

NWT Clinical Practice Information Notice

Upon receipt, please file this notice in **Section C, Clinical Practice Information Binder** for future reference.

The following clinical practice has been approved for use in the Northwest Territories Health and Social Services system, and has been distributed to:

<input checked="" type="checkbox"/>	Hospitals	<input checked="" type="checkbox"/>	Community Health Centers	<input checked="" type="checkbox"/>	Homecare	<input checked="" type="checkbox"/>	LTCF	<input checked="" type="checkbox"/>	Lab Directors
<input checked="" type="checkbox"/>	Doctors' Offices		Social Services Offices	<input checked="" type="checkbox"/>	Public Health Units		Other		

The information contained in this document is a Departmental:									
	Policy	<input checked="" type="checkbox"/>	Standard		Protocol		Procedure		Guideline

Title: NWT Post Exposure Prophylaxis
Effective Date: September 2007

Statement of approved Clinical Practice:

The Chief Medical Health Officer requires the following changes be made immediately to the NWT Post Exposure Prophylaxis Protocol:

Kaletra will replace Nelfinavir (Viracept) for post exposure prophylaxis regime. Nelfinavir has been recalled by Health Canada and the manufacturer.
http://www.hc-sc.gc.ca/dhp-mps/medeff/advisories-avis/prof/2001/videx-zerit_hpc-cps_e.html

The following is the approved regime for PEP:

Starter Kit (2 drug/5 day protocol)¹ contains:

1. Zidovudine (Retrovir) 200 mg PO TID (100 mg caps) 30
2. Lamivudine (3TC, Epivir) 150 mg BID, quantity 10

Starter Kit (3 drug/5 day protocol) contains:

1. Zidovudine (Retrovir) 200 mg PO TID (100 mg caps) 30
2. Lamivudine (3TC, Epivir) 150 mg PO BID: 10
3. Kaletra (200 mg Lopinavir + 50 mg Ritonavir) 2 tabs PO BID

Kaletra is a combination drug.

Please remove and replace NWT's Post Exposure Prophylaxis Protocol in :
 Appendix 7 in your Northwest Territories HIV/AIDS manual, and'
 Appendix 3 In your NWT Infection Control Manual

Attachment: Post Exposure Prophylaxis Protocol, revised September 2007

This clinical practice is approved.



(signature)

Assistant Deputy Minister Chief Medical Health Officer Director, Child & Family Services Director, Adoptions

POST-EXPOSURE PROPHYLAXIS PROTOCOL

Purpose:

- To prevent and/or reduce possible exposures at the worksite or other settings.
- To provide a guideline in the monitoring and protection of individuals who have occupational or accidental exposure to Hepatitis B (HBV), Hepatitis C (HCV), and Human Immunodeficiency Virus (HIV), through exposure to blood and body fluids.

Policy:

- A Medical Health Officer or an Infectious Disease Consultant should be consulted when managing exposures and/or recommending chemoprophylaxis.
- Any employee having significant exposure to human blood or body fluids shall report the incident to their immediate supervisor who will arrange a clinical assessment and follow-up.
- A client reporting direct exposure to human blood and body fluids can be directed to the Public/Community Health Unit, or the emergency room of a hospital
- All employees must follow "Standard Precautions" as outlined in attached "Appendix A".

All known exposures to HBV, HCV or HIV contaminated blood or body fluids must be reported to the Office of the Chief Medical Health Officer.

Procedure:

1. **Treat the *exposed* area immediately** (if not previously done by client):
 - a) Rinses the eye or mucous membrane thoroughly with water and/or normal saline for 15 minutes.
 - b) Allows cuts, punctures, scratches or bites to bleed freely by lowering the extremity below the level of the heart, if possible.
 - c) Avoids squeezing the site as this contributes to inflammation.
 - d) Washes the wound with soap and tap water for 10 minutes. Rinses with water.
 - e) Do not use bleach or disinfectant solution to clean the wound.

POST-EXPOSURE PROPHYLAXIS PROTOCOL

2. For Occupational exposure, notifies the supervisor or designate if not already done.

 3. Assesses the risk of significant exposure using the attached “Exposure to Blood and Body Fluids Accident Report” form.
 - a) Significant exposure is defined as an injury, during which one person’s blood or other high risk body fluid comes in contact with someone else’s blood, through exposure to subcutaneous tissue, non-intact chapped or abraded skin or mucous membrane. Body fluids at risk of transmitting HBV, HCV and HIV from an infected individual in a community setting include:
 - i) Blood,
 - ii) Semen,
 - iii) Vaginal secretions,
 - iv) Breast milk (HIV only),
 - v) Saliva (for HBV, unless blood-stained then at risk for HIV and HCV), and;
 - vi) Any body fluids visibly contaminated with blood:
 - Tears, nasal secretions, sputum, vomit, urine or feces.

 - b) Exposure to body fluids, such as cerebrospinal, synovial, pleural, amniotic etc. is usually confined to a hospital setting. Injuries of concern include the following:
 - i) Parenteral injection (needle-stick or cut with potentially contaminated sharps),
 - ii) Splash to mucous membrane of eyes, nose or mouth, and/or;
 - iii) Human bites in which case both the *Source* and *Exposed* are considered at risk.

 4. **Use the attached (Appendix 4) HBV, HIV, HCV Flowchart to guide the management of exposure to blood and body fluids.**

 5. **Obtain consent and do pre-test counselling if recommending lab work for HBV, HIV. Document same in chart.**
 - a) Testing is voluntary both for the person *exposed* (*Exposed*) and the person who is potentially the *source* of infection (*Source*). Both the *Exposed* and the *Source* have the right to refuse testing. If the *Exposed* refuses to be tested, testing the *Source* is usually not done.
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POST-EXPOSURE PROPHYLAXIS PROTOCOL

- b) If the *Source* is known, attempt to get his/her consent to have blood tested for HIV, HBV and HCV. HBV testing may be eliminated if the *Source* is known to be HbsAg positive or have protective levels of anti-HBs. Otherwise, request anti-HBs, HbsAg, anti-HCV, and HIV antibodies. For the *Source*, consent should include permission to make the test results known to the *Exposed*.
- c) Exposure to body fluids will not be followed for HIV, HBV, or HCV, unless these fluids contain visible blood:

Including: tears, nasal secretions, sputum, sweat, vomitus, urine or feces
- d) Laboratory specimens should be labelled as a possible exposure, so rapid turn around can be achieved. A phone call to the lab is also appropriate to notify them of occupational/accidental exposures.

*** Stat samples are to be sent in a green biohazard bag not the orange biohazard bag.**

6. If Hep B Immune Globulin is recommended:

- a) Consults with the Medical Health Officer (MHO) or Infectious Disease Specialist and, and if necessary, obtains medical order of HBIG.

7. HIV antiretroviral Chemoprophylaxis is recommended in the following circumstances:

- i) Significant exposures where the *Source* is known to be HIV-positive; **or**;
 - ii) Significant exposures where the *Source* is known, but the HIV status is unknown at the time of exposure, and **both** of the following conditions exist;
 - 1) High risk exposure which is defined by **at least one** of the following:
 - a. Deep percutaneous injury,
 - b. Visible blood present on device,
 - c. Exposure from a needle placed directly into the *Source's* vein or artery,
- AND**
- 2) Risk factors for HIV are known in the *Source* which may include:
 - a. Injection drug user,
 - b. Men who have sex with other men, unprotected anal intercourse,

POST-EXPOSURE PROPHYLAXIS PROTOCOL

- c. Recipient of multiple transfusions of blood or blood products prior to 1985,
- d. Sexual partner of persons known to be HIV positive,
- e. History of residence in a country or area with high HIV prevalence,
- f. History of recurrent STIs, or Hepatitis B or C infection.

If the *Source* is doubtful, prophylaxis is not warranted but will not be refused to an exposed staff member or client requesting it.

- In such cases the 2-drug protocol will be followed. This includes exposures to sharps where the *Source* is unknown.

There have been no documented HIV seroconversions after exposure to abandoned sharps. In contrast to HBV, the HIV virus is quite fragile and does not survive long on exposed surfaces.

Consult with an MHO or Infectious Disease Specialist for all clients where anti-retrovirals are being considered.

- Obtain medical order for 5 day Starter Kit (3 drug or 2 drug). (Starter kits are obtained at Stanton and Inuvik Hospital Pharmacies).
- Complete baseline lab-work: (See attached Anti-viral Drug Protocol):
 - CBC, renal and liver function tests at baseline, 2 weeks, and one month after starting the medications.
- **Initiate prophylaxis as soon as possible, ideally within 2 - 4 hours.** Efficacy is thought to be reduced if delayed. However, there is no available data as to a specific time after which HIV antiretrovirals are considered to be ineffective. Consider implementing up to 72 hours post exposure. Must refer to a family physician or to doctor on call, if PEP is initiated, for follow-up and monitoring
- These drugs are toxic and difficult to take. The majority of clients (70%) will feel ill while taking the drugs and many (30%) will be unable to work during prophylaxis.

POST-EXPOSURE PROPHYLAXIS PROTOCOL

Discontinuing PEP: When HIV results of the *Source* are available, therapy should be re-evaluated. If the *Source* is HIV negative, discontinue chemoprophylaxis. Follow-up testing of the *Exposed* is generally not necessary. If the *Source* refuses testing and the exposure is considered “high risk” or if there is concern that the *Source* client is in the “window period”, then PEP and or follow-up HIV testing may be recommended.

8. Offer Counseling:

- a) Counseling is to be offered regardless if PEP is received or not. Advise of local resources as needed. i.e. EAP, family counseling etc.
- b) Advises the client/employee about the following until the 6-month follow-up period post-exposure has ended. Counseling may need to be repeated at a later time if the client/employee is extremely anxious at the time of the critical incident:
 - i) HIV is the least infective, followed by HCV. HBV is the most infectious. HBV can live for one week in dried blood. PEP is not 100% fail proof.
 - ii) The average risk of infection after an accidental percutaneous exposure to HIV-infected blood is 0.3% and 0.1% following a mucocutaneous exposure.
 - iii) The average risk of HCV infection from a single needle stick injury with HCV-infected blood is 1.8%.
 - iv) The risk of acquiring HBV from percutaneous injury ranges from 23% (HBeAg negative *Source*) to 63% (HBeAg positive *Source*). Antiretroviral drug therapy can reduce the risk of HIV transmission by 81%.
 - v) Talk about experience with colleagues and partner.
 - vi) Explore the need for counseling with a health care professional knowledgeable about HIV/HBV/HCV.
 - vii) Use condoms with lubricant and/or dental dams with your partner every time.
 - viii) Delay pregnancy, or if pregnant consult a physician about the need for prophylactic therapies.
 - ix) Discontinue breastfeeding. The risk of transmission of HIV through breastfeeding is high for women who seroconvert while breastfeeding.

POST-EXPOSURE PROPHYLAXIS PROTOCOL

- x) Do not donate blood, sperm, ova, bone marrow, etc.
 - xi) Do not share razors or toothbrushes.
 - c) Have the client/employee signed the attached Refusal of Treatment form if she/he chooses not to follow the care as recommended? (See Attachment "C").
 - d) Complete the following reports:
 - i) Exposure to Blood and Body Fluids Accident Report Form (Appendix "B") – kept on the client's record
 - ii) Worker's Compensation Report Forms: (Appendix "B")
 - (1) The client must complete the "Employee's Report of the Accident" and fax it to the WCB office.
 - (2) The nurse will complete the "Employer's Report of Accident" and submit it to the Director, Community Health who must fax it to the WCB office within 72 hours of the incident. Fax number is at the bottom of each of the forms.
 - e) Post-Exposure Surveillance Record for Client/Employee (Appendix "D")– kept on the client's chart and will be used in place of progress notes.
- 9. If the client's lab reports come back as positive for HBV, HCV or HIV, then the following reports must be completed and faxed to the Health Protection Unit, Department of Health & Social Services:**
- a) Communicable Disease Report Form, (Refer to CDC Manual).
 - b) Hepatitis B & C Case Investigation Form (usually completed by the physician to whom the client is referred, but a public health nurse can complete any known information); (Refer to CDC Manual).
 - i) Interpretation of Lab Reports:**
 - *immune to HBV* - a client/employee who has known documentation of an anti-HBs level > 12IU/L when tested following the complete HB immunization series, or has an anti-HBs level > 12IU/L or is anti-HBc+ or HBsAg+ from HBV infection.
 - *susceptible to HBV* - a client/employee who after HBV immunization has an inadequate anti-HBs level (< 12IU/L) when done 4-8 weeks after completing the series, or when there is no history of HB immunization, and tests for anti-HBs, anti-HBc and HBsAg are negative.
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POST-EXPOSURE PROPHYLAXIS PROTOCOL

- *non-responder* - a client/employee who has had 2 complete series of HB vaccine and has tested anti-HBs negative (< 12IU/L) post-HB immunization after each series.

Attachments:

- Standard Precautions – Appendix “A”.
- Exposure to Blood and Body Fluids Accident Report Form – Appendix “B”.
- Refusal of Treatment Form – Appendix “C”.
- Post-Exposure Surveillance Record for Client/Employee – Appendix “D”.
- Anti-Viral Drug Protocol – Appendix “E”.
- Worker’s Compensation Report Forms (Employer’s Report of Accident & Worker’s Report of Accident).

Other Related Policies/Protocols:

- Handling and Transport of Infectious and Hazardous Materials (in CDC manual).
- NWT Communicable Disease Manual (DHSS).
- HIV Infection and AIDS: Information for Health Professionals (DHSS).
- Pre and Post Test HIV Counselling.

References:

- Management of Accidental Exposure to HIV, British Columbia Centre for Excellence in HIV/AIDS. Dec/2001 Canadian Immunization Guide.
- GNWT Hospital Standards and Regulations, July 2000.
- Canadian Strategy on HIV/AIDS, Health Canada, 2001.
- MMWR – CDC 2003.
- Communicable Diseases Manual, NWT 1999.
- Prophylaxis Guidelines Post HIV Exposure (Epi North, November 1996).

POST-EXPOSURE PROPHYLAXIS PROTOCOL

APPENDIX "A" STANDARD PRECAUTIONS

All staff are encouraged to take the following precautions in clinical situations and at work where applicable:

- Wear protective gloves when performing any procedure which may bring you into contact with blood or body fluids
 - x i.e. venipuncture, swabs, pap smears etc.
- Discard used needles and sleeves into puncture-resistant containers.
 - x Do not recap used needles. Fill "sharps" containers only as far as the "fill" line and dispose of same according to Biohazardous Waste Policy.
 - x Do not stuff sharps in over stuffed container!
- Dispose of all needles, syringes, vials, ampoules, and clinical glass (glass contaminated with blood, body fluids or chemicals) and any other clinical item that could cause a cut, puncture or abrasion, in an approved "sharps" container.
- Wash hands immediately and thoroughly with soap and water:
 - x if they become contaminated with blood or body fluids,
 - x after removing gloves and before leaving the exam room, and/or;
 - x before and after any client contact.
- Wear a mask and/or protective eye wear where splashing or aerosolization of body fluids is anticipated.
- Wear a gown or lab coat when specimens are likely to soil clothing.
- Transport all specimens in clean, secure containers.
- Wear gloves to clean the outside of a soiled specimen container with a disinfectant.
- Transport slides and blood tubes in non-breakable metal containers.
- Avoid pelvic exams if you have significant burns or cuts on your hands and double glove when drawing blood and doing male exams.
- Between clients, clean equipment, counter tops or examination table with a disinfectant especially when there is obvious contamination with body fluids.
- Immediately clean up all spills of blood or body fluids with appropriate disinfectant. Gloves are to be worn and paper towels discarded in the garbage.
- Refer to the protocol, **Handling and Transport of Infectious and Hazardous Materials**. (CDC Manual)



POST-EXPOSURE PROPHYLAXIS PROTOCOL

APPENDIX "B"

Exposure to Blood and Body Fluids Accident Report

SECTION I: CLIENT/EMPLOYEE TO COMPLETE		
1. Client/Employee Information		
<u>Name:</u>		
<u>Work Area:</u>	<u>Position:</u>	
<u>Date of Exposure:</u>	<u>Time of Exposure:</u>	
<u>Location of Exposure:</u>		
2. Source Information		
<u>Name:</u>		
<u>Age:</u>	<u>Sex:</u>	<u>HCP #:</u>

3. Describe the exposure:

- skin puncture/needle stick
- cut/scrape
- splash/spill
- contact with contaminated equipment/surface
- other (describe)

4. If the exposure involved a needle stick, the needle was used for:

- an IM injection
- a SC injection
- venipuncture
- injection drug use
- other (describe):
- did the exposure occur while recapping a needle?

POST-EXPOSURE PROPHYLAXIS PROTOCOL

5. If the exposure did not involve a needle stick, the blood or body fluid contacted:

- intact skin
- non-intact skin
- eyes, nose, mouth
- other (describe

6. The following area(s) of the body were involved:

- mouth/face/eyes/neck
- arm/hand
- leg/foot
- trunk
- other (describe): _____

7. The following body fluids were involved:

- | | |
|--|---|
| <input type="checkbox"/> blood | <input type="checkbox"/> vaginal secretions |
| <input type="checkbox"/> seminal fluid | <input type="checkbox"/> tears |
| <input type="checkbox"/> saliva | <input type="checkbox"/> nasal secretions |
| <input type="checkbox"/> vomitus | <input type="checkbox"/> sputum |
| <input type="checkbox"/> urine | |

8. Was the body fluid blood-tinged?

- yes
- no

9. The blood or body fluid was in contact with my skin or mucous membrane for:

- less than 5 minutes
- 5-14 minutes
- 15-60 minutes
- longer than 1 hour

POST-EXPOSURE PROPHYLAXIS PROTOCOL

10. /The client used the following protective equipment at the time of the exposure:

- | | |
|---------------------------------------|----------------------------------|
| <input type="checkbox"/> latex gloves | <input type="checkbox"/> goggles |
| <input type="checkbox"/> mask | <input type="checkbox"/> gown |
| <input type="checkbox"/> none | |

Signature of Client/Employee: _____ Date: _____

POST-EXPOSURE PROPHYLAXIS PROTOCOL

SECTION II: PUBLIC HEALTH NURSE TO COMPLETE

11. The status of the *Source* client is:

- known HBV-positive
- known HBV-negative
- known HBV-negative with risk behaviors
- unknown HBV status
- known HCV-positive
- known HCV-negative
- known HCV-negative with risk behaviours
- unknown HCV status
- known HIV-positive
- known HIV-negative
- known HIV-negative with risk behaviours
- unknown HIV status

12. The client/employee's immune status with respect to Hepatitis B is:

- immune
- completion of Hepatitis B series (Date: _____)
- most recent HBsAg (Date: _____ Result: _____ -)
- susceptible
- non-responder
- unknown

13. The client/employee received the following interventions:

- no treatment
- first aid
- blood work for Hepatitis B
- HBIG

POST-EXPOSURE PROPHYLAXIS PROTOCOL

- Hepatitis B booster
- Hepatitis B series started
- pre-test counseling for HIV antibody test
- blood work for HIV antibody test
- post-exposure prophylaxis started and reported to Medical Health Officer
- blood work for Hepatitis C

Signature of Health Care Provider _____ **Date:**

POST-EXPOSURE PROPHYLAXIS PROTOCOL

SECTION III: FOLLOW-UP (SUPERVISOR TO COMPLETE)

14. The following policy, procedure or practice was put into place to prevent this incident from occurring again:

15..Comments

POST-EXPOSURE PROPHYLAXIS PROTOCOL

APPENDIX "C"

Refusal of Treatment/Treatment when Not Indicated

This is to certify that I, _____, refuse the care judged necessary by the Public/Community Health Unit and/or the Medical Health Officer.

Or

This is to certify that I, _____ request to be placed on Post-Exposure Prophylaxis (PEP). I understand that Public/Community Health or the Medical Health Officer does not recommend this at this time.

I make this decision freely, in full knowledge of the situation. I acknowledge I have been informed of the consequences related to my decision, and hereby release the Health and Social Services Authority and its professionals from any untoward consequences which may or will result from my decision.

Name: _____ Date: _____

Signature of Client: _____

Signature of Witness: _____

POST-EXPOSURE PROPHYLAXIS PROTOCOL

APPENDIX "D"

Post-Exposure Surveillance Record for Client/Employee

Hepatitis B Intervention		Hepatitis B Screen	
		Date y/m/d	Result
Initial blood work at time of injury	HbsAg		
	Anti-HBc		
	Anti-HBs		
Medical Assessment At 3 months. post exposure	HbsAg		
	Anti-HBc		
	Anti-HBs		
Repeat Blood Work at 6 months if previous result Negative	HBsAg		
	Anti-HBc		
	Anti-HBs		

Hepatitis C Intervention		Hepatitis C Screen	
		Date y/m/d	Result
Initial blood work at time of injury	Anti-HCV		
Repeat Blood Work at 3 months	LFT		
Repeat Blood Work at 6 months	LFT		

POST-EXPOSURE PROPHYLAXIS PROTOCOL

HIV Intervention		HIV Screen	
		Date y/m/d	Result
Initial blood work at time of injury	Anti-HIV		
Medical Assessment	If on PEP, start date		
Repeat Blood Work 2 weeks after starting PEP	Anti HIV		
Repeat Blood Work 1 month after starting PEP	Anti HIV		
Repeat Blood Work at 6 weeks if previous result negative	Anti HIV		
Repeat Blood Work at 3 months if previous result negative	Anti HIV		
Repeat Blood Work at 6 months if previous result negative	Anti HIV		

Intervention	Hepatitis B		Hepatitis C	HIV
Consent	Date:		Date:	Date:
Counselling/Teaching	Date:		Date:	Date:
		Date: y/m/d		
HBIG	Within 48 hrs.		N/A	N/A
	One month later			
Hepatitis B Immunization	#1		N/A	N/A
	#2			
	#3			
Immune Status	<input type="checkbox"/> Immune (no blood work necessary) <input type="checkbox"/> Susceptible <input type="checkbox"/> Non-responder <input type="checkbox"/> Unknown	N/A	N/A	

POST-EXPOSURE PROPHYLAXIS PROTOCOL

APPENDIX “E”

ANTI-VIRAL DRUG PROTOCOL

Baseline labwork to be done now and before starting anti-viral therapy:	Baseline labwork to be done 2 weeks after starting anti-viral therapy:
CBC, Creatinine, Liver Enzymes	If baseline results are normal, just repeat the CBC
If the protease inhibitor is being used, do a Bilirubin as well as the CBC, creatinine & BUN, glucose, liver enzymes and amylase	If a protease inhibitor is being used, do liver enzymes and Bilirubin as well as a CBC, amylase and glucose.

Starter Kit (2 drug/5 day protocol)¹ contains:

1. Zidovudine (Retrovir) 200 mg PO TID (100 mg caps) 30
2. Lamivudine (3TC, Epivir) 150 mg BID, quantity 10

Starter Kit (3 drug/5 day protocol) contains:

1. Zidovudine (Retrovir) 200 mg PO TID (100 mg caps) 30
2. Lamivudine (3TC, Epivir) 150 mg PO BID: 10
3. Kaletra (200 mg Lopinavir + 50 mg Ritonavir) 2 tabs PO BID

Kaletra is a combination drug.

Recommended Regimens:

- Zidovudine (AZT) – 200 mg TID for 4 weeks - should be used in all Chemoprophylactic regimens because it is the only agent for which there is data to support efficacy.
- At least one other agent such as Lamivudine (3TC) – 150 mg BID for 4 weeks - should be given together with the AZT for increased retroviral activity and to assess the possibility presenting AZT resistant strains.
- For clients who have been exposed to a known HIV infected *Source* and have had a High Risk Exposure, consider adding a third agent, a Protease Inhibitor such as Kaletra (200 mg Lopinavir + 50 mg Ritonavir) 2 tabs PO BID. If the *Source* is already on anti-retroviral therapy and drug resistance is a possibility, consult the MHO for the optimal regimen.
- Determine if the client is taking any other medications so as to prevent drug interactions.
- 50% of all clients on PEP develop side effects and 33% will discontinue the drugs for that reason.

¹ Most recommended and better tolerated. However, the use of Combivir® one tablet PO BID is also acceptable (Zidovudine 300 mg. and Lamivudine 150 mg)

POST-EXPOSURE PROPHYLAXIS PROTOCOL

Appendix “E” Antiviral Drug Protocol

<p>Kaletra® (lopinavir/ ritonavir)</p>	<p>Adult or adolescent (>12 years): 400 lopinavir/100 ritonavir po BID (2 tabs po BID)</p> <p>Children (6 months to 12 years): 7 to < 15 kg: 12 mg/kg lopinavir/3 mg/kg ritonavir po BID</p> <p>15 to 40 kg: 10 mg/kg lopinavir/2.5 mg/kg ritonavir po BID</p> <p>>40 kg: use adult dosing</p>	<p>Tablets: (use the tablet information) 200 mg lopinavir + 50 mg ritonavir</p> <p>Pediatric Oral Solution: 80 mg lopinavir + 20 mg ritonavir per mL. Contains 42.4% alcohol</p>	<ul style="list-style-type: none"> ◆ Diarrhea, nausea, perioral tingling, headache, rash, elevated cholesterol and triglycerides, hyperglycemia (long-term use) ◆ Pancreatitis ◆ Hepatitis 	<ul style="list-style-type: none"> ◆ The tablets may be taken with or without food and can be stored at room temperature.. ◆ Numerous drug interactions: (potent CYP3A4 inhibitor): ◆ Avoid concurrent use with: fluticasone (i.e. Advair®, Flovent®, simvastatin, lovastatin, rifampin, astemizole, terfenadine, cisapride, midazolam, triazolam, pimozide, ergot derivatives, St. John’s wort. ◆ Caution with oral contraceptives and phenytoin, phenobarbital and carbamazepine
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POST-EXPOSURE PROPHYLAXIS PROTOCOL

Retrovir® (zidovudine)	Adult or adolescent (>13 years): 300 mg po BID Children (1 month to 12 years): 180 to 240 mg/m ² /dose po BID (max 300 mg)	Capsules: 100 mg Combination tablet: Combivir® zidovudine 300 mg + lamivudine 150 mg in a single tablet. The dose is 1 tablet po BID Syrup: 10 mg/mL (240 mL bottle)	<ul style="list-style-type: none"> ◆ Nausea, headaches, malaise, anorexia, anemia, neutropenia, myopathy ◆ Rare: hepatotoxicity, lactic acidosis 	<ul style="list-style-type: none"> ◆ May take with or without food ◆ Caution when used with other bone marrow suppressing drugs
3TC® (lamivudine)	Adult or adolescent (≥ 13 years): 1250 mg po BID Children (month to 12 years): < 37.5 kg: 4 mg/kg dose po BID >37.5 kg: 150 mg po BID	Tablets: 150 mg and 300 mg Combination tablet: Combivir® zidovudine 300 mg + lamivudine 150 mg in a single tablet. The dose is 1 tablet po BID Oral Solution: 10 mg-mL (240 mL bottle)	<ul style="list-style-type: none"> ◆ Well tolerated ◆ Headache, nausea, diarrhea, abdominal pain and insomnia ◆ Rare: rash, pancreatitis, lactic acidosis 	<ul style="list-style-type: none"> ◆ May take with or without food

Adapted from the Government of Alberta NPEP Protocol

Additional information on drug interactions available at: <http://hivinsite.ucsf.edu/InSite.jsp?page=ar-00-02>

References:

DHHS: Guidelines for the use of Antiretroviral Agents in HIV-1 Infected Adults and Adolescents. May 4, 2006 (Updated guidelines available at: <http://aidsinfo.nih.gov/contentfiles/adultandadolescentGL.pdf>)

Havens PL and the Committee on Pediatric AIDS. Post – exposure prophylaxis in children and adolescents for non-occupational exposure to human immunodeficiency virus. *Pediatrics* 2003; 111: 1475-89

Abbott: http://www.abbott.ca/static/content/document/Kaletra_Tablet_Press_Release.pdf