



CARIBBEAN GUIDELINES RELATED TO HIV POST EXPOSURE PROPHYLAXIS

Introduction

It is generally acknowledged that existing data regarding HIV Post Exposure Prophylaxis (PEP) is based on cohort, retrospective observational studies among people exposed to HIV professionally or otherwise, and not on case-control studies. Thus, recommendations formulated from these studies are not from rigorous statistical analyses. Their conclusions, however, are very convincing. Taking into account the HIV prevalence in the region, it is important to promote and put in place PEP guidelines and programmes as an essential public health measure in every health institution in every Caribbean country.

Action to be Taken After Exposure

Immediately encourage site bleeding while washing the wound and skin sites exposed to blood or body fluids. Wash with soap and water or other antiseptics.

NOTE: *Post Exposure Prophylaxis works best within the first 3 to 24 hours after the accident occurred. It can also be started up to 72 hours after the accident, but is not effective after that.*

LEVELS OF RISK	ACTION
<p><u>Low</u> <i>Exposure to body fluids or secretions from a potential source of HIV infection without any muco-cutaneous penetration</i></p>	<p><i>Counselling, and follow-up for 4 weeks (no antiretroviral treatment)</i></p>
<p><u>Medium</u> <i>Exposure to moderate quantity of body fluids or secretions from a potential source of HIV infection with superficial muco-cutaneous penetration (e.g. needle stick injuries).</i></p>	<p><i>Administer AZT 300 mg x bid + 3TC 150 mg x bid daily for 4 weeks</i></p>
<p><u>High</u> <i>Exposure to large body fluids or secretions from a potential source of HIV infection with deep muco-cuteous penetration</i></p>	<p><i>Administer AZT 300 mg x bid + 3TC 150 mg x bid + Nelfinavir 1250 mg x bid- daily for 4 weeks OR AZT 300 mg x bid + 3TC 150 mg x bid + Indinavir 800 mg x tid- daily for 4 weeks OR AZT 300 mg x bid + 3TC 150 mg x bid + Efavirenz 600 mg at bedtime- daily for 4 weeks</i></p>

scenarios for moderate and high risk levels:

Scenario 1: *After prescribing the ARV treatment for moderate and high risk cases, undertake voluntary counselling and testing for both the exposed individual and the potential source of HIV infection to establish the baseline serological status for both individuals.*

Scenario 2: *Where the two individuals are HIV negative, stop the treatment and re-evaluate for HIV anti-bodies the situation in 3 and 6 months, with ongoing counselling and psychological support.*

Scenario 3: *Where the source is HIV positive and the exposed individual is HIV negative, continue the treatment and do a follow-up check for HIV anti-bodies in 1 month, 3 months and 6 months, with ongoing counselling and psychological support.*

Scenario 4: *Where the exposed individual and/or the potential source of HIV infection refuse to be tested, continue the post exposure prophylaxis treatment for the exposed individual based on the level of the risk. Stop the treatment at the end of four weeks, with ongoing counselling and psychological support.*

Scenario 5: *Where the source and the exposed individuals are HIV positive, stop the post exposure prophylaxis treatment and refer them to an HIV/AIDS treatment centre where they can be evaluated and managed adequately, based on the CAREC regional norms for ARV treatment, using the basic criteria for inclusion.*

Important Laboratory Markers to be Monitored:

1. Haemoglobin
2. Kidney and Liver Functions
3. White Blood Cell Count: Total and Differentials