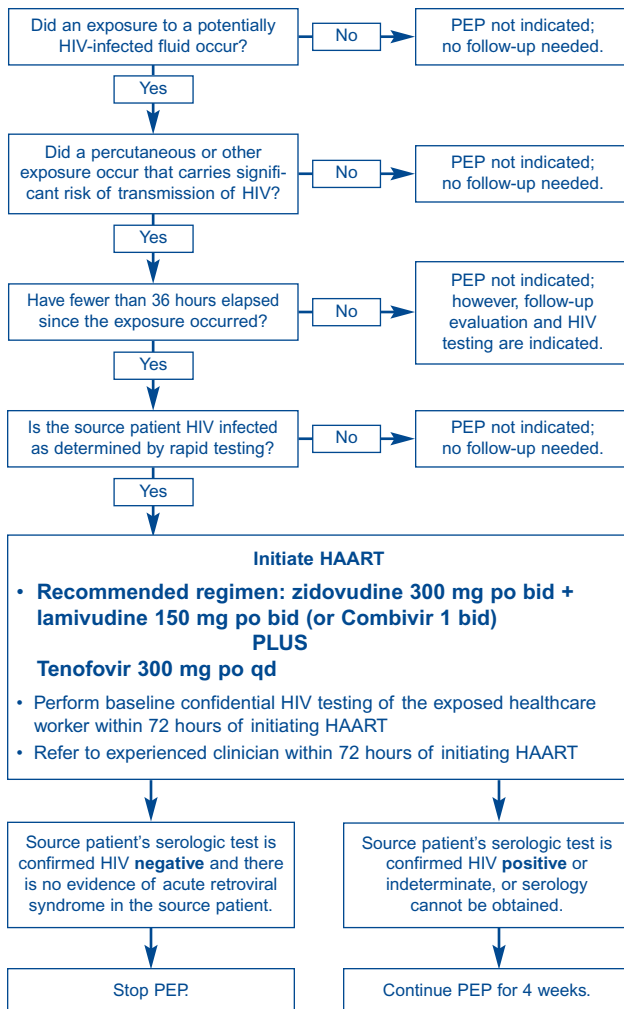
For referrals to HIV Specialists, call the AIDS Institute's Office of the Medical Director: (212) 417-4536 (M-F, 8:30-5:00); All other hours call HIVAIDS Hotline: (800) 541-2437.

NYDS HIV/AIDS Hotline: (800) 541-2437

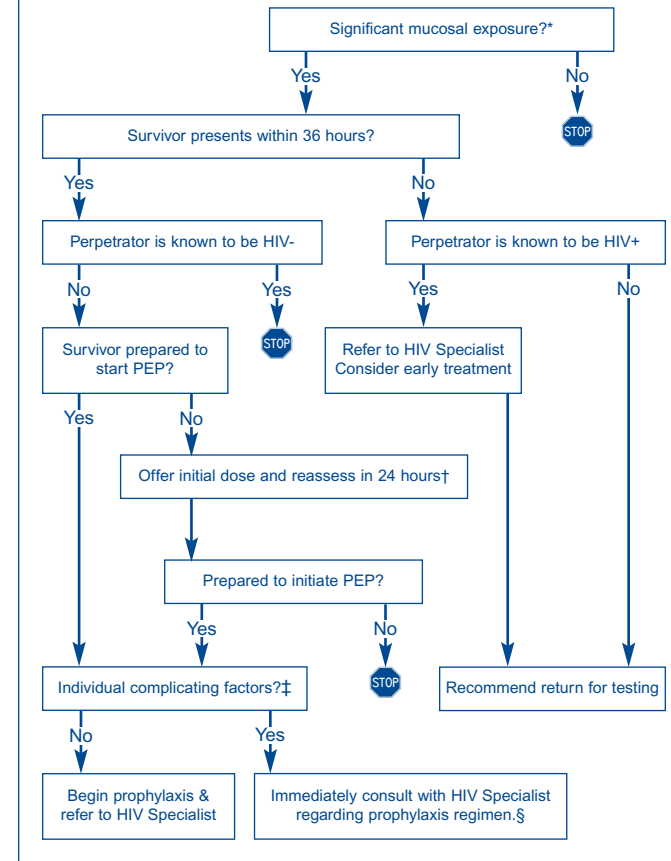
NYSDOH protocol for management of sexual assault survivors: call the NYSDOH Rape Crisis Program: (518) 474-3664

NYSDOH HIV Guidelines Website: www.hivguidelines.org

Criteria for Recommending Postexposure Prophylaxis Following Occupational Exposure



Criteria for Recommending Postexposure Prophylaxis Following Sexual Assault



* Defined by direct contact of the vagina, anus or mouth with the semen or blood of the perpetrator with or without physical injury, tissue damage, or presence of blood at the site of the assault.

† Prophylaxis should be initiated within 36 hours of the assault.

‡ Complicating factors: pregnancy; other medical conditions; drug interactions.

§ If Specialist not available on site, 24-hour consultation information available at www.hivguidelines.org