Chestfeeding for Lactating People Living with HIV

To the Editor: A term infant born to a 24-year-old G1P1 birthing person living with human immunodeficiency virus (HIV) was rooming in on the postpartum unit. When discussing feeding preferences with nursing, the birthing person stated they are interested in chestfeeding, the gender-inclusive term for breastfeeding,[1] however both nursing staff and the birthing person are unsure if it is safe to do so when living with HIV. An initial decision was made to start exclusive formula feeding. When approached with the clinical question the following day, the physician discussed the evidence with the birthing person, explaining that the rates of transmission are low but not zero and professional society recommendations at the time recommended alternative feeding. Notably, the discussion did not include a review of the birthing person's CD4 counts or whether they were prescribed and adherent to highly active antiretroviral therapy (HAART). Following this discussion, the birthing person opted to exclusively formula feed the infant.

This real-life case demonstrates the importance for family physicians to understand the evolving guidelines for chestfeeding infants born to birthing persons living with HIV. Chestfeeding is a personal and important decision for many birthing persons. Chestfeeding, in this context, refers to the use of human milk from people living with HIV both directly from the chest and indirectly using a supplemental feeding system.[1] The benefits that infants and lactating people receive from direct chestfeeding are well documented. Recent changes to professional society recommendations have opened the opportunity for lactating people living with HIV to chestfeed under certain circumstances. Presented below are the current guidelines regarding chestfeeding for lactating people living with HIV. Understanding these guidelines allows the opportunity for informed shared decision making in the best interest of the infant and their family.

Although professional societies report differing conclusions (Table 1), several support birthing persons living with HIV in chestfeeding when their viral load is undetectable on highly active antiretroviral therapy (HAART), and their infant also receives HAART. Family physicians are well suited to discuss these varying recommendations and guide families to make informed decisions.

The rates of HIV transmission are low with chestfeeding; however, they are not zero. This is the rationale behind the American Academy of Pediatrics (AAP) guidelines, which state that HIV infection is an absolute contraindication to chestfeeding.[2] The World Health Organization (WHO), however, released a statement in 2010 stating that persons with HIV on HAART may chestfeed,[3] primarily to support nonaffluent developing nations where human milk can be a safer alternative to contaminated water supplies while also acknowledging that HIV transmission is low for lactating persons on HAART. The Academy of Breastfeeding Medicine (ABM) later endorsed the WHO statement, citing the substantial health benefits, for infants and lactating persons through exclusive chestfeeding.[4] The WHO formalized this recommendation in their 2016 guideline.[3] In January 2023, The United States Department of Health and Human Services (US HHS) also endorsed shared decision making between physicians and lactating persons with undetectable HIV viral loads on HAART regarding chestfeeding.[5] This position is supported by research showing an exceptionally low transmission rate through exclusive chestfeeding when both the lactating person and the newborn are receiving adequate HAART.[5]

These guidelines' differences warrant shared decision making with pregnant persons living with HIV regarding chestfeeding. Based on the most current evidence, family physicians may reasonably consider including chestfeeding as a feeding option for newborns of birthing persons living with HIV if the lactating person is on HAART with undetectable viral loads and the newborn is also on HAART.

Bailey White, DO
Bryce Ringwald, MD
Emily Gorman, DO
From the OhioHealth Riverside Methodist Hospital Family Medicine Residency Program, Columbus, OH (BW, BR, EG)
E-mail: Bryceringwald@gmail.com

To see this article online, please go to: http://jabfm.org/content/37/3/512.full.

References

1. Chetwynd EM, Facelli V. Lactation support for LGBTQIA+ families. J Hum Lact 2019;35:244–7.
2. Meek J, Noble YL. Section on breastfeeding policy statement: breastfeeding and the use of human milk. Pediatrics July 2022;150:e2022057988.
3. Guideline: updates on HIV and infant feeding: the duration of breastfeeding, and support from health services to improve feeding practices among mothers living with HIV. Geneva: World Health Organization; 2016.
4. Chantry CJ, Eglash A, Labbok M. ABM position on breastfeeding-revised 2015. Breastfeed Med 2015;10:407–11.
5. Panel on Treatment of HIV During Pregnancy and Prevention of Perinatal Transmission. Recommendations for the use of antiretroviral drugs during pregnancy and interventions to reduce perinatal HIV transmission in the United States. Department of Health and Human Services. Available at: https://clinicalinfo.hiv.gov/en/guidelines/perinatal. (Accessed September 11, 2023).

doi: 10.3122/jabfm.2024.240001R1

Table 1. Position Statement Excerpts from Professional Societies Regarding Chestfeeding in Lactating Persons Living with HIV

Organization	Position	Date
Academy of Breastfeeding Medicine	"ABM accepts and endorses the 2010 WHO statement on HIV and infant feeding, recognizing that exclusive breastfeeding reduces mother-to-child transmission compared with mixed feeding and that breastfeeding is an important choice for HIV-positive women in many settings, and these dyads must have access to appropriate antiretroviral prophylaxis or treatment while breastfeeding."[4]	October 2015
American Academy of Pediatrics	"Mothers in the United States should not breastfeed or feed expressed milk to their infants if they have HIV infection."[2]	June 2022
United States Department of Health and Human Services	"Individuals with HIV who are on ART with a sustained undetectable viral load and who choose to breastfeed should be supported in this decision."[5]	January 2023
World Health Organization	"Mothers living with HIV should breastfeed for at least 12 months and may continue breastfeeding for up to 24 months or longer (similar to the general population) while being fully supported for ART adherence"[3]	July 2016

Abbreviations: ABM, academy of breastfeeding medicine; WHO, world health organization; HIV, human immunodeficiency virus; ART, antiretroviral therapy.
Original table created from references 2–5.

Outbreak of Hand, Foot, and Mouth Disease Among University Residential Students

To the Editor: Between mid-September and mid-October, 2023 our university student health clinic encountered 60 cases of hand, foot, and mouth disease that occurred primarily among freshman residential students. Diagnoses were made clinically. None of the students became seriously ill and there were likely additional infected students who did not present to our clinic. Diagnosed students were instructed on hygiene measures and to isolate in place until they were fever-free and the lesions had healed.

As was the case in the students we saw, typical symptoms of hand, foot, and mouth disease include a low-grade fever with a maculopapular rash or papulovesicular rash on the hands and soles of the feet as well as painful oral ulcerations that resolve in 7 to 10 days.[1,2] Fingernail and toenail changes can include Beau's lines, yellow-orange discoloration, and separation of the nail plate from the nail matrix that occur 4 to 8 weeks after disease onset and resolve within 1 to 2 months.[3]

Rare serious complications from hand, foot, and mouth disease include aseptic meningitis, encephalomyelitis, pulmonary edema, pulmonary hemorrhage, and viral myocarditis, and cardiorespiratory failure.[1,2] Erythema multiforme-like lesions with atypical presentation on the torso have been reported in adult immunocompetent patients which can delay the diagnosis of hand, foot, and mouth disease and institution of mitigation measures.[4,5]

Most cases of hand, foot, and mouth disease occur in patients under 10 years old.[1] Outbreaks on college campuses have occurred but are infrequent.[6] Our experience demonstrates the need for vigilance in the immediate post-COVID-19 pandemic era for outbreaks of infectious diseases that may follow an atypical epidemiologic pattern as a result of prior social distancing measures, particularly in adolescent and young adult populations.

Philip Hunter Spotts, MD, FAAFP
Assistant Professor in Community Medicine and Community Health;
Medical Director, Duke Student Health, Duke University School of Medicine, Durham, NC
E-mail: hunter.spotts@duke.edu

To see this article online, please go to: http://jabfm.org/content/37/3/513.full.

References

1. Saguil A, Kane SF, Lauters R, Mercado MG. Hand-foot-and-mouth disease: rapid evidence review. Am Fam Physician 2019;100:408–14.
2. Zhang X, Zhang Y, Li H, Liu L. Hand-foot-and-mouth disease-associated enterovirus and the development of multivalent HFMD vaccines. Int J Mol Sci 2022;24:169.
3. Verma S, Singal A. Nail changes in hand-foot-and-mouth disease (HFMD). Indian Dermatol Online J 2021;12:656–7.
4. Farah M, El Chaer F, El Khoury J, El Zakhem A. Erythema multiforme-like hand, foot, and mouth disease in an immunocompetent adult: a case report. Int J Dermatol 2020;59:487–9.
5. Jung Y, Woo YR, Kim M, Park HJ. Hand-foot-mouth disease mimicking erythema multiforme in an immunocompetent adult. Ann Dermatol 2022;34:392–3.
6. Buttery VW, Kenyon C, Grunewald S, Oberste MS, Nix WA. Atypical presentations of hand, foot, and mouth disease caused by coxsackievirus A6 — Minnesota, 2014. MMWR Morb Mortal Wkly Rep 2015;64:805.

doi: 10.3122/jabfm.2023.230447R0