PAEDIATRIC HIV CASES

OCTOBER 7TH 2011

AWACC CONFERENCE

DURBAN

KWA ZULU NATAL – PAEDIATRIC HAART PUBLIC HEALTH PROGRAMME

1. **Largest in the world - > 55000 children on HAART**

2. **PMTCT –programme showing some success**

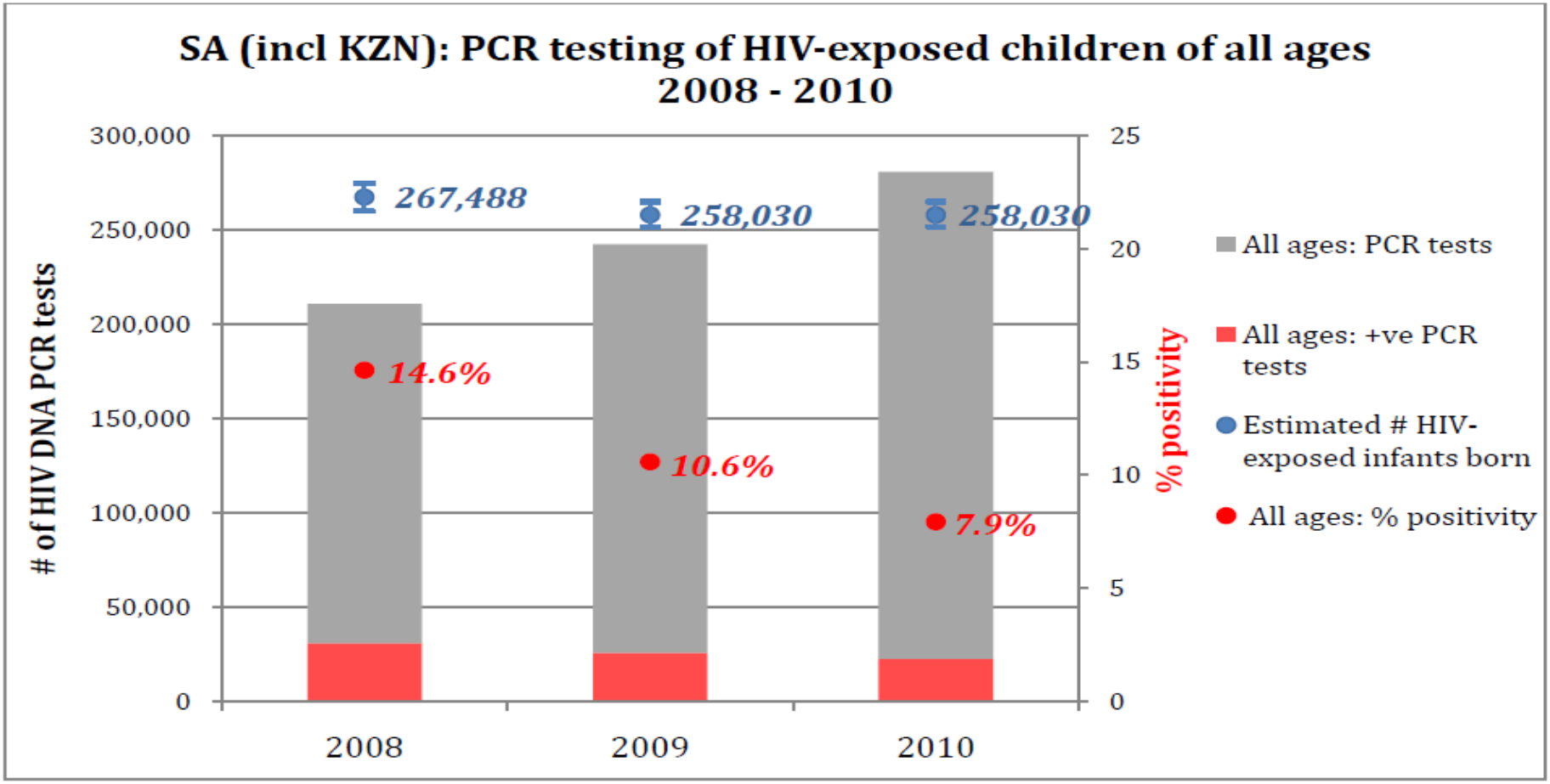
3. **Challenges – changing our scope of practice**

- **Ensuring sustainability – Nurse initiated ART- NIMART – for children**
- **Adolescent care – disclosure , ensuring sexuality dealt with**
- **Resistance to 2nd line therapies**
- ***TB co-infection – prophylaxis***
- ***Dealing with treatment failure – including – caring for the dying child and teenager***

ANTENATAL SERO-PREVALENCE

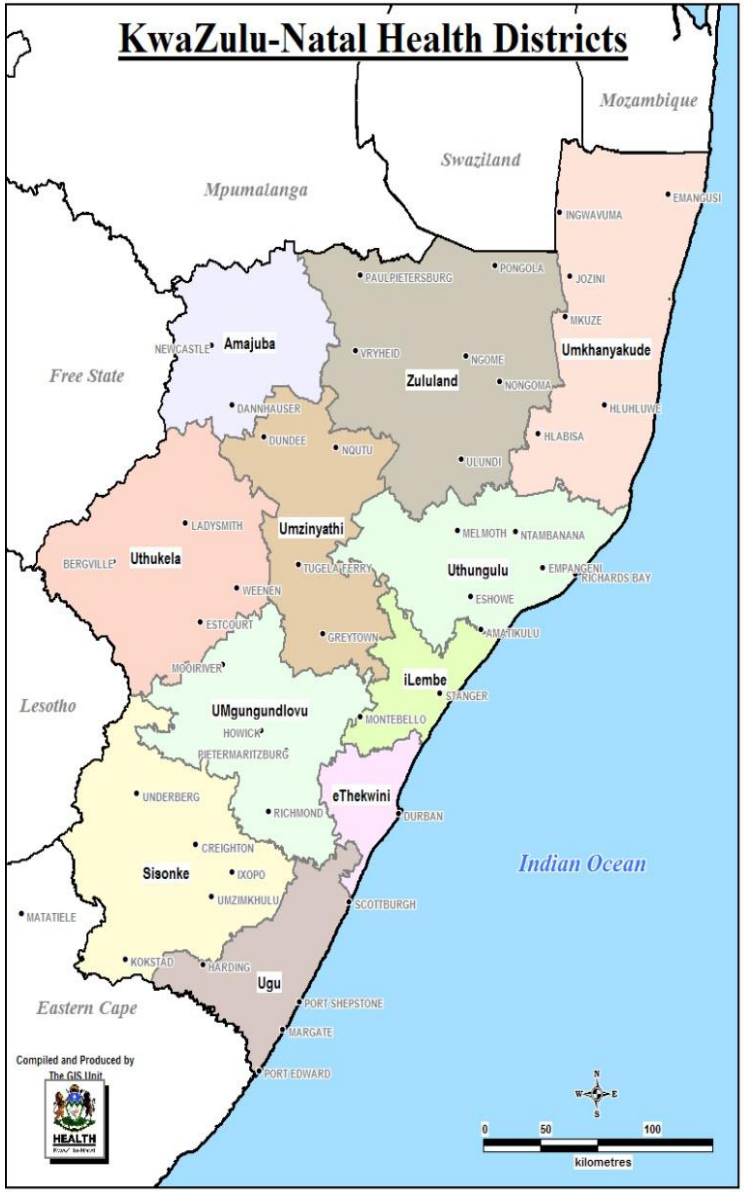
	EC	FS	GP	KZN	LP	MP	NC	NW	WC	ZA
2008	27.6	32.9	29.9	38.7	20.7	35.5	16.2	29.0	8	29.3
2009	28.1	30.1	29.8	39.5	21.4	34.7	17.2	30.0	16.9	29.4

HIV TESTING IN INFANTS



Early infant diagnosis of HIV infection in South Africa: 2008 to 2010

Gayle Sherman[a,b*], Rivka Lilian[b]



200 000 deliveries /year
30% antenatal seroprevalence
80 000 HIV exposed infants/year

HIV infected infants/year

No PMTCT → 26 000

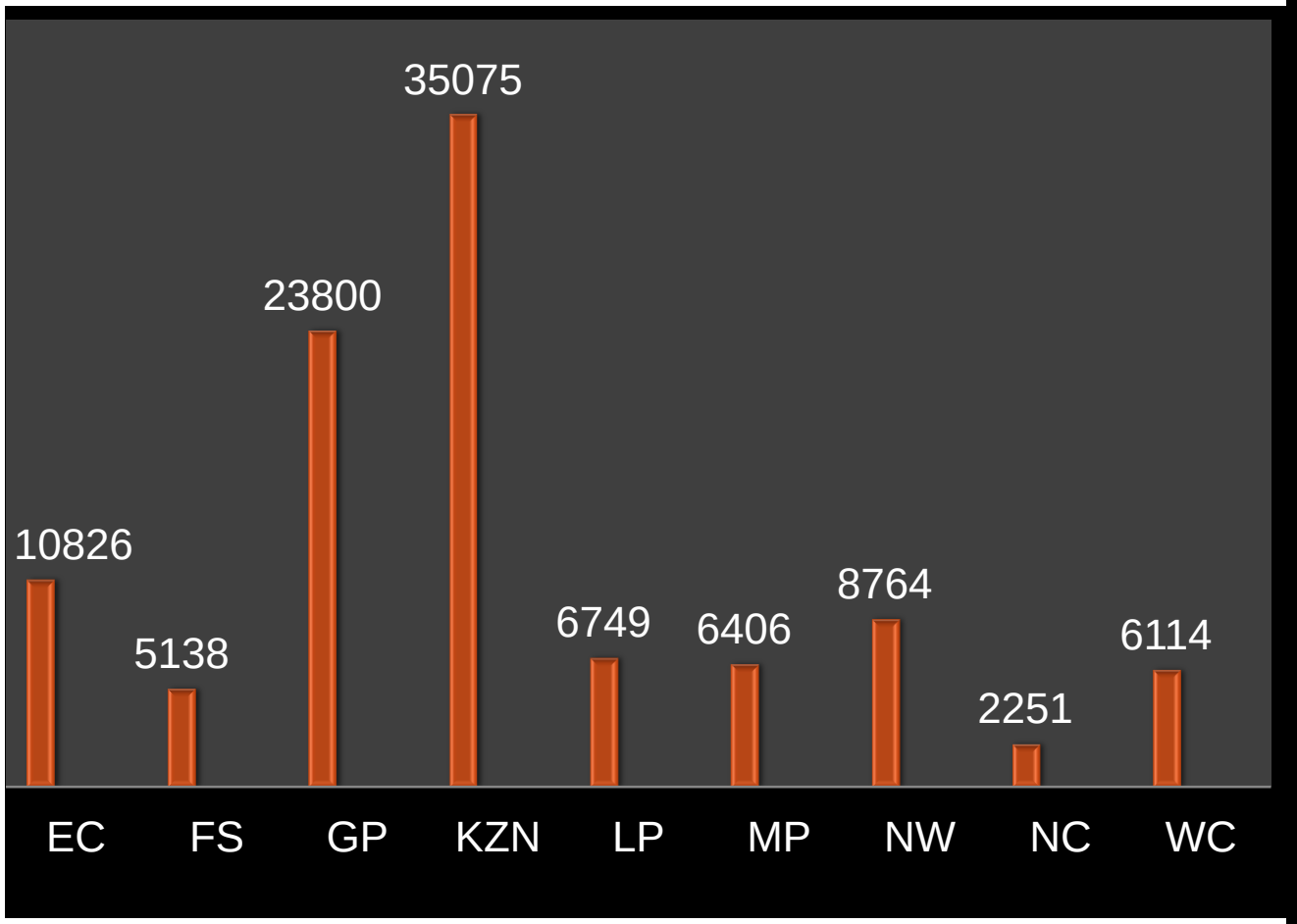
sdNVP → 12 000

Dual Therapy → 4 000

HAART at 350 → 800

NUMBER CHILDREN INITIATED ON HAART

105 123 Children Initiated on HAART



AUGUST 2010
National Comprehensive HIV and AIDS Plan Statistics*

8 YEAR OLD M M
HIV +
CD4 5% STAGE 4

- Social – orphan with 2 siblings (elder-HIV negative)- lives with maternal grandmother and maternal aunt
- Started 1 year ago on HAART (Abacavir +3TC +Effavirenz)
- Progress since HAART initiation – very slight weight gain by 6/12 – CD4 increased to 12% and Viral load suppressed
- In school – intermittently – very often ill – needed 5 admissions past 1 year (previous year needed 7 admissions)

CLINICAL COURSE PAST 1 YEAR

- 4 Feb 2010 – age 7 Yrs. Completed ARV training
- Chronic Lung Disease – stunted , clubbing and chest deformities
- Completed 2 courses of PTB – at age 5 and again at 6 yrs. – no MDR TB
- CXR – Bronchiectasis – Spiral CT scan confirmed this
- Repeated sputa – various multiplicity of organisms
- Regular physiotherapy – intermittent postural drainage at home
- First 3 admissions – Increasing Respiratory distress with fever , raised White cell count and bilateral wheeze and crackles
- Responded to antibiotics (iv), intense physiotherapy, Oxygen and B2 agonist nebulisations

ADMISSIONS

- Last 2 admissions – more distressed , tender RUQ – hepatomegaly , loud P2 – palpable P2 – Right parasternal heave
- CXR – increased cardiac size ECG – RVH
- Responded to IV furosemide
- **Impression – Chronic Ling disease secondary to Bronchiectasis-(repeated chest infections) – pulmonary hypertension – RVH – RVF-Cor Pulmonale**
- Echo – shows cardiomyopathy – poor Ejection Fraction and Fractional shortening – impression Cor Pulmonale
- Suggest diuretics and inotropic support
- Overall poor prognosis
- No transplant possible

NEW ADMISSION – 6TH

- Severely distressed
- Admitted – IV – Oxygen – antibiotics – bloods – repeat CXR – Furosemide – Ace Inhibitors – inotropic support
- Deteriorates – more distressed – pulmonary oedema

PSYCHO SOCIAL

- Child 8 years – has never been asked about what she thinks - ? Not sure of disclosure
- Grandmother and aunt – not in favour of disclosure
- Child hates admissions – last admission – ‘begged’ to go home
- Granny and aunt – want to know why HAART not working
- Social Worker input , psychologist not available

DECISION TIME :

- Consultants – decide not for escalation of care
- Morphine to be given orally –supportive care
- Notes made – not for resuscitation
- Granny counselled – accepts decision

SUBSEQUENT DAY

- Aunt arrives – afternoon – 2 interns – handover – she overhears (‘ we are not doing anything for this patient’ Not for ventilation)
- She is angry
- Child dies later that night

REVIEW

1. Nurses – upset – they were not consulted
2. Aunt upset
3. ?Child – what did she think and feel?
4. Was morphine enough?
5. Exclusion criteria in public health programme – end organ damage?

WHAT ARE YOUR THOUGHTS ?