

Considerations for Antiretroviral Therapy in Women

Several studies have suggested that plasma HIV RNA levels are significantly lower in adult women compared to men. Several analyses have been reported from the ALIVE cohort of intravenous drug users in Baltimore. In a cross-sectional study from this cohort, there was a consistent trend toward lower viral load (quantitative microculture as well as HIV RNA measured by branched chain DNA and RT-PCR) in women compared to men after adjustment for CD4⁺ lymphocyte count, race and drug use within the prior 6 months; the difference in RNA levels was approximately 0.25 log (1). When women and men were matched for CD4⁺ T cell count there was no difference in the risk for progression to AIDS. However, when matched for RNA copy number, the risk of AIDS was 1.6-fold higher for women. In a further longitudinal case-control evaluation of seroconverters from this cohort, the sex-specific difference in viral load was present at seroconversion, but viral load tended to increase more rapidly in women and median viral loads in women and men became similar within 5-6 years of seroconversion (2). The relationship between initial HIV RNA level at seroconversion and progression to AIDS was examined in a longitudinal study of 202 seroconverters (156 men and 46 women) from this cohort (3). HIV RNA levels following seroconversion were significantly lower in women than men (by approximately 0.5 log), but these differences became attenuated over time. There was no significant sex-specific difference in rates of progression to AIDS. In another longitudinal study of 14 women and 28 men in the armed forces, median RNA levels were lower in women, but these differences were less than 0.5 log and diminished over time; no differences in HIV DNA load were observed (4). In a virology substudy of ACTG 175, cross-sectional HIV RNA levels were 0.28 log lower in 71 women at baseline compared with men after adjustment for CD4⁺ T cell count (5).

Other large cohort studies have had less convincing results. In 647 women from the Swiss HIV Cohort Study, there was a slightly lower viral load among female injection drug users (0.13 log) but not among heterosexually infected women (6). Additionally, there was no difference in disease progression between women and men matched for HIV RNA level and CD4⁺ T cell count. In 712 women in the ICONA study, viral load was only 0.13 log lower in women after adjustment for CD4⁺ T cell count; however, in contrast

to the Swiss HIV Cohort Study, the sex-specific difference was larger in women with heterosexually acquired HIV infection compared with injection drug use-acquired HIV infection (7). Data reported from Johns Hopkins showed little evidence of lower viral load after stratification by CD4⁺ T cell count (8), and in a comparison of 1262 women from the Women's Interagency HIV Study and men from the Multicenter AIDS Cohort Study, a small viral load difference of ~0.10-0.14 log was present only at higher CD4 count levels (9). Finally, in an analysis of adults with advanced transfusion-acquired HIV infection, no significant differences in HIV RNA levels between women and men were observed (10) and no difference in viral load by sex was observed for age and CD4⁺ T cell-matched antiretroviral naïve men and women either before or after antiretroviral therapy (11).

Limited studies in HIV-infected adults have indicated that women may have higher CD4⁺ T cell count than men. In a French study, this difference was observed only for CD4 percentage and was of borderline significance for CD4 absolute number once women and men were matched for age (12). In a second European study, while absolute CD4⁺ T cell count was higher in women than men, these differences were only statistically significant at AIDS onset and not at seroconversion or death (13). Neither study evaluated the relationship of sex and CD4⁺ T count to disease progression. However, other studies have shown similar rates of disease progression between men and women matched for CD4⁺ T cell count and/or HIV RNA level (6, 14, 15).

Taken together, these data suggest that gender-based differences in viral load occur predominantly during a window of time when the CD4⁺ T cell count is relatively preserved and treatment is recommended only in the setting of high levels of plasma HIV RNA. Clinicians may wish to consider lower plasma HIV RNA thresholds for initiating therapy in women with CD4⁺ T cell counts >350 cells/mm³, although there are insufficient data to determine an appropriate threshold. In patients with CD4⁺ T cell counts <350 cells/mm³, very small sex-based differences in viral load are apparent; therefore, no changes in treatment guidelines for women are recommended for this group.

Further study is warranted regarding sex differences in viral and immunologic parameters. It is likely that any such differences would be hormonally related;

estrogen-related effects have been described on immune function (16). Consistent with this hypothesis are some preliminary studies of variation in viral load according to menstrual cycle. One study has suggested that the ovulatory cycle influences circulating HIV-1 RNA levels (17). Additionally, another study suggests that pharmacokinetic parameters may vary over the ovulatory cycle; considerable variations in indinavir pharmacokinetics were found during the menstrual cycle, with a trend to more drug exposure during the follicular phase (18).

References

1. Farzadegan H, Hoover DR, Astemborski J, et al. Sex differences in HIV-1 viral load and progression to AIDS. *Lancet*, 1998. 352: p. 1510-1514.
2. Sterling TR, Lyles CM, Vlahov D, et al. Sex differences in longitudinal human immunodeficiency virus type 1 RNA levels among seroconverters. *J Infect Dis*, 1999. 180: p. 666-672.
3. Sterling TR, Vlahov D, Astemborski J, et al. Initial HIV-1 RNA level and progression to AIDS in women and men. *N Engl J Med*, 2001.
4. Evans JS, Nims T, Cooley J, et al. Serum levels of virus burden in early-stage human immunodeficiency virus type 1 disease in women. *J Infect Dis*, 1997. 175: p. 795-800.
5. Katzenstein DA, Hammer SM, Hughes MD, et al. The relation of virologic and immunologic markers to clinical outcomes after nucleoside therapy in HIV-infected adults with 200 to 500 CD4 cells per cubic millimeter. AIDS Clinical Trials Group Study 175 Virology Study Team. *N Engl J Med*, 1996. 335: p. 1091-1098.
6. Junghans C, Ledergerber B, Chan P, et al. Sex differences in HIV-1 viral load and progression to AIDS. Swiss HIV Cohort Study. *Lancet*, 1999. 353: p. 589.
7. Moroni M. Sex differences in HIV-1 viral load and progression to AIDS. ICONA Study Group. Italian cohort of HIV-1 positive individuals. *Lancet*, 1999. 353: p. 589-590.
8. Moore RD, Cheever L, Keruly JC, Chaisson RE. Lack of sex difference in CD4 to HIV-1 RNA viral load ratio [letter]. *Lancet*, 1999. 353: p. 463-464.
9. Anastos K, Gange SJ, Lau B, et al. Gender specific differences in quantitative HIV-1 RNA levels. 6th Conference on Retroviruses and Opportunistic Infections. Chicago, IL, 1999. (Abstract 274).
10. Kalish LA, Collier AC, Flanigan TP, Kumar PN. Plasma HIV RNA viral load in women and men with advanced HIV disease. 39th Interscience Conference on Antimicrobial Agents and Chemotherapy. San Francisco, CA, 1999. (Abstract 2190).
11. Bush CE, Donovan RM, Markowitz N, et al. Gender is not a factor in serum human immunodeficiency virus type 1 RNA levels in patients with viremia. *J Clin Microbiol*, 1996. 34: p. 970-972.
12. Delmas MC, Jadand C, De Vincenzi I, et al. Gender difference in CD4+ cell counts persist after HIV-1 infection. SEROCO Study Group [letter]. *AIDS*, 1997. 11: p. 1071-1073.
13. Prins M, Robertson JR, Brettle RP, et al. Do gender differences in CD4 cell counts matter? *AIDS*, 1999. 13: p. 2361-2364.
14. Webber MP, Schoenbaum EE, Gourevitch MN, et al. A prospective study of HIV disease progression in female and male drug users. *AIDS*, 1999. 13: p. 257-262.
15. Blair J, Hanson D, Jones J, et al. Do gender differences in viral load predict differences in HIV disease progression? 7th Conference on Retroviruses and Opportunistic Infections. San Francisco, CA, 2000. (Abstract 195).
16. Styrt B, Sugarman B. Estrogens and infection. *Rev Infect Dis*, 1991. 13: p. 1139-1150.
17. Greenblatt RM, Ameli N, Grant RM, et al. Impact of the ovulatory cycle on virologic and immunologic markers in HIV-infected women. *J Infect Dis*, 2000. 181: p. 82-90.
18. Adams J, Frost C, Shelton M, et al. Indinavir pharmacokinetics and menstrual cycle physiology. 5th Conference on Retroviruses and Opportunistic Infections. Chicago, IL, 1998. (Abstract 356).

Hydroxyurea

Hydroxyurea is indicated for use in the treatment of certain malignancies and in sickle cell anemia, and has been used investigationally for the treatment of HIV. Its potential safety and effectiveness for treatment of HIV have not been established, and clinicians should be aware of important safety precautions regarding its use. Hydroxyurea does not have direct antiretroviral activity; rather, it inhibits the cellular enzyme ribonucleotide reductase, resulting in reduced intracellular levels of deoxynucleoside triphosphates (dNTPs) that are necessary for DNA synthesis.

Depletion of the dNTP pool results in arrest of the cell cycle in the G1 phase prior to DNA synthesis; in an HIV-infected cell, incomplete reverse transcription of the viral genome also results from depletion of the dNTP pool (1). Hydroxyurea preferentially depletes intracellular dATP; therefore, it has been hypothesized that the antiretroviral activity of ddI and d4T may be enhanced in combination with hydroxyurea.

Hydroxyurea also induces the activity of cellular kinases that phosphorylate nucleoside analogue reverse transcriptase inhibitors, potentially further enhancing their antiretroviral activity.

Few data are available from controlled clinical trials that provide support for the clinical utility of hydroxyurea as an adjunct in the treatment of HIV infection. In limited studies, the addition of hydroxyurea to a regimen of ddI +d4T or ddI alone appeared to result in moderately enhanced antiretroviral activity (2-4), although the optimal dosage and dosing schedule were not determined. In contrast, in ACTG 5025, a randomized, controlled clinical trial conducted in subjects on potent antiretroviral therapy with levels of plasma viremia <200 copies/mL (5), no statistically significant differences in viral load suppression were observed in patients receiving hydroxyurea 600 mg twice daily in combination with ddI+d4T+indinavir compared to those receiving the combination regimen without hydroxyurea. Importantly, this trial was prematurely closed due to higher rates of drug toxicity in patients randomized to the hydroxyurea-containing arm. Among 68 patients randomized to hydroxyurea, three deaths related to complications of pancreatitis were reported, and a substantial decrease in median CD4⁺T cell count was observed in the hydroxyurea treatment group. The increased frequency of fatal pancreatitis in the hydroxyurea-containing arm was not statistically

significant and had not been reported previously.

These cases of fatal pancreatitis do, however, raise the question of whether hydroxyurea in combination with ddI+d4T may increase the risk of ddI-associated pancreatitis. Additional concerns regarding the use of hydroxyurea in HIV infection have been raised in this trial and other studies, and include an increased risk of persistent cytopenias (6) and hepatotoxicity (7), the drug's teratogenic properties, and the possibility of an increased risk of neuropathy. Given these concerns, more data on the potential safety and efficacy of lower doses of hydroxyurea are necessary to determine if hydroxyurea in combination with antiretroviral agents has a therapeutic role for HIV infection. Clinicians considering the use of hydroxyurea in a treatment regimen for HIV should be aware of the limited and conflicting nature of data in support of its efficacy, and the importance of monitoring patients closely for potentially serious toxicity (DII).

References

1. Rutschmann OT, Opravil M, Iten A, et al. A placebo-controlled trial of didanosine plus stavudine, with and without hydroxyurea, for HIV infection. The Swiss HIV Cohort Study. *AIDS*, 1998. 12: p. F71-F77.
2. Montaner JS, Zala C, Conway B, et al. A pilot study of hydroxyurea among patients with advanced human immunodeficiency virus (HIV) disease receiving chronic didanosine therapy: Canadian HIV trials network protocol 080. *J Infect Dis*, 1997. 175: p. 801-806.
3. Gao WY, Cara A, Gallo RC, Lori F. Low levels of deoxynucleotides in peripheral blood lymphocytes: A strategy to inhibit human immunodeficiency virus type 1 replication. *Proc Natl Acad Sci USA*, 1993. 90: p. 8925-8928.
4. Federici ME, Lupo S, Cahn P, et al. Hydroxyurea in combination regimens for the treatment of antiretroviral-naive HIV-infected adults. 12th World AIDS Conference. Geneva, 1998. (Abstract 12235).
5. ACTG 5025 Team. *Closure of ACTG 5025*. 1999.
6. Goodrich J, Khardori N. Hydroxyurea toxicity in human immunodeficiency virus-positive patients. *Clin Infect Dis*, 1999. 29: p. 692-693.
7. Weissman SB, Sinclair GI, Green CL, Fissell WH. Hydroxyurea-induced hepatitis in human immunodeficiency virus-positive patients. *Clin Infect Dis*, 1999. 29: p. 223-224.

Safety and Toxicity of Individual Antiretroviral Agents in Pregnancy

NUCLEOSIDE & NUCLEOTIDE ANALOGUE REVERSE TRANSCRIPTASE INHIBITORS

There are currently six approved nucleoside analogue reverse transcriptase inhibitors. Data are available from clinical trials in human pregnancy for zidovudine and lamivudine, while didanosine and stavudine are under study. Zalcitabine and abacavir have not been studied in pregnant women. **Tenofovir disoproxil fumarate is the first acyclic nucleotide analogue reverse transcriptase inhibitor. The nucleoside analogue drugs require three intracellular phosphorylation steps to form the triphosphate nucleoside, which is the active drug moiety; tenofovir, an acyclic nucleotide analogue drug, contains a mono-phosphate component attached to the adenine base, and hence only requires two phosphorylation steps to form the active moiety.**

Abacavir (Ziagen, ABC) is classified as FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies of abacavir in rodents are not completed; however, some in vitro mutagenesis and clastogenesis screening tests are positive.
- Reproduction/fertility animal studies
No effect of abacavir on reproduction or fertility in male and female rodents has been seen at doses of up to 500 mg/kg per day (about 8 times that of human therapeutic exposure).
- Teratogenicity/developmental toxicity animal studies
Abacavir is associated with developmental toxicity (decreased fetal body weight and reduced crown-rump length) and increased incidence of fetal anasarca and skeletal malformations in rats treated with abacavir during organogenesis at doses of 1000 mg/kg (about 35 times that of human therapeutic exposure based on area under the curve). Toxicity to the developing embryo and fetus (increased resorptions and decreased fetal body weight) occurred with abacavir administration to pregnant rodents at 500 mg/kg per day. The offspring of female rats treated with 500 mg/kg of abacavir beginning at embryo implantation and ending at

weaning had an increased incidence of stillbirth and lower body weight throughout life.

However, in the rabbit, no evidence of drug-related developmental toxicity was observed and no increase in fetal malformations was observed at doses up to 700 mg/kg (about 8.5 times that of human therapeutic exposure).

- Placental and breast milk passage in animal studies
Abacavir crosses the placenta and is excreted into the breast milk of lactating rats.
- Human studies in pregnancy
No studies have been conducted with abacavir in pregnant women or neonates. Serious hypersensitivity reactions have been associated with abacavir therapy in non-pregnant adults and have rarely been fatal; symptoms include fever, skin rash, fatigue, and gastrointestinal symptoms such as nausea, vomiting, diarrhea or abdominal pain. Abacavir should not be restarted following a hypersensitivity reaction because more severe symptoms will recur within hours and may include life-threatening hypotension and death.

Didanosine (Videx, ddl) is classified as FDA pregnancy category B.

- Animal carcinogenicity studies
Long-term animal carcinogenicity screening studies in rodents given didanosine have been negative.
- Reproduction/fertility animal studies
There has been no effect of didanosine on reproduction or fertility in rodents or on preimplantation mouse embryos (14).
- Teratogenicity/developmental toxicity animal studies
No evidence of teratogenicity or toxicity was observed with administration of high doses of didanosine to pregnant rats, mice, or rabbits.

- **Placental and breast milk passage in humans**
Placental transfer of didanosine was limited in a phase I/II safety and pharmacokinetic study (cord-to-maternal blood ratio, 0.35-0.11) (15). Didanosine is excreted in the milk of lactating rats; it is not known if didanosine is excreted in human breast milk.
- **Human studies in pregnancy**
A phase I study (PACTG 249) of didanosine was conducted in 14 HIV-infected pregnant women enrolled at gestational age 26 to 36 weeks and treated through six weeks postpartum (15). The drug was well-tolerated during pregnancy by the women and the fetuses. Preliminary analyses indicate that pharmacokinetic parameters after oral administration were not significantly affected by pregnancy, and that dose modification from the usual adult dosage is not needed.

Lamivudine (Epivir, 3TC) is classified as FDA pregnancy category C.

- **Animal carcinogenicity studies**
Long-term animal carcinogenicity screening studies in rodents administered lamivudine have been negative.
- **Reproduction/fertility animal studies**
There appears to be no effect of lamivudine on reproduction or fertility in rodents.
- **Teratogenicity/developmental toxicity animal studies**
There is no evidence of lamivudine-induced teratogenicity. Early embryoletality was seen in rabbits but not rats at doses similar to human therapeutic exposure.
- **Placental and breast milk passage in humans**
Lamivudine readily crosses the placenta in humans, achieving comparable cord blood and maternal concentrations (16). Lamivudine is excreted into human breast milk.
- **Human studies in pregnancy**
A small phase I study in South Africa evaluated the safety and pharmacokinetics of lamivudine alone or in combination with zidovudine in 20 HIV-infected pregnant women; therapy was started at 38 weeks gestation, continued through labor, and given for one week following birth to the infants (16). The drug was well-tolerated in the women at the recommended adult dose of 150 mg orally twice daily; pharmacokinetics were similar to those observed in

nonpregnant adults, and no pharmaco-kinetic interaction with zidovudine was observed.

Zidovudine and lamivudine, given in combination orally intrapartum, were well-tolerated. Lamivudine was well-tolerated in the neonates, but clearance was about 50 percent that of older children, requiring a reduced dosing regimen (4 mg/kg per day in neonates compared to 8 mg/kg per day for infants older than three months). There are currently no data on the pharmacokinetics of lamivudine between two to six weeks of age, and the exact age at which lamivudine clearance begins to approximate that in older children is not known.

Stavudine (Zerit, d4T) is classified as FDA pregnancy category C.

- **Animal carcinogenicity studies**
Long-term animal carcinogenicity studies of stavudine in rodents are not completed; some in vitro and in vivo mutagenesis and clastogenicity tests are positive.
- **Reproduction/fertility animal studies**
No effect of stavudine on reproduction or fertility in rodents has been seen. A dose-related cytotoxic effect on preimplantation mouse embryos, with inhibition of blastocyst formation at a concentration of stavudine of 100 μ M and of postblastocyst development at 10 μ M (14).
- **Teratogenicity/developmental toxicity animal studies**
No evidence of teratogenicity of stavudine has been observed in pregnant rats and rabbits. Developmental toxicity, consisting of a small increase in neonatal mortality and minor skeletal ossification delay, occurred at the highest dose in rats.
- **Placental and breast milk passage in animals**
Stavudine crosses the rat placenta in vivo and the human placenta ex vivo, resulting in a fetal/maternal concentration of approximately 0.50. In primates (pigtailed macaques), fetal/maternal plasma concentrations were approximately 0.80 (17). Stavudine is excreted into the breast milk of lactating rats.
- **Human studies in pregnancy**
A phase I/II safety and pharmacokinetic study of combination stavudine and lamivudine in pregnant HIV-infected women and their infants (PACTG 332) is being conducted, but data are not yet available. In

primate studies, pregnancy did not affect the pharmacokinetics of stavudine (18).

Tenofovir disoproxil fumerate [DF]

(Viread) is classified as FDA pregnancy category B.

Animal carcinogenicity studies

Long-term animal carcinogenicity studies of tenofovir DF in rodents are not completed; however, some *in vitro* mutagenesis and clastogenesis screening tests are positive.

Reproduction/fertility animal studies

Reproductive toxicity has been evaluated in rats and rabbits. Tenofovir had no adverse effects on fertility or general reproductive performance in rats at doses up to 600 mg/kg/day (exposure equivalent to approximately 10 times the human dose based on body surface area comparisons). However, there was an alteration of the estrous cycle in female rats administered 600 mg/kg/day of tenofovir.

Teratogenicity/developmental toxicity animal studies

No adverse effects on embryo/fetal development were seen when tenofovir was given in doses up to 450 mg/kg/day to pregnant rats and 300 mg/kg/day to pregnant rabbits. When tenofovir was administered to pregnant rats in doses of 450-600 mg/kg/day, which are maternally toxic doses, peri- and post-natal development studies of their offspring showed reduced survival and slight delay in sexual maturation. However, there were no adverse effects on growth, development, behavior, or reproductive parameters when tenofovir was administered to pregnant animals at doses that were not associated with maternal toxicity (150 mg/kg/day).

Chronic administration of tenofovir to immature animals of multiple species has resulted in reversible bone abnormalities; these effects were dose-, exposure-, age- and species-specific. Abnormalities ranged from minimal decrease in bone mineral density and content (with oral dosing in rats and dogs that achieved drug exposures 6 to 10 times that achieved with therapeutic dosing in humans) to severe, pathologic osteomalacia (with subcutaneous dosing given to monkeys). Juvenile monkeys given chronic subcutaneous tenofovir at 30 mg/kg/day (exposure equivalent to 25 times the AUC achieved with therapeutic dosing in humans) developed osteomalacia, bone fractures, and marked hypophosphatemia. However, no clinical or radiologic bone toxicity was seen when juvenile monkeys received subcutaneous dosing of 10 mg/kg/day (exposure

equivalent to 8 times the AUC achieved with therapeutic dosing in humans). Evidence of nephrotoxicity was observed in newborn and juvenile monkeys given tenofovir in doses resulting in exposures 12 to 50 times higher than the human dose based on body surface area comparisons.

Placental and breast milk passage in humans

Studies in rats have demonstrated that tenofovir is secreted in milk. Intravenous administration of tenofovir to pregnant cynomolgus monkeys resulted in a fetal/maternal concentration of 17%, suggesting tenofovir does cross the placenta. There are no data on whether tenofovir crosses the placenta or is excreted in breast milk in humans.

Human studies in pregnancy

No studies of tenofovir have been conducted in pregnant women or neonates.

Zalcitabine (HIVID, ddC) is classified as FDA pregnancy category C.

Animal carcinogenicity studies

High doses of zalcitabine (over 1,000 times that of human therapeutic exposure) have been associated with the development of thymic lymphomas in rodents.

Reproduction/fertility animal studies

No effect of zalcitabine on reproduction or fertility in rodents has been seen. However, there is a dose-related cytotoxic effect on preimplantation mouse embryos, with inhibition at a zalcitabine concentration of 100 μ M; no inhibition of postblastocyst development was observed (14).

Teratogenicity/developmental toxicity animal studies

Teratogenicity (hydrocephalus) occurred in rats given very high doses (over 1000 times the maximally recommended human exposure) of zalcitabine. Developmental toxicity, consisting of decreased fetal weight and skeletal defects, has been seen in rodents at moderate to high zalcitabine doses. Cytotoxic effects were observed on rat fetal thymocytes at zalcitabine concentrations as low as 10 μ M (approximately 100 times human therapeutic exposure).

Placental and breast milk passage in animal studies

In primate and placental perfusion studies, zalcitabine crosses the placenta (fetal-to-maternal drug ratio approximately 0.50 to 0.60) (19). In

rodents, zalcitabine concentrates in the fetal kidney and a relatively small proportion (approximately 20 percent) reaches the fetal brain. It is unknown if ddC is excreted in breast milk.

▪ Human studies in pregnancy

No studies of zalcitabine have been conducted in pregnant women or neonates.

Zidovudine (Retrovir) is classified as FDA pregnancy category C.

▪ Animal carcinogenicity studies

Prolonged, continuous, high-dose zidovudine administration to adult rodents is associated with the development of nonmetastasizing vaginal squamous tumors in 13 percent of female rodents (at estimated drug concentrations three and 24 times that of human therapeutic exposure in mice and rats, respectively) (1). In rodents, unmetabolized zidovudine is concentrated in urine with reflux into the vaginal vault. Therefore, vaginal tumors could be a topical effect of chronic zidovudine exposure on the vaginal mucosa. The observation that vaginal squamous cell carcinomas were observed in rodents exposed to 20 mg/mL zidovudine intravaginally is consistent with this hypothesis (1). In humans, only metabolized zidovudine is excreted in the urine. No increase in tumors in other organ sites has been seen in adult rodent studies.

Two transplacental carcinogenicity studies of zidovudine were conducted in mice, with differing results. In one study, two very high daily doses of zidovudine were administered during the last third of gestation in mice (2). These doses were near the maximum dose beyond which lethal fetal toxicity would be observed and approximately 25 and 50 times greater than the daily dose given to humans (although the cumulative dose was similar to the cumulative dose received by a pregnant woman taking six months of zidovudine). In the offspring of zidovudine-exposed pregnant mice at the highest dose level followed for 12 months, a statistically significant increase in lung, liver, and female reproductive organ tumors was observed; the investigators also documented incorporation of zidovudine into the DNA of a variety of newborn mouse tissues, although this did not clearly correlate with the presence of tumors. In the second study, pregnant mice were given one of several regimens of zidovudine, at doses intended to achieve blood levels approximately threefold higher than human

therapeutic exposure (3). The daily doses received by the mice during gestation ranged from one-twelfth to one-fiftieth the daily doses received in the previous study. Some of the offspring also received zidovudine for varying periods of time over their lifespan. No increase in the incidence of tumors was observed in the offspring of these mice, except among those that received additional lifetime zidovudine exposure, in which vaginal tumors were again noted.

Transplacental carcinogenicity studies have not been performed for any of the other available antiretroviral drugs or combinations of drugs. In January 1997, the National Institutes of Health convened an expert panel to review these animal data (4). The panel concluded that the known benefit of zidovudine in reducing vertical transmission of HIV by nearly 70 percent (7.2 versus 21.9 percent with placebo) (5) far outweighs the theoretical risks of transplacental carcinogenicity. The panel also concluded that infants with *in utero* exposure to zidovudine (or any other antiretroviral) should have long-term follow-up for potential adverse effects. No tumors have been observed in 727 children with *in utero* ZDV exposure followed for over 1,100 person-years (6). While these data are reassuring, follow-up is still limited and needs to be continued into adulthood before it can be concluded that there is no carcinogenic risk.

▪ Reproduction/fertility animal studies

No effect of zidovudine on reproduction or fertility in rodents has been seen. A dose-related cytotoxic effect on preimplantation mouse embryos can occur, with inhibition of blastocyst and postblastocyst development at a zidovudine concentrations similar to levels achieved with human therapeutic doses (7).

▪ Teratogenicity/developmental toxicity animal studies

No evidence of teratogenicity or toxicity was observed with administration of doses up to 500 to 600 mg/kg per day of zidovudine to pregnant rats, mice or rabbits. However, marked maternal toxicity and an increase in fetal malformations were noted in rats given a zidovudine dose of 3000 mg/kg per day (near the lethal dose, and 350 times the peak human plasma concentration).

In humans, data from PACTG 076 study and the Antiretroviral Pregnancy Registry do not demonstrate an increased incidence of congenital abnormalities in infants born to women with antepartum ZDV exposure (5, 8-10). In the PACTG

076 study, the incidence of minor and major congenital abnormalities were similar between zidovudine and placebo groups, and no specific pattern of defects was seen (5, 9). However, definitive conclusions regarding teratogenic risk cannot be made due to the limited numbers of children that have been evaluated.

- **Placental and breast milk passage in humans**
Zidovudine rapidly crosses the human placenta, achieving cord-to-maternal blood ratios of about 0.80. ZDV is excreted into human breast milk.
- **Human studies in pregnancy**
Zidovudine is well-tolerated in pregnancy at recommended adult doses and in the full-term neonate at 2 mg per kg body weight orally every six hours (5, 11). Long-term data on the safety of *in utero* drug exposure in humans are not available for any antiretroviral drug; however, short-term data on the safety of zidovudine are reassuring. No difference in disease progression between women in PACTG 076 who received zidovudine and those who received placebo has been seen in follow-up through four years postpartum (12). Infants with *in utero* zidovudine exposure followed for nearly six years have shown no significant differences from those who received placebo in immunologic, neurologic and growth parameters (9, 13); follow-up of these infants is continuing.

Issues Related to Use of Nucleoside Analogue Drugs and Mitochondrial Toxicity

Nucleoside analogue drugs are known to induce mitochondrial dysfunction, as the drugs have varying affinity for mitochondrial gamma DNA polymerase. This affinity can result in interference with mitochondrial replication, resulting in mitochondrial DNA depletion and dysfunction (20). The relative potency of the nucleosides in inhibiting mitochondrial gamma DNA polymerase *in vitro* is highest for zalcitabine (ddC), followed by didanosine (ddI), stavudine (d4T), lamivudine (3TC), ZDV and abacavir (ABC). Toxicity related to mitochondrial dysfunction has been reported in infected patients receiving long-term treatment with nucleoside analogues, and generally has resolved with discontinuation of the drug or drugs; a possible genetic susceptibility to these toxicities has been suggested (21). These toxicities may be of particular concern for pregnant women and

infants with *in utero* exposure to nucleoside analogue drugs.

Issues in Pregnancy: Clinical disorders linked to mitochondrial toxicity include neuropathy, myopathy, cardiomyopathy, pancreatitis, hepatic steatosis, and lactic acidosis. Among these disorders, symptomatic lactic acidosis and hepatic steatosis may have a female preponderance (22).

These syndromes have similarities to the rare but life-threatening syndromes of acute fatty liver of pregnancy and hemolysis, elevated liver enzymes and low platelets (the HELLP syndrome) that occur during the third trimester of pregnancy. A number of investigators have correlated these pregnancy-related disorders with a recessively-inherited mitochondrial abnormality in the fetus/infant that results in an inability to oxidize fatty acids (23-25). Since the mother would be a heterozygotic carrier of the abnormal gene, there may be an increased risk of liver toxicity due to an inability to properly oxidize both maternal and accumulating fetal fatty acids (26). Additionally, animal studies show that in late gestation pregnant mice have significant reductions (25%-50%) in mitochondrial fatty acid oxidation and that exogenously administered estradiol and progesterone can reproduce these effects (27, 28); whether this can be translated to humans is unknown. However, these data suggest that a disorder of mitochondrial fatty acid oxidation in the mother or her fetus during late pregnancy may play a role in the etiology of acute fatty liver of pregnancy and HELLP syndrome, and possibly contribute to susceptibility to antiretroviral-associated mitochondrial toxicity.

Lactic acidosis with microvacuolar hepatic steatosis is a toxicity related to nucleoside analogue drugs that is thought to be related to mitochondrial toxicity; it has been reported in infected individuals treated with nucleoside analogue drugs for long periods of time (>6 months). Initially, most cases were associated with AZT, but subsequently other nucleoside analogue drugs have been associated with the syndrome, particularly d4T. In a report from the FDA Spontaneous Adverse Event Program of 106 individuals with this syndrome (60 in patients receiving combination and 46 receiving single nucleoside analogue therapy), typical initial symptoms included 1 to 6 weeks of nausea, vomiting, abdominal pain, dyspnea, and weakness (22). Metabolic acidosis with elevated serum lactate and elevated hepatic enzymes was common. Patients in this report were predominantly female gender and high body weight.

The incidence of this syndrome may be increasing, possibly due to increased use of combination nucleoside analogue therapy or increased recognition of the syndrome. In a cohort of infected patients receiving nucleoside analogue therapy followed at Johns Hopkins University between 1989-1994, the incidence of the hepatic steatosis syndrome was 0.13% per year (29). However, in a report from a cohort of 964 HIV-infected individuals followed in France between 1997-1999 the incidence of symptomatic hyperlactatemia was 0.8% per year for all patients and 1.2% for patients receiving a regimen including d4T (30).

The frequency of this syndrome in pregnant HIV-infected women receiving nucleoside analogue treatment is unknown. In 1999, Italian researchers reported a case of severe lactic acidosis in an infected pregnant woman who was receiving d4T/3TC at the time of conception and throughout pregnancy who presented with symptoms and fetal demise at 38 weeks gestation (31). Bristol-Myers Squibb has reported 3 maternal deaths due to lactic acidosis, 2 with and 1 without accompanying pancreatitis, in women who were either pregnant or postpartum and whose antepartum therapy during pregnancy included d4T and ddI in combination with other antiretroviral agents (either a protease inhibitor or nevirapine) (32). All cases were in women who were receiving treatment with these agents at the time of conception and continued for the duration of pregnancy; all presented late in gestation with symptomatic disease that progressed to death in the immediate postpartum period. Two cases were also associated with fetal demise.

It is unclear if pregnancy augments the incidence of the lactic acidosis/hepatic steatosis syndrome reported in non-pregnant individuals receiving nucleoside analogue treatment. However, because pregnancy itself can mimic some of the early symptoms of the lactic acidosis/hepatic steatosis syndrome or be associated with other significant disorders of liver metabolism, these cases emphasize the need for physicians caring for HIV-infected pregnant women receiving nucleoside analogue drugs to be alert for early diagnosis of this syndrome. Pregnant women receiving nucleoside analogue drugs should have hepatic enzymes and electrolytes assessed more frequently during the last trimester of pregnancy and any new symptoms should be evaluated thoroughly. Additionally, because of the reports of several cases of maternal mortality secondary to lactic acidosis with prolonged use of the combination of d4T and ddI by HIV-infected pregnant

women, clinicians should prescribe this antiretroviral combination during pregnancy with caution and generally only when other nucleoside analogue drug combinations have failed or caused unacceptable toxicity or side effects.

Issues with In Utero Exposure: A French group reported eight cases of uninfected infants with in utero and/or neonatal exposure to either ZDV/3TC (four infants) or ZDV alone (four infants) who developed indications of mitochondrial dysfunction after the first few months of life (30). Two of these infants developed severe neurologic disease and died (both of whom had been exposed to ZDV/3TC), three had mild to moderate symptoms, and three had no symptoms but had transient laboratory abnormalities. It is important to note that an association between these findings and in utero exposure to antiretroviral drugs has not been established.

In infants followed through age 18 months in PACTG 076, the occurrence of neurologic events was rare – seizures occurred in one child exposed to ZDV and 2 exposed to placebo, and one child in each group had reported spasticity; mortality at 18 months was 1.4% in ZDV-exposed compared to 3.5% in placebo infants (9). In a large database that included 223 deaths in over 20,000 children with and without antiretroviral drug exposure who were born to HIV-infected women followed prospectively in several large cohorts in the United States, no deaths similar to those reported from France were identified (33). However, most of the infants with antiretroviral exposure had been exposed to ZDV alone and only a relatively small proportion (approximately 6%) had been exposed to ZDV/3TC. Evaluation is ongoing to determine if there is any evidence of mitochondrial dysfunction among any of the living children in these cohorts. Data have been reviewed relating to neurologic adverse events in 1,798 children that participated in PETRA, an African perinatal trial that compared three regimens of ZDV/3TC (before, during and one week postpartum; during labor and postpartum; and during labor only) to placebo for prevention of transmission. No increased risk of neurologic events was observed among children treated with ZDV/3TC compared to placebo, regardless of the intensity of treatment (34). Echocardiograms were prospectively performed every 4 to 6 months during the first 5 years of life in 382 uninfected infants born to HIV-infected women; 9% of infants had been exposed to ZDV prenatally (35). No significant differences in ventricular function were observed between infants exposed and unexposed to ZDV.

If the association of mitochondrial dysfunction and in utero antiretroviral exposure proves to be real, the development of severe or fatal mitochondrial disease in these infants appears to be extremely rare, and should be compared to the clear benefit of ZDV in reducing transmission of a fatal infection by nearly 70% (36). These data emphasize the importance of the existing Public Health Service recommendation for long-term follow-up for any child with in utero exposure to antiretroviral drugs.

Non-Nucleoside Reverse Transcriptase Inhibitors

Delavirdine (Rescriptor) is classified as FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies with delavirdine in rodents are not completed; in vitro screening tests have been negative.
- Reproduction/fertility animal studies
Delavirdine does not impair fertility in rodents. Teratogenicity/developmental toxicity animal studies: Delavirdine is teratogenic in rats; doses of 50 to 200 mg/kg per day during organogenesis caused ventricular septal defects. Exposure of rats to doses approximately five times human therapeutic exposure resulted in marked maternal toxicity, embryotoxicity, fetal developmental delay, and reduced pup survival.

+Abortions, embryotoxicity and maternal toxicity were observed in rabbits at doses approximately six times human therapeutic exposure.
- Placental and breast milk passage in animal studies
Whether delavirdine crosses the placenta is unknown. Delavirdine is excreted in the milk of lactating rats; however, it is unknown if the drug is excreted in human breast milk.
- Human studies in pregnancy
Delavirdine has not been evaluated in HIV-infected pregnant women. In premarketing clinical studies, the outcomes of seven unplanned pregnancies were reported: three resulted in ectopic pregnancies, three resulted in healthy live births, and one infant was born prematurely with a small muscular ventricular septal defect to a patient who received approximately six weeks of treatment with delavirdine and zidovudine early in the course of pregnancy.

Efavirenz (Sustiva) is FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies with efavirenz in rats and mice are not completed; in vitro screening tests have been negative.
- Reproduction/fertility animal studies
No effect of efavirenz on reproduction or fertility in rodents has been seen. An increase in fetal resorptions has been observed in rats at doses comparable to or lower than those used to achieve human therapeutic exposure.
- Teratogenicity/developmental toxicity animal studies
Malformations were observed in three of 20 infants born to pregnant cynomolgus monkeys receiving efavirenz from gestational days 20 to 150 at a dose of 30 mg/kg twice daily (resulting in plasma concentrations comparable to systemic human therapeutic exposure). The malformations included anencephaly and unilateral anophthalmia in one; microphthalmia in another; and cleft palate in the third. Primate teratogenicity studies have not been conducted for delavirdine or nevirapine.
- Placental and breast milk passage in animal studies
Efavirenz crosses the placenta in rats, rabbits, and primates, producing cord blood concentrations similar to concentrations in maternal plasma. It is unknown whether efavirenz is excreted in human breast milk.
- Human studies in pregnancy
No studies with efavirenz in pregnant humans are planned at this time. Because teratogenic effects were seen in primates at drug exposures similar to those representing human therapeutic exposure, pregnancy should be avoided in women receiving efavirenz.

Nevirapine (Viramune) is FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies with nevirapine in rats and mice are not completed; in vitro screening tests have been negative.

- **Reproduction/fertility animal studies**
Evidence of impaired fertility was seen in female rats at nevirapine doses providing systemic exposure comparable to human therapeutic exposure.
- **Teratogenicity/developmental toxicity animal studies**
Teratogenic effects of nevirapine have not been observed in reproductive studies with rats and rabbits. In rats, however, a significant decrease in fetal weight occurred at doses producing systemic concentrations approximately 50 percent higher than human therapeutic exposure.
- **Placental and breast milk passage in humans**
Nevirapine crosses the placenta and achieves neonatal blood concentrations equivalent to that in the mother (cord-to-maternal blood ratio approximately 0.90) (37). Nevirapine is excreted into human breast milk; the median concentration in four breast milk samples obtained from three women during the first week after delivery was approximately 76 percent (range 54 to 104 percent) of serum levels (37).
- **Human studies in pregnancy**
A phase I study (PACTG 250) evaluated the safety and pharmacokinetics of nevirapine, administered to infected pregnant women as a single 200 mg dose at the onset of labor and as a single 2 mg/kg dose to the infant at age 48 to 72 hours (37). No adverse effects were seen in the women or the infants. Pharmacokinetic parameters in pregnant women receiving intrapartum nevirapine were similar though somewhat more variable than in nonpregnant adults, possibly due to incomplete drug absorption associated with impaired gastrointestinal function during labor. Pharmacokinetic data on chronic antenatal nevirapine dosing in pregnant women are under study but not yet available. Nevirapine elimination was prolonged in the infants. The regimen maintained serum concentrations associated with antiviral activity in the infants for the first week of life. The HIVNET 012 study in Uganda compared nevirapine (200 mg orally to the mother at the onset of labor and 2 mg/kg to the neonate within 72 hours of birth) with zidovudine (600 mg orally to the mother at the onset of delivery and 300 mg every 3 hours until delivery, and 4 mg/kg orally twice daily for the first 7 days of life to the neonate). In this study, nevirapine lowered the risk of HIV transmission by nearly 50% during the first 14-16 weeks of life compared with zidovudine (38). However, the women in this African trial were not receiving any other antiretroviral therapy. In the U.S., most

infected women who know their HIV status during pregnancy receive standard ZDV prophylaxis combined with whatever antiretroviral therapy is needed for treatment of their HIV disease; it is unknown whether adding the HIVNET 012 nevirapine regimen to standard antiretroviral prophylaxis and treatment offers any additional benefit in terms of reducing perinatal transmission. A phase III perinatal trial (PACTG 316) being conducted in the United States, Europe, the Bahamas and Brazil is evaluating this regimen in combination with standard maternal antiretroviral therapy and ZDV antiretroviral therapy and ZDV prophylaxis for the prevention of perinatal HIV transmission. Selection of nevirapine-resistant virus was found at 6 weeks postpartum in both the untreated and antiretroviral-treated pregnant women who received a single dose of nevirapine in labor in HIVNET 012 and PACTG 316. In HIVNET 012, 7 of 31 women (23%) evaluated developed genotypic resistance mutations at 6 weeks postpartum; these mutations were no longer present in 4 women studied at 13-18 months postpartum (34, 39). In the antiretroviral-treated women in PACTG 316, 4 of 32 women (13%, 95% CI 4-25%) with HIV-1 RNA above 3,000 copies/mL at delivery who received nevirapine developed genotypic nevirapine resistance mutations compared to none of 38 women in the placebo arm (36).

Severe, life-threatening and in some cases, fatal hepatotoxicity, including fulminant and cholestatic hepatitis, hepatic necrosis and hepatic failure, has been reported in HIV-infected patients receiving nevirapine in combination with other drugs for treatment of HIV disease and in a small number of individuals receiving nevirapine as part of a combination regimen for post-exposure prophylaxis of nosocomial or sexual HIV exposure (BI physician letter). These events have generally occurred during the first 12 weeks of therapy, and may present with non-specific prodromal signs or symptoms of hepatitis. This has not been reported in women or infants receiving two-dose nevirapine (the HIVNET 012 regimen) for prevention of perinatal transmission. Severe, life-threatening hypersensitivity skin reactions, including Stevens-Johnson syndrome, have been reported in HIV-infected individuals receiving nevirapine for treatment, usually during the first 12 weeks of therapy. This has not been reported with use of the HIVNET 012 two-dose nevirapine regimen.

PROTEASE INHIBITORS

Issues Related to the Use of Protease Inhibitors

Hyperglycemia and diabetes mellitus:

Hyperglycemia, new onset diabetes mellitus, exacerbation of existing diabetes mellitus, and diabetic ketoacidosis have been reported with administration of protease inhibitor antiretroviral drugs in HIV-infected patients (40-43). In addition, pregnancy is itself a risk factor for hyperglycemia; it is unknown if the use of protease inhibitors will exacerbate the risk for pregnancy-associated hyperglycemia. Clinicians caring for HIV-infected pregnant women who are receiving protease inhibitor therapy should be aware of risk of this complication, and closely monitor glucose levels. Symptoms of hyperglycemia should be discussed with pregnant women who are receiving protease inhibitors.

Combination Therapy: There are limited data concerning combination antiretroviral therapy in pregnancy. A retrospective Swiss report evaluated the pregnancy outcome in 37 HIV-infected pregnant women treated with combination therapy; all received two reverse transcriptase inhibitors and 16 received one or two protease inhibitors (44). Almost 80 percent of women developed one or more typical adverse effects of the drugs such as anemia, nausea/vomiting, aminotransferase elevation, or hyperglycemia. A possible association of combination antiretroviral therapy with preterm births was noted, as 10 of 30 babies were born prematurely. The preterm birth rate did not differ between women receiving combination therapy with or without protease inhibitors. The contribution of maternal HIV disease stage and other covariates that might be associated with a risk for prematurity were not assessed. Furthermore, some studies have shown elevated preterm birth rates in HIV-infected women who have not received any antiretroviral therapy (45-47). To evaluate the baseline rates of adverse pregnancy outcome and risk factors for such outcomes in HIV-infected pregnant women, a meta-analysis of multiple PACTG perinatal trials and cohort studies is in progress. Preliminary analyses do not indicate an elevated risk of preterm delivery among infants born to women receiving combination antiretroviral therapy with or without protease inhibitors compared to those receiving single drug or no antiretroviral therapy. Until more information is known, it is recommended that HIV-infected pregnant women who are receiving combination therapy for treatment of their HIV infection should continue their

provider-recommended regimen. They should receive careful, regular monitoring for pregnancy complications and for potential toxicities.

Individual Agents: Protease Inhibitors

Phase I studies of four of the approved protease inhibitors (indinavir, ritonavir, nelfinavir and saquinavir soft gel capsule in combination with ZDV and 3TC) in pregnant HIV-infected women and their infants are ongoing in the United States. However, complete data are not yet available regarding drug dosage, safety, and tolerance of the protease inhibitors in pregnancy or in neonates. Amprenavir and lopinavir/ritonavir (Kaletra), two more recently approved protease inhibitors, have not yet been studied in pregnant women or neonates.

Amprenavir (Agenerase) is classified as FDA pregnancy category C.

- **Animal carcinogenicity studies**
Long-term animal carcinogenicity studies of amprenavir in rats and mice are not completed; in vitro screening tests have been negative.
- **Reproduction/fertility animal studies**
No effect has been seen on reproductive performance, fertility, or embryo survival in rats at exposures about twice those of human therapeutic exposure.
- **Teratogenicity/developmental toxicity animal studies**
In pregnant rabbits, administration of amprenavir resulting in systemic exposures about one-twentieth of that observed with human therapeutic exposure was associated with abortions and an increased incidence of minor skeletal variations resulting from deficient ossification of the femur, humerus trochlea and humerus. In rat fetuses, thymic elongation and incomplete ossification of bones were also attributed to amprenavir at systemic exposures about one-half that associated with the recommended human dose. Reduced body weights of approximately 10-20% were observed in offspring of rodents administered amprenavir from day 7 of gestation to day 22 of lactation (exposures approximately twice that observed with the human therapeutic dose). However, the subsequent development of the offspring, including fertility and reproductive performance, was not affected by maternal administration of amprenavir.

- Placental and breast milk passage in animals
Whether amprenavir crosses the placenta is unknown. Amprenavir is excreted in the milk of lactating rats; it is not known if it is excreted in human milk.
- Human studies in pregnancy
There have been no studies of amprenavir in pregnant women or neonates.

Indinavir (Crixivan) is classified as FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies with indinavir in rats and mice are not completed; *in vitro* screening tests have been negative.
- Reproduction/fertility animal studies
No effect of indinavir has been seen on reproductive performance, fertility, or embryo survival in rats.
- Teratogenicity/developmental toxicity animal studies
There has been no evidence of teratogenicity of indinavir in rats, rabbits or dogs. In rats, developmental toxicity manifest by increase in supernumerary and cervical ribs was observed at doses comparable to those administered to humans. No treatment-related external, visceral or skeletal changes were seen in rabbits (fetal exposure limited, approximately 2 percent of maternal levels) or dogs (fetal exposure approximately 50 percent of maternal levels). Indinavir was administered to Rhesus monkeys during the third trimester of pregnancy (at doses up to 160 mg/kg twice daily) and to neonatal Rhesus monkeys (at doses up to 160 mg/kg twice daily). When administered to neonates, indinavir caused an exacerbation of the transient physiologic hyperbilirubinemia seen in this species after birth; serum bilirubin values were approximately fourfold above controls at 160 mg/kg twice daily. A similar exacerbation did not occur in neonates after *in utero* exposure to indinavir during the third trimester of pregnancy. In Rhesus monkeys, fetal plasma drug levels were approximately 1 to 2% of maternal plasma drug levels approximately 1 hour after maternal dosing at 40, 80, or 160 mg/kg twice daily.
- Placental and breast milk passage in animals
Significant placental passage of indinavir occurs in rats and dogs, but only limited placental transfer occurs in rabbits. Indinavir is excreted in the milk of lactating rats at concentrations slightly above maternal

levels (milk-to-plasma ratio 1.26 to 1.45); it is not known if indinavir is excreted in human milk.

- Human studies in pregnancy:
A phase I/II safety and pharmacokinetic study (PACTG 358) of indinavir (800 mg tid) in combination with ZDV and lamivudine in pregnant HIV-infected women and their infants is being conducted (the infants do not receive indinavir in this study). Preliminary data are available from 5 women and infants (48). One woman discontinued indinavir due to nausea and vomiting; adverse effects in the women included one case of moderately severe hyperbilirubinemia and one case of flank pain without renal stones, both of which resolved spontaneously and did not require drug discontinuation. Pharmacokinetic data from three women indicate that the plasma area under the curve (AUC) indinavir level was lower during pregnancy than postpartum or than observed in non-pregnant HIV-infected individuals. However, HIV RNA levels in the four women who completed the study decreased to undetectable levels (<400 copies/mL) prior to delivery and CD4 cell number and percentage significantly increased. The median gestational age of the five infants was 39 weeks (range 36-39 weeks). In a pharmacokinetic study of 2 pregnant HIV-infected women receiving combination therapy including indinavir (800 mg tid), a marked difference was noted between the AUC indinavir exposure between the third trimester and postpartum evaluations (49). The AUC during the third trimester was reduced by 63% in one and 86% in the other woman when compared to 9-12 week postpartum evaluations in the same women. Similar reductions in maximum plasma indinavir concentrations were observed.

Lopinavir/Ritonavir (Kaletra) is classified as FDA pregnancy category C.

- Animal carcinogenicity studies
Long-term animal carcinogenicity screening studies of lopinavir/ritonavir in animal systems are not completed. *In vitro* mutagenicity and clastogenicity screening tests are negative for both lopinavir and ritonavir. Carcinogenicity studies in mice and rats have been carried out for ritonavir. In male mice, at levels of 50, 100 or 200 mg/kg/day, a dose-dependent increase in liver adenomas and combined adenomas and carcinomas was observed; based on AUC, exposure in male mice at the highest dose was approximately 4-fold that in male humans at the recommended

therapeutic dose (400 mg lopinavir/100 mg ritonavir bid). No carcinogenic effects were observed in female mice with exposures 9-fold that of female humans at the recommended therapeutic dose. No carcinogenic effects were observed in rats at exposures up to 0.7-fold that of humans at the recommended therapeutic dose.

- Reproduction/fertility animal studies
Lopinavir in combination with ritonavir at a 2:1 ratio produced no effects on fertility in male and female rats with exposures approximately 0.7-fold for lopinavir and 1.8-fold for ritonavir of the exposures in humans at the recommended therapeutic dose.
- Teratogenicity/developmental toxicity animal studies
There has been no evidence of teratogenicity with administration of lopinavir/ritonavir to pregnant in rats or rabbits. In rats treated with maternally toxic dosage (100 mg lopinavir/50 mg ritonavir/kg/day), embryonic and fetal developmental toxicities (early resorption, decreased fetal viability, decreased fetal body weight, increased incidence of skeletal variations and skeletal ossification delays) were observed; drug exposure in the pregnant rats was 0.7-fold for lopinavir and 1.8-fold for ritonavir of the exposures in humans at the recommended therapeutic dose. In a peri- and postnatal study in rats, a decrease in survival of pups between birth and postnatal day 21 occurred with exposures of 40 mg lopinavir/20 mg ritonavir/kg/day or greater. In rabbits, no embryonic or fetal developmental toxicities were observed with maternally toxic dosage, where drug exposure was 0.6-fold for lopinavir and 1.0-fold for ritonavir of the exposures in humans at recommended therapeutic dose.
- Placental and breast milk passage in animals
Data on placental passage of lopinavir in animals are not available. For ritonavir, Tran placental passage has been observed in rat fetuses at mid- and late-gestation. Lopinavir and ritonavir are secreted in the breast milk of lactating rats; it is not known if either drug is excreted in human milk.
- Human studies in pregnancy
No studies of lopinavir in human pregnancies have been conducted. A phase I/II safety and pharmacokinetic study of ritonavir given at therapeutic doses (600 mg bid) in combination with ZDV and lamivudine in pregnant HIV-infected women and their infants (PACTG 354) is being conducted but complete data are not yet available; preliminary data indicate that there is minimal, if any, placental passage of ritonavir in humans.

Nelfinavir (Viracept) is classified as FDA pregnancy category B.

- Animal carcinogenicity studies
Long-term animal carcinogenicity studies of nelfinavir in rats and mice are not completed; in vitro screening tests have been negative.
- Reproduction/fertility animal studies
No effect of nelfinavir has been seen on reproductive performance, fertility, or embryo survival in rats at exposures comparable to human therapeutic exposure.
- Teratogenicity/developmental toxicity animal studies
No teratogenicity or effect on fetal development by nelfinavir has been demonstrated in rodent or rabbit studies at exposures comparable to human therapeutic exposure.
- Placental and breast milk passage in animals
Whether nelfinavir crosses the placenta is unknown. Nelfinavir is excreted in the milk of lactating rats; it is not known if it is excreted in human milk.
- Human studies in pregnancy
A phase I/II safety and pharmacokinetic study (PACTG 353) of nelfinavir in combination with ZDV and lamivudine in pregnant HIV-infected women and their infants is being conducted, but complete data are not yet available. In preliminary data from this study, the standard adult dose of nelfinavir (750 mg tid) produced drug exposures in the first 9 pregnant HIV-infected women enrolled in the study that were variable and generally lower than those reported in non-pregnant adults for both tid and bid dosing. Therefore, the study has been modified to evaluate an increased dose of nelfinavir (1250 mg) administered bid. In infants, nelfinavir was not detectable in cord blood from 4 infants born to mothers receiving 750 mg nelfinavir tid; in one additional infant, the cord blood nelfinavir concentration was 11.7% that detected in maternal blood at delivery.

Ritonavir (Norvir) is classified as FDA pregnancy category B.

- Animal carcinogenicity studies
In vitro mutagenicity and clastogenicity screening tests are negative for ritonavir. Carcinogenicity studies in mice and rats have been completed. In male mice, at levels of 50, 100 or 200 mg/kg/day, a dose-dependent increase in liver adenomas and combined adenomas and carcinomas was observed; based on AUC, exposure in male mice at the highest dose was

approximately 4-fold that in male humans at the recommended therapeutic dose (400 mg lopinavir/100 mg ritonavir bid). No carcinogenic effects were observed in female mice with exposures 9-fold that of female humans at the recommended therapeutic dose. No carcinogenic effects were observed in rats at exposures up to 0.7-fold that of humans at the recommended therapeutic dose.

▪ Reproduction/fertility animal studies

No effect of ritonavir has been seen on reproductive performance or fertility in rats at drug exposures 40 percent (male) and 60 percent (female) of that achieved with human therapeutic dosing; higher doses were not feasible due to hepatic toxicity in the rodents.

▪ Teratogenicity/developmental toxicity animal studies

No ritonavir-related teratogenicity has been observed in rats or rabbits. Developmental toxicity was observed in rats, including early resorptions, decreased body weight, ossification delays, and developmental variations such as wavy ribs and enlarged fontanelles; however, these effects occurred only at maternally toxic dosages (exposure equivalent to 30 percent of human therapeutic exposure). In addition, a slight increase in cryptorchidism was also noted in rats at exposures equivalent to 22 percent of the human therapeutic dose. In rabbits, developmental toxicity (resorptions, decreased litter size, and decreased fetal weight) was observed only at maternally toxic doses (1.8 times human therapeutic exposure).

▪ Placental and breast milk passage in animals

Transplacental passage of ritonavir has been observed in rats with fetal tissue-to-maternal serum ratios >1.0 at 24 hours post-dose in mid- and late-gestation fetuses. In a human placental perfusion model, the clearance index of ritonavir was very low, with little accumulation in the fetal compartment and no accumulation in placental tissue (50). Ritonavir is excreted in the milk of lactating rats; it is unknown if it is excreted in human milk.

▪ Human studies in pregnancy

A phase I/II safety and pharmacokinetic study (PACTG 354) of ritonavir in combination with zidovudine and lamivudine in pregnant HIV-infected women and their infants is being conducted, but complete data are not yet available. Preliminary data indicate minimal, if any, placental passage of ritonavir.

Saquinavir (Invirase [Hard Gel Capsule]; Fortovase [Soft Gel Capsule]) is classified as FDA pregnancy category B.

▪ Animal carcinogenicity studies

Long-term animal carcinogenicity studies of saquinavir in rats and mice are not completed; in vitro screening tests have been negative.

▪ Reproduction/fertility animal studies

No effect of saquinavir has been seen on reproductive performance, fertility, or embryo survival in rats. Administration of low doses of saquinavir to newborn rats was associated with gastrointestinal toxicity, including inflammation at the rectoanal junction and red anal fluid; mortality was seen at very high doses (1200 mg/kg per day).

▪ Teratogenicity/developmental toxicity animal studies

No evidence for embryotoxicity or teratogenicity of saquinavir has been found in animal studies.

▪ Placental and breast milk transfer in animal studies

Placental transfer of saquinavir in the rat and rabbit was minimal. Saquinavir is excreted in the milk of lactating rats; it is not known if it is excreted in human milk.

▪ Human studies in pregnancy

A phase I/II safety and pharmacokinetic study (PACTG 386) of saquinavir in combination with ZDV and lamivudine in pregnant HIV-infected women and their infants is being conducted, but complete data are not yet available. In preliminary data from this study, the standard adult dose of saquinavir (1200 mg tid) was not sufficient to produce adequate drug exposure in the first 4 pregnant HIV-infected women enrolled in the study compared to those obtained with standard dosing in non-pregnant adults. Therefore, the study has been modified to evaluate a dose of saquinavir 800 mg combined with ritonavir 100 mg both administered bid.

MISCELLANEOUS AGENTS

Hydroxyurea is classified as FDA pregnancy category D.

Hydroxyurea is a cytotoxic and antimitotic agent that inhibits DNA synthesis and has been used for treatment of myeloproliferative disorders and sickle cell anemia. It

has recently been studied for treatment of HIV disease in combination with nucleoside analogue antiretroviral agents. By inhibiting ribonucleotide reductase, it depletes the pool of deoxynucleoside triphosphates, particularly dATP, thereby potentiating the incorporation of the nucleoside analogue drugs into viral DNA and increasing their antiretroviral effect. However, the drug has significant toxicities and its role in HIV therapy is not well defined.

▪ Animal carcinogenicity studies and human data

Hydroxyurea is genotoxic in a wide range of *in vitro* and *in vivo* animal test systems, causes cellular transformation to a tumorigenic phenotype, and is a transspecies carcinogen, which implies a potential carcinogenic risk to humans. Conventional long-term animal carcinogenicity studies have not been performed. However, intraperitoneal administration of 125 to 250 mg per kg of hydroxyurea (approximately 0.6 to 1.2 times the maximum recommended human oral dose on a mg per meter squared basis) three times weekly for 6 months to female rats increased the incidence of mammary tumors in rats surviving to 18 months compared to controls.

In humans receiving long-term hydroxyurea for myeloproliferative disorders such as polycythemia vera, secondary leukemias have been reported. It is unknown whether this leukemogenic effect is secondary to hydroxyurea or is associated with the patients' underlying disease. Skin cancer has also been reported in patients receiving long-term therapy.

▪ Reproduction/fertility animal studies

Hydroxyurea administered to male rats at doses of 60 mg per kg per day (about 0.3 times the maximum recommended human daily dose on a mg per meter squared basis) produced testicular atrophy, decreased spermatogenesis, and significantly reduced their ability to impregnate females.

▪ Teratogenicity/developmental toxicity animal studies

Potent teratogenic effects have been observed in all animal species tested, with defects reported in multiple organ systems (51-57). Administration of hydroxyurea to pregnant rats at doses as low as 180 mg per kg per day (about 0.8 times the maximum recommended human daily dose on a mg per meter squared basis) and pregnant rabbits at 30 mg per kg per day (about 0.3 times the maximum recommended human daily dose on a mg per meter squared basis) was associated with embryotoxicity and fetal malformations. In pregnant rats administered doses ranging from 185 to 1000 mg per kg body weight, fetal

defects that have been observed include central nervous system, cardiovascular, ocular, craniofacial, and skeletal anomalies, limb deformities, and diaphragmatic hernia, with the pattern of defects dependent on gestational day of exposure (51, 54, 55). Exposure early in gestation was frequently associated with embryo death in a large percentage of cases. In pregnant rats, single doses of 375 mg per kg body weight or more (about 1.7 times the maximum recommended human daily dose on a mg per meter squared basis), were associated with growth retardation and impaired learning ability in their offspring. In hamsters, neural tube defects and cardiovascular abnormalities were produced after 50 mg of hydroxyurea was given intravenously (52). In pregnant rhesus monkeys administered a cumulative dose greater than 500 mg per kg body weight, multiple skeletal, genitourinary, cardiac and ocular anomalies were found in their offspring (54). Teratogenicity was also demonstrated in pregnant cats given a single oral dose of 50 or 100 mg per kg body weight (53).

▪ Placental and breast milk passage in animal studies

Hydroxyurea has been shown to cross the placenta in animals.

▪ Placental and breast milk passage in humans

Hydroxyurea is excreted in human milk (58).

▪ Human studies in pregnancy

Published reports of hydroxyurea during human pregnancy include 16 women, all treated for primary hematologic illnesses (e.g., chronic myeloid leukemia, sickle cell anemia, primary thrombocytopenia) (59). Doses ranged from 0.5 to 3 grams per day and 13 women had first trimester exposure. No fetal anomalies were seen and normal pregnancy outcomes were reported, except for one stillbirth with eclampsia at 26 weeks gestation and four elective pregnancy terminations.

Because of concerns raised by the significant anomalies seen in multiple animal species exposed to hydroxyurea and limited human information, as well as the uncertain role of Hydroxyurea in HIV therapy, hydroxyurea use as a component of antiretroviral regimen should be avoided during pregnancy. Clinicians should counsel women of childbearing potential about potential risks of teratogenicity if they are treated with hydroxyurea and become pregnant, and encouraged to use effective contraception and avoid becoming pregnant while being treated with hydroxyurea.

ANTIRETROVIRAL PREGNANCY REGISTRY

The Antiretroviral Pregnancy Registry is an epidemiologic project to collect observational, nonexperimental data on antiretroviral exposure during pregnancy for the purpose of assessing the potential teratogenicity of these drugs. Registry data will be used to supplement animal toxicology studies and assist clinicians in weighing the potential risks and benefits of treatment for individual patients. The registry is a collaborative project of the pharmaceutical manufacturers with an advisory committee of obstetric and pediatric practitioners.

It is strongly recommended that health care providers who are treating HIV-1-infected pregnant women and their newborns report cases of prenatal exposure to antiretroviral drugs (either alone or in combination) to the Antiretroviral Pregnancy Registry. The registry does not use patient names, and birth outcome follow-up is obtained by registry staff from the reporting physician.

Referrals should be directed to
Antiretroviral Pregnancy Registry
1410 Commonwealth Drive
Wilmington, NC 28403
Telephone (800) 258-4263
Fax (800) 800-1052

References

1. Ayers KM, Clive D, Tucker WE, Jr., et al., *Nonclinical toxicology studies with zidovudine: genetic toxicity tests and carcinogenicity bioassays in mice and rats. Fundam Appl Toxicol.* 1996. 32: p. 148-158.
2. Olivero OA, Anderson LM, Diwan BA, et al., Poirier MC, Transplacental effects of 3'-azido-2',3'-dideoxythymidine (AZT): tumorigenicity in mice and genotoxicity in mice and monkeys. *J Natl Cancer Inst*, 1997. 89: p. 1602-1608.
3. Ayers KM, Torrey CE, Reynolds DJ., A transplacental carcinogenicity bioassay in CD-1 mice with zidovudine. *Fundam Appl Toxicol*, 1997. 38: p. 195-198.
4. Reggy AA, Rogers MF, Simonds RJ., Using 3'-azido-2',3'-dideoxythymidine (AZT) to prevent perinatal human immunodeficiency virus transmission and risk of transplacental carcinogenesis. *J Natl Cancer Inst*, 1997. 89: p. 1566-1567.
5. Connor EM, Sperling RS, Gelber R, et al., Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. Pediatric AIDS Clinical Trials Group Protocol 076 Study Group. *N Engl J Med*, 1994. 331: p. 1173-1180.
6. Hanson IC, Antonelli TA, Sperling RS, et al., Lack of tumors in infants with perinatal HIV-1 exposure and fetal/neonatal exposure to zidovudine. *J Acquir Immune Defic Syndr Hum Retrovirol*, 1999. 20: p. 463-467.
7. Toltzis P, Marx CM, Kleinman N, et al., Zidovudine-associated embryonic toxicity in mice. *J Infect Dis*, 1991. 163: p. 1212-1218.
8. Antiretroviral pregnancy registry. PharmaResearch Corp., W., NC. January 1989 - July 1997.
9. Sperling RS, Shapiro DE, McSherry GD, et al., Safety of the maternal-infant zidovudine regimen utilized in the Pediatric AIDS Clinical Trials Group 076 Study. *AIDS*, 1998. 12: p. 1805-1813.
10. White A, Eldridge R, Andrews E., Birth outcomes following zidovudine exposure in pregnant women: the Antiretroviral Pregnancy Registry. *Acta Paediatr Suppl*, 1997. 421: p. 86-88.
11. O'Sullivan MJ, Boyer PJ, Scott GB, et al., The pharmacokinetics and safety of zidovudine in the third trimester of pregnancy for women infected with human immunodeficiency virus and their infants: phase I acquired immunodeficiency syndrome clinical trials group study (protocol 082). Zidovudine Collaborative Working Group. *Am J Obstet Gynecol*, 1993. 168: p. 1510-1516.
12. Bardeguet AD, Mofenson LM, Spino C, et al., Lack of clinical and immunologic disease progression with transient use of zidovudine (zdv) to reduce perinatal HIV-1 transmission in PACTG 076. In: 12th World Conference on AIDS. Geneva, 1998 (abstract 12233).

13. Culnane M, Fowler M, Lee SS, et al., Lack of long-term effects of *in utero* exposure to zidovudine among uninfected children born to HIV-infected women. Pediatric AIDS Clinical Trials Group Protocol 219/076 Teams. *J Am Med Assoc*, 1999. 281: p. 151-157.
14. Toltzis P, Mourton T, Magnuson T, Comparative embryonic cytotoxicity of antiretroviral nucleosides. *J Infect Dis*, 1994. 169: p. 1100-1102.
15. Wang Y, Livingston E, Patil S, et al., Pharmacokinetics of didanosine in antepartum and postpartum human immunodeficiency virus-infected pregnant women and their neonates: an AIDS Clinical Trials Group study. *J Infect Dis*, 1999. 180: p. 1536-1541.
16. Moodley J, Moodley D, Pillay K, et al., Pharmacokinetics and antiretroviral activity of lamivudine alone or when coadministered with zidovudine in human immunodeficiency virus type 1-infected pregnant women and their offspring. *J Infect Dis*, 1998. 178: p. 1327-1333.
17. Odinecs A, Nosbisch C, Keller RD, et al., In vivo maternal-fetal pharmacokinetics of stavudine (2',3'-didehydro- 3'-deoxythymidine) in pigtailed macaques (*Macaca nemestrina*). *Antimicrob Agents Chemother*, 1996. 40: p. 196-202.
18. Odinecs A, Pereira C, Nosbisch C, Unadkat JD., Prenatal and postpartum pharmacokinetics of stavudine (2',3'-didehydro- 3'-deoxythymidine) and didanosine (dideoxyinosine) in pigtailed macaques (*Macaca nemestrina*). *Antimicrob Agents Chemother*, 1996. 40: p. 2423-2425.
19. Sandberg JA, Binienda Z, Lipe G, et al., Placental transfer and fetal disposition of 2',3'-dideoxycytidine and 2',3'-dideoxyinosine in the rhesus monkey. *Drug Metab Dispos*, 1995. 23: p. 881-884.
20. Brinkman K, ter Hofstede HJ, Burger DM, et al., Adverse effects of reverse transcriptase inhibitors: mitochondrial toxicity as common pathway. *AIDS*, 1998. 12: p. 1735-1744.
21. Mofenson, L., Perinatal exposure to zidovudine: benefits and risks. *N Engl J Med*, 2000. 343: p. 803-805.
22. Boxwell DE, Styrt BA. Lactic acidosis (LA) in patients receiving nucleoside reverse transcriptase inhibitors (NRTIs). 39th Interscience Conference on Antimicrobial Agents and Chemotherapy. San Francisco, CA, September 26-29, 1999 (Abstract 1284).
23. Ibdah JA, et al., A fetal fatty-acid oxidation disorder as a cause of liver disease in pregnant women. *N Engl J Med*, 1999. 340: p. 1723-1731.
24. Strauss AW, Bennett MJ, Rinaldo P, et al., Inherited long-chain 3-hydroxyacyl-CoA dehydrogenase deficiency and a fetal-maternal interaction cause maternal liver disease and other pregnancy complications. *Semin Perinatol*, 1999. 23: p. 100-112.
25. Sims HF, Brackett JC, Powell CK, et al., The molecular basis of pediatric long-chain 3-hydroxyacyl Co-A dehydrogenase deficiency associated with maternal acute fatty liver of pregnancy. *Proc Natl Acad Sci USA*, 1995. 92: p. 841-845.
26. Ibdah JA, Yang Z, Bennett MJ., Minireview: Liver disease in pregnancy and fetal fatty acid oxidation defects. *Molecular Genetics and Metabolism*, 2000. 71: p. 182-189.
27. Grimbert S, Fromenty B, Fisch C, et al., Decreased mitochondrial oxidation of fatty acids in pregnant mice: possible relevance to development of acute fatty liver of pregnancy. *Hepatology*, 1993. 17: p. 628-637.
28. Grimbert S, Fisch C, Deschamps D, et al., Effects of female sex hormones on mitochondria: possible role of acute fatty liver of pregnancy. *Am J Physiol*, 1995. 268: p. 6107.
29. Fortgang IS, et al., Hepatomegaly and steatosis in HIV-infected patients receiving nucleoside analogue antiretroviral therapy. *Am J Gastroenterol*, 1995. 90: p. 1433-1436.
30. Gerard Y, Maulin L, Yazdanpanah Y, et al., Symptomatic hyperlactatemia: an emerging complication of antiretroviral therapy. *AIDS*, 2000. 14: p. 2723-2730.
31. Luzzati R, Del Bravo P, Di Perri G, et al., Riboflavine and severe lactic acidosis. *Lancet*, 1999. 353: p. 901-902.
32. Bristol-Myers Squibb Company. Healthcare Provider Important Drug Warning Letter. January 5, 2001.
33. The Perinatal Safety Review Working Group. Nucleoside exposure in the children of HIV-infected women receiving antiretroviral drugs: absence of clear evidence for mitochondrial disease in children who died before 5 years of age in five United States cohorts. *J Acquir Immune Defic Syndr* 2000;15:261-8.
34. Jackson JB, Becker-Pergola G, Guay L, et al., Identification of the K103N resistance mutation in Ugandan women receiving nevirapine to prevent HIV-1 vertical transmission. *AIDS*, 2000. 14: p. F111-F115.
35. Lipshultz SE, Easley KA, Orav EJ, et al., Absence of cardiac toxicity of zidovudine in infants. *N Engl J Med*, 2000. 343: p. 759.
36. Sullivan J, Cunningham C, Dorenbaum A, et al., Genotypic resistance analysis in women participating in PACTG 316 with HIV-1 RNA \geq 10,000 copies/ml. XIII International AIDS Conference. Durban, South Africa, July 9-14, 2000 (abstract LbOr14).
37. Mirochnick M, Fenton T, Gagnier P, et al., Pharmacokinetics of nevirapine in human immunodeficiency virus type 1- infected pregnant women and their neonates. Pediatric AIDS Clinical Trials Group Protocol 250 Team. *J Infect Dis*, 1998. 178: p. 368-374.
38. Guay LA, Musoke P, Fleming T, et al., Intrapartum and neonatal single-dose nevirapine compared with zidovudine for prevention of mother-to-child transmission of HIV-1 in Kampala, Uganda: HIVNET 012 randomised trial. *Lancet*, 1999. 354: p. 795-802.

39. Jackson JB, Mracnz M, Guay L, et al., Selection of nevirapine (NVP) resistance mutations in Ugandan women and infants receiving NVP prophylaxis to prevent HIV-1 vertical transmission (HIVNET 012). XIII International AIDS Conference. Durban, South Africa, July 9-14, 2000 (abstract LbOr13).
40. Food and Drug Administration Advisory. FDA Public Health Advisory: reports of diabetes and hyperglycemia in patients receiving protease inhibitors for treatment of human immunodeficiency virus (HIV). Food and Drug Administration, Public Health Service, Department of Health and Human Services, Rockville, MD: June 11, 1997.
41. Visnegarwala F, Krause KL, Musher DM., Severe diabetes associated with protease inhibitor therapy. *Ann Intern Med*, 1997. 127: p. 947.
42. Eastone JA, Decker CF, New-onset diabetes mellitus associated with use of protease inhibitor. *Ann Intern Med*, 1997. 127: p. 948.
43. Dube, M., Metabolic complications of antiretroviral therapies. *AIDS Clinical Care*, 1998. 10: p. 41-48.
44. Lorenzi P, Spicher VM, Laubereau B, et al., Antiretroviral therapies in pregnancy: maternal, fetal and neonatal effects. Swiss HIV Cohort Study, the Swiss Collaborative HIV and Pregnancy Study, and the Swiss Neonatal HIV Study. *AIDS*, 1998. 12: p. F241-247.
45. Martin R, Boyer P, Hammill H, et al., Incidence of premature birth and neonatal respiratory disease in infants of HIV-positive mothers. The Pediatric Pulmonary and Cardiovascular Complications of Vertically Transmitted Human Immunodeficiency Virus Infection Study Group. *J Pediatr*, 1997. 131: p. 851-856.
46. Leroy V, Ladner J, Nyiraziraje M, et al., Effect of HIV-1 infection on pregnancy outcome in women in Kigali, Rwanda, 1992-1994. Pregnancy and HIV Study Group. *AIDS*, 1998. 12: p. 643-650.
47. Brocklehurst P, French R, The association between maternal HIV infection and perinatal outcome: a systematic review of the literature and meta-analysis. *Br J Obstet Gynaecol*, 1998. 105: p. 836-848.
48. Wara D, Tuomala R, Bryson Y, et al., PACTG 358-safety, pharmacokinetics and antiretroviral activity of indinavir, zidovudine (ZDV), and lamivudine (3TC) in HIV-1 seropositive pregnant women and infants. 2nd Conference on Global Strategies for the Prevention of HIV Transmission from Mothers to Infants. Montreal, Canada, September 1-6, 1999 (abstract 447).
49. Hayashi S, Beckerman K, Homma M, et al., Pharmacokinetics of indinavir in HIV-positive pregnant women. *AIDS*, 2000. 14: p. 1061-1062.
50. Casey BM, Bawdon RE., Placental transfer of ritonavir with zidovudine in the ex vivo placental perfusion model. *Am J Obstet Gynecol*, 1998. 179: p. 758-761.
51. Chaube S, Murphy ML, The effects of hydroxyurea and related compounds on the rat fetus. *Cancer Res*, 1966. 26: p. 1448-57.
52. Ferm, V., Severe developmental malformations. *Arch Pathol*, 1966. 81: p. 174-177.
53. Khera, K., A teratogenicity study on hydroxyurea and diphenylhydantoin in cats. *Teratology*, 1979. 20: p. 447-452.
54. Wilson JG, Scott WJ, Ritter EJ, Fradkin R, Comparative distribution and embryotoxicity of hydroxyurea in pregnant rats and rhesus monkeys. *Teratology*, 1975. 11: p. 169-178.
55. Aliverti V, Bonanomi L, Giavini E., Hydroxyurea as a reference standard in teratological screening. Comparison of the embryotoxic and teratogenic effects following single intraperitoneal or repeated oral administrations to pregnant rats. *Arch Toxicol Suppl*, 1980. 4: p. 239-247.
56. DeSesso JM, Jordan RL., Drug-induced limb dysplasias in fetal rabbits. *Teratology*, 1977. 15: p. 199-211.
57. Fritz H, Hess R., Effects of hydroxyurea on postnatal growth and behaviour of rats. *Agents Actions*, 1980. 10: p. 389-393.
58. Sylvester RK, Lobell M, Teresi ME, et al., Excretion of hydroxyurea into milk. *Cancer Res*, 1987. 60: p. 2177-2178.
59. Diav-Citrin O, Hunnisett L, Sher GD, Koren G., Hydroxyurea use during pregnancy: a case report in sickle cell disease and review of the literature. *Am J Hematol*, 1999. 60: p. 148-150.