CASE 075

CŌRE DIAGNOSTICS™

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INTRODUCTION:

The seroprevalence of anti-HCV antibody in pregnancy in Indian population is 1.03 %. Risk factors for acquiring HCV infection include IV drug abuse, blood transfusion, previous surgeries, and sexual transmission. However, in 40 % of the cases, no risk factor can be identified. Nearly 7–8 % of HCV-positive women transmit the virus to their children. Routine antenatal HCV screening is not mandatory in India. But identification of HCV in infected pregnant women is important because of their risk of long-term complications, potential effects of infection on pregnancy, and risk of transmission to their infants.

CASE REPORT:

A 24 year old primigravida presented to the Antenatal Clinic for her first visit at 10 weeks during pregnancy. As per protocol, she was screened for HBsAg, Anti-HCV and HIV antibodies. She was found to be HIV-positive on this screening and further testing confirmed the diagnosis. Her HIV viral load was 48800 IU/ml and CD4 count was 380 cells/mm3.

As per National Guidelines, she was started on Tenofovir (TDF) (300 mg) + Lamuvidine (3TC) (300 mg) + Efavirenz (EFV) (600 mg) at 12 weeks gestation. Follow-up was done at 16 weeks and HIV viral load was undetectable. She had an unremarkable antenatal period till 35 weeks, when she presented with acute onset severe pruritus. On investigation, elevated bile acids and transaminitis were observed. (AST: 268 u/L, ALT: 314 u/L, bile acids: 78 umol/L.) She was diagnosed with intrahepatic cholestasis of pregnancy. Oral ursodiol was started with plan for early delivery at 37 weeks. At 36 weeks, her bile acid level rose further (159 umol/L) and transaminases were still elevated. She was retested for viral markers and this time was found Anti-HCV positive. HCV RNA PCR was positive with a viral load of 74,265 IU/ml. Treatment was deferred due to pregnancy and follow-up was planned post delivery. She delivered via LSCS at 37 weeks, as planned and had an uncomplicated delivery and early post-partum period. On further investigation, it was found that her partner had not been tested for any of the viral markers after she came for her ANC visits. On testing post delivery, her partner was found to be HIV negative but Anti-HCV positive, and HCV RNA PCR was positive as well with viral load of 1,20,000 IU/ml. Genotyping was conducted for the couple and both were found to be infected with HCV genotype 3. The newborn was healthy and tested negative for both HIV and HCV. The couple were referred for management of HCV and HIV.