Bleeding Disorders - Management of HIV Infection - Full Clinical Guideline

Reference no.: CG-HAEM/2023/016

1. Introduction

The emergence and transmission of HIV(and hepatitis B and C viruses) through clotting factor products resulted in high mortality of people with haemophilia and other bleeding disorders in the 1980s and early 1990s. Many studies conducted all over the world indicate that HIV transmission through factor concentrate has been almost completely eliminated. This has been achieved through the implementation of several risk-mitigating steps, which include careful selection of donors and screening of plasma and effective virucidal steps in the manufacturing process. Recombinant factor concentrates have been adopted (mainly for haemophilia) over the past two decades, and have contributed significantly to infection risk reduction.

It is highly unlikely therefore that new patients treated in the UK will contract HIV as a result of clotting factor concentrate treatment. However, this possibility must always be considered, particularly in patients previously lost to follow up, or arriving from low resource countries.

There are a small number of individuals who were infected during the original high risk period who continue to live with HIV infection and who require access to services to ensure optimal treatment.

2. Aim and Purpose

To ensure the safe and effective management of HIV infection in people with bleeding disorders.

3. HIV testing in individuals with bleeding disorders

1. Patients who will only receive recombinant products do not need HIV testing, unless indicated by clinical symptoms or where otherwise recommended by current guidelines[1]
2. Baseline HIV testing should be considered in patients who are likely to, or will definitely receive a plasma derived product.
3. HIV testing should be offered in patients who have previously received plasma products and are potentially at risk. For example, a potential scenario would be a patient arriving from a low resource country who has received plasma products in the past and has not previously been tested.
4. Any individual with a bleeding disorder treated with plasma derived products that are not adequately virus-inactivated should be tested for HIV at least every 6-12 months and whenever clinically indicated.

Prior to HIV testing, a discussion should happen about the reasons for testing; the potential benefit to the individual from testing; and how the results will be communicated.

Management of individuals with bleeding disorders and HIV infection

HIV treatment in people with hemophilia and other bleeding disorders is largely informed by guidelines used in the non-hemophilia population.[2]

The diagnosis, counselling, initiation of treatment, and monitoring of HIV, as well as the treatment of HIV-associated complications in infected people with hemophilia, should be the same as in the non-hemophilic population.

At RDH, all individuals with HIV infection are managed by the department of Genito Urinary Medicine (GUM) in accordance with their current guidelines.

All individuals with HIV will be followed up by a named consultant in GUM.

The status of treatment for HIV will be reviewed and recorded at each regular attendance at the haemophilia clinic and any concerns will be raised with the individual's consultant as necessary.

References (including any links to NICE Guidance etc.)

1. Guidelines for the management of haemophilia. A. Srivastava, A. K. Brewer, E. P. Mauser-Bunschoten, N. S. Key, S. Kitchen, A. Llinas, C. A. Ludlam, J. N. Mahlangu, K. Mulder, M. C. Poon And A. Street; Treatment Guidelines Working Group On Behalf Of The World Federation Of Hemophilia. Hemophilia 2013, 19, e1–e47
2. UK National Guidelines for HIV Testing 2008. British HIV Association; British Association for Sexual Health and HIV; British Infection Society
3. HIV referral Pathway CG-GUM/2016/001 on RDH Trust intranet

4. Documentation Controls

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