EXECUTIVE SUMMARY

Background

The purpose of the Antiretroviral Pregnancy Registry (Registry) is to detect any major teratogenic effects involving any of the Registry drugs* to which pregnant women are exposed (1). Registration is voluntary and confidential with information obtained from the health care provider. A Registry-assigned identifier allows for follow-up capability. Information on subjects is provided to the Registry prospectively (prior to the outcome of pregnancy being known) through their health care provider, with follow-up obtained from the health care provider after the outcome is determined. (For more details, see Appendix F: Methods beginning on page 153.) Providers are strongly urged to enroll their patients as early in pregnancy as possible to maximize the validity of the data. In addition, the Registry is very interested in assembling a group of providers who are willing to make a commitment to report all of their site’s antiretroviral pregnancy exposures to the Registry, thereby assuring all cases can be considered prospective.

Providers are encouraged to contact the Registry for more information about this group. The Registry is informed in its analysis by other data, for example, retrospective reports and clinical studies.

Prospective tracking of fetal drug exposure during pregnancy, particularly newer agents and new combinations of therapies remains critically important in evaluating the safety of these agents among reproductive-age women and the exposed fetus.

Each year the Registry has enrolled approximately 1300 pregnant women in the US exposed to antiretroviral drugs. This number represents approximately 15% of the 8,700 HIV positive women who give birth to live infants annually in the US (2). Each year the Registry also enrolls approximately 200 pregnant women from other countries. Given the continued emergence of newer therapies used for treatment and prevention for which there is an ongoing need for evidence of their safety in pregnancy, sustained reporting is vital to the registry’s ability to fulfill its mission of early detection of a birth defect signal, if present. Health care providers are strongly encouraged to continue reporting eligible patients to the Registry.

Data Summary

Primary Registry Analysis (Prospective Reports): In review of the data through 31 July 2016, among the prospective Registry reports, the prevalence of birth defects per 100 live births among women with a first trimester exposure to any of the antiretroviral therapies included in the Registry is 2.8 (95%
confidence interval (CI): 2.4 - 3.2, i.e., 230 outcomes with defects of 8227 live births (Table 7). The prevalence of defects is not significantly different from the prevalence of defects among women with an initial exposure during the second and/or third trimester (2.8 per 100 live births) (prevalence ratio: 1.01, 95% CI: 0.85, 1.21).

Measured against 17371 live births with exposure at any time during pregnancy, there were 484 outcomes with birth defects identified, a prevalence of 2.8 birth defects per 100 live births (95% CI: 2.5 - 3.0). This proportion is not significantly higher than those reported in the Registry’s two population based comparators, the CDC’s birth defects surveillance system (MACDP) (3, 4, 5, 6) (2.72 per 100 live births) and the Texas Birth Defects Registry (TBDR) (7) (4.17 per 100 live births). No increases in risk of specific defects have been detected to date when compared with observed MACDP or TBDR rates or with rates among those with earliest exposure in the second or third trimester. In analyzing individual drugs with sufficient data to warrant a separate analysis with the exception of didanosine and nelfinavir, no increases of concern in risk have been detected. For didanosine and nelfinavir, there is a modest but statistically significant increase in overall rates of defects when compared with the MACDP though not the TBDR. These defects are listed in Appendix C. No pattern of birth defects has been detected with didanosine or nelfinavir. The clinical relevance of this statistical finding is unclear. The Registry will continue to monitor didanosine and nelfinavir for any signal or pattern of birth defects.

A previously noted transient increase in rate of hypospadias cases from the addition of data from one large clinical study (WITS) has not persisted and detailed analysis does not confirm that signal. There are no additional cases of hypospadias with relevant exposure in this update.

For darunavir, didanosine, efavirenz, indinavir, raltegravir, rilpivirine, and stavudine, sufficient numbers of first trimester exposures have been monitored to detect at least a two-fold increase in risk of overall birth defects. No such increases have been detected to date. For abacavir, atazanavir, emtricitabine, lamivudine, lopinavir, nelfinavir, nevirapine, ritonavir, tenofovir disoproxil fumarate, and zidovudine sufficient numbers of first trimester exposures have been monitored to detect at least a 1.5-fold increase in risk of overall birth defects and a 2-fold increase in risk of birth defects in the more common classes, cardiovascular and genitourinary systems. No such increases have been detected to date. (See table below for number of defects and prevalence per 100 live births for first trimester exposures to all drugs with sufficient data to warrant separate analysis. See Appendix A for additional data.) There are insufficient data to make similar comparisons for other drugs or specific subgroups of defects.

The Advisory Committee pays particular attention to findings from animal studies. Therefore, the Advisory Committee is closely monitoring first trimester exposures to efavirenz for anomalies including central nervous system defects. Defects have been reported in 22 among the 934 infants with first trimester exposure to efavirenz, including a single case of myelomeningocele and a single case of anophthalmia with severe oblique facial clefts and amniotic banding. During the July 2014 report period an undefined abnormality of the cerebellar vermis seen on prenatal ultrasound was reported. At birth, the infant’s physical exam was normal. Upon February 2015 follow-up, it was reported that the infant was developing normally and that the parents have declined further imaging at this time. Without postnatal imaging, a central nervous system abnormality cannot be confirmed.
Supplemental Analyses

Retrospective Reports: Though the Registry is a prospective registry, data from retrospective reports (pregnancies with a known outcome at the time of reporting) are also reviewed to assist in the detection of any unusual patterns in birth defects. Retrospective reports can be biased toward the reporting of more unusual and severe cases and are less likely to be representative of the general population experience. Therefore, the calculation of prevalence from these reports is inappropriate. Isolated cases of neural tube defects with efavirenz exposure have been reported. No other pattern of defects (isolated or syndromic) has been found in the overall evaluation of retrospective reports and Registry cases of birth defects.

Clinical Studies: In the analysis of reports from clinical studies in pregnancy, 16 infants with defects were identified among 373 live births with first trimester exposures to an antiretroviral therapy. The prevalence of birth defects per 100 live births among women with first trimester exposures to an antiretroviral (primarily nucleoside reverse transcriptase inhibitors) is 4.3 (95% CI: 2.5 - 6.9) (Table 12). The number of defects identified with an initial exposure in the second or third trimester is 28 among 1822 live births, and the prevalence of birth defects per 100 live births is 1.5 (95% CI: 1.0 - 2.2). It is not surprising that the rate of detection of birth defects was relatively high among infants born to women enrolled in clinical studies conducted in pregnant women, as this group is often very different compared with either the CDC population-based surveillance system or the Registry. Differences include severity of disease at the time of maternal enrollment in clinical studies and rigorous infant follow-up and evaluation (e.g., echocardiography). In addition, women with first trimester exposures appeared to have more advanced disease. The higher rates of defects observed in clinical studies compared to the primary analysis are principally minor, spontaneously resolving cardiovascular defects that were detected on echocardiogram. To date, we have received 52 prospective cases of VSD, distributed across trimesters and drug exposures. Thus, the overall rate remains low and there is no apparent excess of cases among zidovudine or any drug exposure group or relevant trimester of exposure.
Reports from the Published Literature: There is a growing body of literature on the potential association between prenatal antiretroviral exposure and birth defects. The Registry attempts to identify these studies through a systematic literature search conducted annually. The Registry has not identified a signal in any of the published studies reviewed to date.

Data Limitations

The Registry is designed to detect teratogenic effects of antiretroviral medications used in pregnancy. The occurrence of other developmental or functional defects is not systematically collected, although the Advisory Committee carefully reviews each pregnancy outcome received by the Registry. Potential limitations of registries such as this should be recognized. The limitations include, but are not limited to, underreporting (i.e., not every report of an exposure is obtained), differential reporting (i.e., there may be reasons why one report would be provided to the Registry and another would not), underascertainment of birth defects (i.e., not every birth defect is identified, e.g., reporter may not see the defect at birth), differential ascertainment of birth defects (e.g., variable use of diagnostic tests), and loss to follow-up (e.g., reports where no outcome information is obtained). Despite these limitations, such reports have been useful to supplement animal toxicology studies and clinical trial data, and to assist clinicians in weighing the risks and benefits of antiretroviral treatment during pregnancy and in counseling women with exposure during the first trimester. Moreover, accrual of additional patient experience over time will provide more definitive information regarding risks, if any, of exposure during pregnancy to the antiretroviral therapies followed in the Registry.

ADVISORY COMMITTEE CONSENSUS*

In reviewing all reported defects from the prospective registry, informed by clinical studies and retrospective reports of antiretroviral exposure, the Registry finds no apparent increases in frequency of specific defects with first trimester exposures and no pattern to suggest a common cause. The Registry notes modest but statistically significant elevations of overall defect rates with didanosine and nelfinavir compared with its population based comparator, the MACDP, but not the TBDR. While the Registry population exposed and monitored to date is not sufficient to detect an increase in the risk of relatively rare defects, these findings should provide some assurance when counseling patients. However, potential limitations of registries such as this should be recognized. The Registry is ongoing. Given the emergence of new therapies about which data are still insufficient, health care providers are strongly encouraged to report eligible patients to the Registry at www.APRegistry.com.

PRÉCIS*

The Antiretroviral Pregnancy Registry finds no apparent increases in frequency of specific defects with first trimester exposures and no pattern to suggest a common cause; however, potential limitations of registries should be recognized. The Registry is ongoing. Health care providers are strongly encouraged to report eligible patients to www.APRegistry.com.

* Those wishing to cite data from this Report are encouraged to do so. However, to ensure consistency of reporting, you are required to include the consensus statement verbatim. Shorter presentations of Registry data (i.e., abstracts) may use the abbreviated précis. Editors should be reminded of this requirement and encouraged to exempt the sentence from any word count restrictions. Suggested citation: Antiretroviral Pregnancy Registry Steering Committee. Antiretroviral Pregnancy Registry International Interim Report for 1 January 1989 through 31 July 2016. Wilmington, NC: Registry Coordinating Center; 2016. Available from URL: www.APRegistry.com.