HIV infection is a substantial risk factor for maternal death, particularly in Sub-Saharan Africa. Global estimates attribute 20% of maternal deaths to HIV [1]. Statistics from Sub-Saharan Africa show that maternal mortality among HIV-infected women is approximately 8 times higher than among uninfected women [2].

Obstetric hemorrhage is the most common cause of maternal mortality, accounting for 30% of global maternal deaths [3]. It is important to understand better the contribution of HIV to maternal death from obstetric hemorrhage. The aim of the present analysis was to investigate whether HIV infection was associated with severe obstetric hemorrhage among a group of peripartum women.

We analyzed data collected at study entry for 349 women who participated in a cluster-randomized controlled trial of the non-pneumatic anti-shock garment in Zambia (ClinicalTrials.gov: NCT00488462) [4]. The present study used de-identified data for secondary analysis.

HIV-positive women (n = 59)  HIV-negative women (n = 262)  P value
Age, y 27.5 ± 6.0 28.2 ± 7.2 0.45
Parity 2.2 ± 1.7 2.8 ± 2.3 0.05
Gestational age, wk 31.8 ± 9.6 33.4 ± 8.3 0.22
Level of consciousness 0.38
Normal 11 (19) 66 (25)
Confused 44 (75) 186 (71)
Unconscious 3 (5) 5 (2)
Under anesthesia 1 (2) 5 (2)
City 0.73
Lusaka 38 (64) 158 (60)
Kitwe 12 (20) 66 (25)
Ndola 9 (15) 38 (15)
Estimated blood loss ≥1000 mL 39 (66) 136 (52) 0.05

a Values are given as mean ± SD or number (percentage) unless otherwise indicated.
b P values calculated via 2-sided t test.
c P values calculated via 2-sided χ² or Fisher exact test.
Familial hypertriglyceridemia in pregnancy

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Familial hypertriglyceridemia is not often seen in pregnancy, and case reports are scarce. The goal for pregnant patients with familial hypertriglyceridemia is to maintain low levels of triglycerides and prevent complications such as acute pancreatitis.

These results are an important step toward elucidating the impact of HIV on hemorrhage-related maternal mortality; however, there were limitations to the present study. Because the parent study was not designed to explore this association, we were unable to investigate any potential underlying mechanisms; furthermore, HIV status might have been underreported owing to missing HIV data. Another limitation was the overlap between inclusion criteria and the characterization of EBL (mild, 500–999 mL vs severe, 1000 mL) across HIV status. The composite nature of the inclusion criteria added a degree of complexity to the analysis.

Despite the limitations, the present analysis adds to a growing body of literature characterizing the impact of HIV on maternal health and has generated an interesting and testable hypothesis. An association between these 2 conditions has direct clinical implications for the care of HIV-positive pregnant women. Furthermore, it would highlight dual gains that could be achieved through integrating HIV and maternal healthcare services.

Conflict of interest

The authors have no conflicts of interest.

References


Table 1

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<thead>
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<th>Gestational age, wk</th>
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