# HIV Post-Exposure Prophylaxis (PEP) – New Zealand Guideline Summary

| Topic | Recommendation (NZ) | Clinical Pearls / Pitfalls |
|---|---|---|
| **What is PEP?** | A **28-day course of antiretroviral therapy** started after a potential HIV exposure to reduce the risk of HIV infection. | PEP is a **medical emergency**—do not delay assessment. |
| **When should PEP be started?** | **As soon as possible**, ideally within **2 hours** and **no later than 72 hours** after exposure. | Do **not** initiate PEP if >72 hours after exposure unless advised by an HIV/Infectious Diseases specialist. Earlier initiation is associated with greater effectiveness. |
| **Who should receive PEP?** | Individuals with a significant exposure to potentially infectious body fluids where the source is HIV-positive (or high risk/unknown) and transmission risk is clinically significant. | Consider type of exposure, source HIV status, viral load (if known), and whether the exposed person was taking PrEP correctly. |
| **High-risk exposures** | • Receptive anal intercourse (highest sexual risk)• Insertive anal intercourse• Receptive vaginal intercourse• Needle-sharing exposure• Occupational sharps injury with HIV-positive source | Receptive anal intercourse carries the highest risk of sexual HIV transmission. |
| **Low-risk / no PEP usually indicated** | Oral sex without ejaculation, kissing, mutual masturbation, intact skin contact, saliva, urine, tears or sweat without blood. | Individualise if blood is present or unusual circumstances exist. |
| **Recommended NZ PEP regimen** | **Tenofovir disoproxil fumarate 245 mg / Emtricitabine 200 mg (1 tablet daily) PLUS Dolutegravir 50 mg once daily** for **28 days**. | This is the preferred first-line regimen for most adults. Alternative regimens may be required for pregnancy, significant drug interactions or renal impairment. |
| **Baseline assessment** | • HIV Ag/Ab (4th generation)• HIV RNA if symptoms suggest acute HIV infection• Renal function (eGFR, creatinine)• Liver function tests• Hepatitis B serology• Hepatitis C testing if indicated• Pregnancy test if applicable• STI screen based on exposure | Do not delay starting PEP while awaiting blood results. Baseline tests should ideally be taken before the first dose but treatment should commence immediately. |
| **Follow-up HIV testing** | HIV testing at **baseline**, **12 weeks after exposure** (or according to local laboratory recommendations). | Ensure patients understand the importance of completing follow-up testing even if they finish PEP without issues. |
| **Monitoring during PEP** | Review within **3–7 days** to assess adherence, adverse effects, laboratory results and ongoing risk. | Early review improves adherence and provides an opportunity to transition to PrEP if appropriate. |
| **Common adverse effects** | Mild nausea, diarrhoea, headache, fatigue, insomnia. | Most adverse effects are self-limiting and should not lead to discontinuation without specialist advice. |
| **Drug interactions** | Dolutegravir interacts with iron, calcium, magnesium-containing antacids and supplements (separate administration by at least 2 hours before or 6 hours after). | Check for anticonvulsants, rifampicin and other enzyme-inducing drugs which may require specialist advice. |
| **Hepatitis B** | TDF/FTC is active against HBV. Determine HBV status at baseline. | If chronic HBV is present, stopping PEP may precipitate hepatitis flare—consider specialist input. |
| **Sexual health management** | Offer full STI screening, hepatitis A/B vaccination if indicated, counselling and partner notification where appropriate. | PEP is an opportunity to discuss ongoing HIV prevention and risk reduction. |
| **Transition to PrEP** | Patients with ongoing HIV risk should **commence PrEP immediately after completing PEP**, provided HIV testing remains negative. | Avoid gaps between finishing PEP and starting PrEP in patients with continuing exposure risk. |

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| **Occupational exposure** | Follow local occupational exposure protocols while initiating PEP immediately if indicated. | Do not wait for source testing if there will be significant delay. Source testing can guide continuation. |

## Assessment of HIV Exposure

| Exposure | PEP Usually Recommended? |
|---|---|
| Receptive anal intercourse with HIV-positive or unknown high-risk partner | **Yes** |
| Insertive anal intercourse with HIV-positive or unknown high-risk partner | **Usually yes** |
| Receptive vaginal intercourse | **Usually yes** |
| Insertive vaginal intercourse | Consider based on source risk |
| Needle-sharing | **Yes** |
| Human bite without blood | No |
| Oral sex (no blood, no ejaculation) | Usually no |
| Kissing, saliva, tears, urine | No |

## Baseline Investigations

| Investigation | Reason |
|---|---|
| HIV Ag/Ab test | Exclude established HIV infection |
| HIV RNA (if acute HIV suspected) | Detect early infection before seroconversion |
| U&E / eGFR | Assess suitability for TDF |
| LFTs | Baseline monitoring |
| Hepatitis B serology | TDF/FTC is active against HBV |
| Hepatitis C | Screen where risk factors exist |
| Syphilis serology | Baseline STI assessment |
| Three-site GC/CT NAAT | If sexual exposure |
| Pregnancy test | If applicable |

## Follow-up Schedule

| Time | Assessment |
|---|---|
| **Day 0** | Risk assessment, baseline bloods, start PEP immediately |
| **3–7 days** | Review adherence, adverse effects, laboratory results, counselling |
| **Completion (28 days)** | Confirm treatment completed, assess ongoing HIV risk |
| **12 weeks after exposure** | Repeat HIV testing (and additional STI testing if indicated) |
| **After completion** | Assess eligibility for PrEP if ongoing HIV exposure risk |

## Counselling Points

| Topic | Advice |
|---|---|
| Start immediately | PEP is most effective when started as early as possible and should not be delayed for investigations. |
| Complete the full course | Take all medication for **28 days**, even if the source is later found to have a low risk of HIV, unless advised otherwise. |
| Adherence | Missing doses may reduce effectiveness; encourage strategies to support daily dosing. |
| Side effects | Usually mild and manageable; seek review rather than stopping medication. |
| Sexual activity | Use condoms or avoid exposures until follow-up confirms HIV-negative status. |
| Ongoing prevention | Discuss PrEP for patients with recurrent or anticipated HIV exposure. |
| Acute HIV symptoms | Fever, rash, sore throat, lymphadenopathy or myalgia during or after PEP require urgent review and repeat HIV testing. |

**High-yield clinical pearls**

- **PEP is indicated only if presentation is within 72 hours of a clinically significant exposure.**
- **Do not delay PEP while awaiting HIV test results or source patient testing.**
- **A source patient with a sustained undetectable viral load (U=U) has effectively no risk of sexually transmitting HIV**, and PEP is generally not indicated for sexual exposures in this situation after appropriate assessment.
- Patients already **taking PrEP correctly and adherently generally do not require PEP** after sexual exposure.
- Every PEP consultation should include discussion of **PrEP**, vaccination (hepatitis A/B and mpox where appropriate), and comprehensive STI screening.