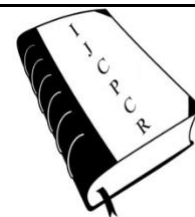




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ACUTE HIV INFECTION IN PREGNANCY: THE CASE FOR RESCREENING IN THE THIRD TRIMESTER

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ABSTRACT

Testing against HIV is both sensitive and specific to diagnosing existing HIV-1 infection but it is unable to detect acute HIV infection (AHI). AHI has an exceptionally high level of viral load, which can imply a greater risk of vertical or horizontal transmission. In this way an intervention can limit transmission via early detection of AHI. It may be difficult, however, to recognise AHI, as there may be no symptoms or ambiguous; therefore AHI, especially during pregnancy, is commonly neglected. There is a case report of AHI with headache and fever in a pregnant lady. In the first trimester and during the period of AHI, Anti-HIV Elisa confirmed her to be HIV negative 26 3/7 weeks ago, yet she had an HIV RNA viral load of 434 000 copies/mL diagnosed. A 23-year-old headache G1P0 presented to the emergency department (ED) of a private hospital for 26 weeks and three days of gestation. She had persistent hypertension, depression, anxiety and uterine fibroids in her medical history. Her four-week history was pregnant with obstetrics and sometimes stomach upsets she was diagnosed with laparoscopy that only revealed the rented corpus luteum. This case study emphasises the constant concern about the current HIV testing recommendations and problems in the recognition and diagnosis of acute HIV infection for women who are pregnant. In its early phases, obstetricians have to be able to detect and know how to diagnose HIV infection. In the case study, the chronology of HIV infection from initial exposure to antigens HIV-1 and the consequences of early detection of the disease are emphasised. In the context of acute HIV-infection seronegative phase, we support guidelines for the testing of viral reflexes of every pregnancy sequencing. An increased risk of HIV infection while pregnant leads us to suggest a recreation of HIV-1 in all women who are pregnant irrespective of their risk factors, due to hormone changes and cases where HIV-1 negative women are tested early in their pregnancy, giving rise to positive babies soon after they are born. Further testing during pregnancy would allow the use of vertical transmission methods for women and unborn offspring. More cost-benefit analyses may be helpful to evaluate repeat tests in the United States. In addition to rapid screening, the use of pooled ser detection approaches can decrease increased costs for assessing viral load.

Key words: Acute diseases, HIV Infection, Pregnancy.

INTRODUCTION

Testing against HIV is both sensitive and specific to diagnosing existing HIV-1 infection but it is unable to detect acute HIV infection (AHI) [1]. AHI has an exceptionally high level of viral load, which can imply a greater risk of vertical or horizontal transmission. In this way an intervention can limit transmission via early detection of AHI [2, 3]. It may be difficult, however, to recognise AHI, as there may be no symptoms or ambiguous; therefore AHI, especially during pregnancy, is

commonly neglected [4, 5, 6]. There is a case report of AHI with headache and fever in a pregnant lady. In the first trimester and during the period of AHI, Anti-HIV Elisa confirmed her to be HIV negative 26 3/7 weeks ago, yet she had an HIV RNA viral load of 434 000 copies/mL diagnosed [7, 8, 9]. It argued that AHI should be more sensitive in pregnancy and that HIV tests in late pregnancy should be repeated.

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It also argued that HIV RN AHI may be identified early by incorporating HIV testing in the Elisa standard HIV pregnancy test [10, 11]. By means of novel lab processes such as HIV RNA testing, serum pooling could minimise the cost of HIV RNA testing [12].

Case Presentation:

A 23-year-old women presented to the emergency OBG department of a private hospital for headache, with 26 weeks and three days of gestation. She had persistent hypertension, depression, anxiety and uterine fibroids in her medical history. Her four-week history was pregnant with obstetrics and sometimes stomach upsets, she was diagnosed with laparoscopy that only revealed the rented corpus luteum. She was diagnosed. She had been patient in our teaching facilities from the beginning of the first quarter when all prenatal labs were done. The rh-negative status and Trichomonas vaginal infection were the only noteworthy findings. Elisa's HIV test was negative. The care of the patient was shifted from the teaching institution to a community doctor when she was about 20 weeks pregnant. All prenatal laboratory have been repeated; the abnormal pap smear save for all laboratories, including the HIV antibody test. A few days after the admission of laboratory findings, more than 500 000 copies/ml and a CD4 count of 227 cells/mm³ were conveyed to the hospital no. 1. Therefore, a new HIV infection has been detected for the patient. Combivir 150 mg/300 mg 1 tablet twice a day and Viracept 625 mg 2 twice a day were used as an antiretroviral medication. Her fever and headache faded, and without any additional problems or findings, she was returned home. A CD4 count of 447 cells/mm³ and a viral charge of 869,000 copies/mL were reported in laboratory examinations as outpatients, approximately 3 weeks later. Antiretroviral treatment was continued with outpatient therapy. Her CD4 count at 33 weeks and 5 days of pregnancy was 177 cells per mm³ and her viral load was 128 copies/mL. The patient came at Hospital No. II early on in work for 37 weeks and 2 days, which was exacerbated by continuous hypertension and preeclampsia. She was allowed to be born in the hospital. Due to a viral load in recent times of fewer than 1,000 copies/mL. She had the chance to try vaginal birth. A 2 mg/kg zidovudine loading dosage is taken during the work, followed by a dose of 1 mg/kg for maintenance. Magnesium sulphate was also given as a preventive seizure. The web has become viral. The load was 74 copies/mL at this admission. She's been passing a lot. A small cross-section of caesarea was made due to deferment and a small daughter of 4 pounds 11 ounces was born. In one and five minutes, the apgar values 8 and 9 were reported. On the day after the procedure, the patient was released. HIV was negatively tested by the newborn.

Discussion:

Estimates of the number of people infected with HIV in the India. Annually, 40,000 to 56,300 people are killed in the India. In any case, up to 25% of HIV-positive people are uninformed of their current situation. Despite the fact that the number of new HIV infections is on the decline, In the India, there are presently over 1,000,000 HIV-positive people. Despite the fact that the number of sick people has risen, and the prevalence of the number of new infections has remained steady, indicating a decrease in the number of new infecti. Women make up a bigger share of newlyweds than men. More people are infected with HIV than ever before. In recent years, more women have contracted HIV through heterosexual contact, many of whom have never had the disease before. Infection risk factors have been identified. Pregnant women are at a higher risk of contracting HIV. Even when behavioral risk factors are taken into account Pregnant women and their partners have twice the risk than non-pregnant women. When compared to breastfeeding mothers, there is a higher risk of infection and non-lactating, non-pregnant women Hormonal changes linked to pregnancy have been cited as a cause. As well as the vaginal mucosa's response to these hormones. The explanation for the higher infection susceptibility as a result, pregnancy is a time when women are more susceptible to AHI than men. Acute HIV-1 infection causes significant changes in the body. The viral load, as well as the immune system of the host, which may both horizontal and vertical transmission risks are increased. During the course of pregnancy Because acute HIV-1 infection can resemble other common viral infections. This sickness may be misdiagnosed, as in the case of the patient. They exhibited Perinatal transmission can be reduced by using HIV testing should be repeated in late pregnancy as well as during childbirth Patterson et al recommends preparing the food and delivering it. While repeat third trimester testing would likely be beneficial. Some newly afflicted people have been identified, but others may still be afflicted be in the phase of the window as a result, more reflex RNA testing recommendations for antibody-negative women are being made. It should be considered to detect acute HIV infection. Despite the fact that the focus of this research is on testing in the United States. The feasibility of reflexology has been established in a number of investigations RNA testing in underdeveloped countries. The treatment of HIV in non-pregnant people has improved dramatically. It has been thoroughly investigated. There are already established criteria for when and how to use them and how to get started with treatment. Presently HAART therapy appears to be effective in the treatment of acute HIV infection, according to research. It reduces viremia and hence, theoretically, vertical, transmittance.

Conclusion:

This case study emphasises the constant concern about the current HIV testing recommendations and problems in the recognition and diagnosis of acute HIV infection for women who are pregnant. In its early phases, obstetricians have to be able to detect and know how to diagnose HIV infection. In the case study, the chronology of HIV infection from initial exposure to antigens HIV-1 and the consequences of early detection of the disease are emphasised. In the context of acute HIV-infection seronegative phase, we support guidelines for the testing of viral reflexes of every pregnancy sequencing. An increased

risk of HIV infection while pregnant leads us to suggest a recreation of HIV-1 in all women who are pregnant irrespective of their risk factors, due to hormone changes and cases where HIV-1 negative women are tested early in their pregnancy, giving rise to positive babies soon after they are born. Further testing during pregnancy would allow the use of vertical transmission methods for women and unborn offspring. More cost-benefit analyses may be helpful to evaluate repeat tests in the United States. In addition to rapid screening, the use of pooled ser detection approaches can decrease increased costs for assessing viral load.

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