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STATEMENT ON DOLUTEGRAVIR (DTG) USE IN PREGNANCY & FOR WOMEN OF CHILDBEARING POTENTIAL (WOCP)

Problem Statement

As more data has been added to the Tsepamo cohort, the difference in DTG vs non-DTG regimens regarding neural tube defect (NTD) risk is now no longer statistically significant.[1] In addition, other cohorts, albeit smaller ones, have not found any increase in NTDs when dolutegravir was being taken at conception.[2, 3] Therefore, there is no longer any clear signal of harm.

In contrast, there are benefits to DTG over EFV with respect to virological suppression rates, virological barrier to resistance, tolerability, and side-effects, and many of these may well also translate to better overall maternal and fetal outcomes.[4-6]

Recommendations

The Southern African HIV Clinicians Society (SAHCS), therefore, recommends DTG-containing regimens as the preferred first-line antiretroviral therapy due to superior efficacy, tolerability and higher threshold for resistance when compared to EFV-containing regimens. All ART-naive individuals testing HIV serum positive must be initiated onto a DTG-containing regimen and SAHCS recommends TLD as first line treatment for all, whether the individual is male or female; pregnant or of childbearing potential or not.

In addition, virologically suppressed women of childbearing potential on non-DTG first- and second-line regimens can be safely switched to DTG-based regimens if appropriate. **Always confirm viral suppression prior to switching regimens.**

As any medication use during conception and pregnancy carries some risk, counselling is still advised.

References

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