CONGENITAL HEPATITIS C



DURING PREGNANCY

Incidence	Hepatitis C virus (HCV), the most frequently reported bloodborne infection in the United States, affects 1-2.5%, some studies indicate the prevalence up to 4% of pregnancies, with a 6-7% risk of transmission to infant.
Risk Factors	The primary method of transmission is direct exposure to blood. • Syringes sharing (most common) • Sharing equipment used for with infected blood non-injection drugs • Vertical transmission • Condomless sexual intercourse, especially anal sex • Multiple sexual partners • Occupational contact • Blood transfusion before 1992
Signs/ Symptoms	In 75% of cases, the infection is asymptomatic. Some people recover from symptomatic acute infection and progress to chronic viral infection. Symptoms: nausea, anorexia, malaise, abdomen pain, and jaundice **Signs of end-stage liver disease** • Muscle wasting • Ascites • Spider angioma • Palmar erythema • Hepatic encephalopathy Hepatitis C infection in pregnant women increases the risk of preterm delivery, gestational diabetes, and intrahepatic cholestasis.
Evaluation	If possible, HCV infection should be screened and treated prior to pregnancy. Screen pregnant women, ideally at the first prenatal visit, with HCV-antibody testing with reflex HCV RNA polymerase chain reaction (PCR).
Treatment/ Management	• If receiving treatment then the person becomes pregnant, c During Pregnancy onsult with MFM and/or ID. • Consult an HCV infectious disease specialist for monitoring and treatment, when possible. • Counsel the pregnant/postpartum woman about possible health implications for both the woman and the infant. • Antiviral treatment is not currently recommended during pregnancy but can be considered with shared decision making (AASLD/IDSA HCV Guidance Panel). • Breastfeeding is safe for patients with HCV infection. Because blood exposure is the primary risk factor, pause breastfeeding in the event of nipple trauma with bleeding. Pumping is encouraged to maintain milk production, but the milk should be discarded until the nipples are fully healed.

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NEONATE

- Vertical transmission of HCV can occur.
- There's an increased risk of perinatal HCV transmission with co-existing HIV.
- The rate of vertical transmission is estimated at 7.2% among HIV-negative pregnant women and 12.1% among those with poorly controlled HIV.
- Among infants and children infected perinatally, an estimated 20% will clear the infection spontaneously (median age of 14.9 months), 50% will develop asymptomatic infections, and 30% will experience chronic hepatitis C that could become symptomatic by adolescence or young adulthood.
- Parental HCV infection is not a contraindication to breastfeeding but should be paused in the event of nipple trauma with bleeding.
- HCV infection should not alter mode of delivery.
- Pre-labor cesarean delivery doesn't reduce vertical transmission, and there's insufficient evidence to recommend routinely avoiding invasive obstetric procedures like internal monitoring, episiotomy, and operative vaginal delivery.
- Prolonged rupture of membranes beyond 6 hours increases risks so amniotomy should be avoided. However, there is no evidence of a difference in transmission with the mode of delivery - c-section vs. vaginal.

Refer for maternal-fetal medicine and infectious disease specialist consultations.

Evaluation

Upon delivery (all infants born to seropositive persons)

- HCV RNA should be done between 2 to 6 months of age.
- HCV RNA can still be done until 18 months of age.
- Children aged ≥18 months who were not previously tested should receive an anti-HCV test with reflex to HCV RNA

If the pregnant woman's hepatitis C status is unknown, HCV RNA testing at 2 months or at anti-HCV testing with reflex to HCV RNA at > 18 months is recommended.

Treatment

Treatment is approved for children aged 3 years and older.

- Consult an HCV infectious disease specialist.
- Counsel the pregnant/postpartum woman about possible health implications for both the woman and the infant.

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