Risk for mother to child HIV-1 infection was increased by breast feeding


QUESTION: In the infants of HIV-1 infected women, does formula feeding instead of breast feeding reduce the rate of HIV-1 transmission and mortality?

Design
Randomised (allocation concealed*), blinded (investigators to interim results),* controlled trial with 2 year follow up.

Setting
4 antenatal clinics in Nairobi.

Patients
425 HIV-1 infected pregnant women (mean age 23 y) who resided in Nairobi and had access to municipally treated water. 401 mother-infant pairs (94%) were included in the analysis.

Intervention
Women were allocated to breast feed (n = 212) or formula feed (n = 213) their infants. Women in the formula feed group were told to feed their infant with a cup and had to demonstrate proper formula preparation and cup feeding to a visiting nurse.

Main outcome measures
Infant HIV-1 infection and mortality within the first 2 years. Mortality rates were compared using Kaplan-Meier survival analysis.

Main results
Analysis was by intention to treat. At 24 months, the cumulative probability of HIV-1 infection was higher in breastfed infants than in formula fed infants (p = 0.001) (table). A significant difference existed between breast fed and formula fed infants at all ages after birth, with a 10.2% cumulative difference occurring at 6 weeks (CI 3.1 to 17.3, p = 0.005). The groups did not differ for mortality (p = 0.30) (table), and no difference existed at any age after birth.

Conclusions
In HIV-1 infected women, breast feeding was associated with a greater transmission rate of HIV-1 infection to infants than was formula feeding, with a 10% difference between groups occurring by 6 weeks of age. The method of feeding did not affect mortality rates at 2 years.

COMMENTARY
The study by Nduati et al, done in a resource poor setting where breast feeding is the norm, confirmed that breastfed infants are at increased risk for HIV-1 infection. Applying these results in practice, however, is not easy. A major issue, raised by the authors themselves, is the lack of acceptability of formula feeding. In the study, many women in the formula feeding group admitted to breast feeding. The stigma associated with not breast feeding, the convenience of breast feeding, the cost of formula, and the potential for increased early mortality in infants not breast fed all add to the difficulties of implementing a change in feeding patterns in these settings. Perhaps we should instead be looking at strategies to reduce the risk for HIV-1 transmission despite breast feeding.

One strategy might be to use antiretroviral agents postpartum to prevent mother to child transmission. In a Ugandan trial, nevirapine was given as a single dose intrapartum and to the infant at 2 to 3 days. Nearly all the infants were breast fed, and the transmission rates at 2 and 4 months were 11.9% and 13.1%, respectively.

A second strategy might be to determine whether a period of breast feeding exists in resource-poor countries: translating research into policy and practice. JAMA 2000;283:1175–82.

A third strategy might be to consider other factors that could affect transmission from breast milk. For example, in an observational study of 549 infants in South Africa, the rates of HIV-1 transmission at 3 months in those who were either formula fed, mixed fed, or exclusively breast fed were 18.8%, 24.1%, and 14.6%, respectively. The intriguing possibility that the exclusion of other food modifies HIV-1 transmission from breast milk needs further study.

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