Pregnant Pauses

One HIVer mom makes tough treatment decisions for two

December 1, 2004 By Charlotte Huff

Pickles and ice cream: Those words conjure up the emotional roller coaster most pregnant women ride for nine months. So imagine weighing the risks and benefits of HIV meds for you and your baby while awaiting that bundle of joy.

Take HIVer mom Lisa Fleming, 41, of San Francisco. Many expecting HIVers start taking meds in the second trimester of pregnancy, when morning sickness subsides—even those, like Fleming, whose viral loads without meds are low—to minimize the risk of transmission to the baby by ensuring control of their own HIV. But while pregnant with each of her two sons, Fleming couldn't bring herself to start HAART, despite her doctor's reassurance. She fretted that meds might harm her unborn child. That's always a remote possibility (mostly in the first 12 weeks, when the baby's organs are forming), but it must be balanced against the track record: Doctors credit the drugs with lowering mom-to-child transmission rates to 1 percent or less in women with viral loads below 1,000 in the third trimester of pregnancy and during labor and delivery.

To protect the baby's health, Fleming shunned caffeine, cigarettes and her old nemesis, methamphetamines. But approaching her third trimester in late 2002, she still hadn't popped a single HIV pill.

"She was just really afraid of the [HIV] meds," says Deborah Cohan, MD, Fleming's obstetrician and the medical director of San Francisco's Bay Area Perinatal AIDS Center, adding that such fears are not uncommon among pregnant women. Cohan did a PowerPoint presentation for Fleming, explaining that her recommended combo—Combivir (AZT/3TC) and Viracept (nelfinavir)—hasn't, to date, been linked to birth defects. Fleming started the meds, but says, "I still had a seed of doubt: Was I making my baby a guinea pig?"

The Backstory

In 1999, a doctor told Fleming she was pregnant and HIV positive—and handed her an abortion clinic's card. "He said my life expectancy would be five years," Fleming says. She had the abortion, which she calls "devastating," moved on, and met and married HIV negative Farrel, a comrade in meth recovery. As Fleming neared 40, the couple decided it was time to have a child.

Delivering the Goods

Two-thirds of mom-to-baby transmissions occur during delivery. Before HIV combo therapy, docs urged HIVer moms to have C-sections to cut the chance of transmission, considered likely amid the messy fluids of vaginal delivery. But once it became clear that the new HIV combos lowered the danger of mother-to-child transmission, the American College of Obstetricians and Gynecologists began recommending C-section only if the mom's late-pregnancy viral load tops 1,000.

Fleming, whose decision (however torturous) to start HAART had kept her viral load undetectable, chose vaginal. In March 2003, after more than 24 grueling hours of labor, she delivered Jessiah. He had good color and strong lungs. He was hers. He tested negative.

Six weeks later, plagued by nausea and fatigue, Fleming ditched her combo. Seven months later, she found herself pregnant again, and the cycle started anew: dread, questioning, uncertainty.

Just before Fleming's third trimester with her second child, Izrael, Farrel set the pill bottles before her. "I told her 'We need to trust and go with [the meds],'" he says. She knew he was right—why tempt transmission?

Happy Beginning

Haunted by the memory of Jessiah's lengthy delivery, Fleming chose a C-section in June 2004, when Izrael was born, "to do anything humanly possible to ensure that the baby wouldn't be exposed to my blood." Cohan, who would normally prefer vaginal delivery for an undetectable HIVer like Fleming, says the decision was made for obstetric reasons: Izrael was in breech position (turned so that his bottom would enter the birth canal first, instead of his head).

Fleming recovered quickly from the surgery, without the complications of anemia or infection that are more common in HIVers than in neggie moms. Izrael passed his first two HIV tests—at birth and four weeks—giving his proud parents at least 96 percent reassurance. They'll know for sure by year's end.

Meanwhile, the couple keeps plenty busy chasing two boys under the age of 2. "They give me a run for my money," Fleming says, "but they give me more reason to live." She has stopped taking her meds again, and some days she toys with rolling the dice one more time. "I really want a little girl," she says. "But then the fear factor comes in again."

LIGHTENING THE MOTHER LOAD

Pregger tips from Deborah Cohan, MD

Find a prenatal provider (family doc, obstetrician, midwife or nurse) who's hip to HIV—and your needs. Your doctor can call the National Perinatal HIV Consultation and Referral hotline.

Lose cigarettes, alcohol and drugs, and swallow a healthy diet and prenatal vitamins to help baby

and you.

Unload. Low viral loads are the best insurance against transmitting HIV to your baby. Talk treatment with Doc.

Give your baby a healthy mom by sticking to your own med schedule postpartum, when dosing meds for your tot and waiting to learn baby's HIV status can make adherence hard.

Take time for you. Breathe, relax —decisions will be easier to make.

© 2026 Smart + Strong All Rights Reserved.

http://beta.docker.poz.com/article/Pregnant-Pauses-11256-5050