

MANAGEMENT OF GENITAL HERPES SIMPLEX VIRUS INFECTION DURING PREGNANCY

General

Herpes simplex virus (HSV) can be differentiated into HSV type 1 and HSV type 2, both are associated with genital herpes. The risk of transmission of HSV to the fetus or newborn is the major concern. The risk of vertical transmission is greatest (30-50%) among women who acquire HSV near delivery. Diagnostic methods available include viral culture, PCR assays for HSV DNA and serologic testing of HSV antibodies. PCR testing is more sensitive than viral culture and can differentiate between HSV-1 and HSV-2 infection. It is therefore becoming the preferred method of diagnosis.

Management

- 1) Identification of the Population at Risk
 - a. Women with history of genital HSV infection
 - b. Women with an active genital HSV infection during their current pregnancy
 - c. Women whose sexual partners have or have had genital HSV infection
- 2) All prenatal patients should be screened for genital herpes using specific and easily understood terms about symptoms of genital herpes. If there is a history of genital herpes in the patient or her partner recurrence patterns, prodromal symptoms, usual lesion site and partner's history are recorded in the prenatal record.
- 3) Patients should be counseled on natural history of disease and prevention of HSV transmission. This includes avoiding intercourse with partners who have known or suspected genital HSV when symptoms or lesions are present and during the third trimester.
- 4) It is no longer recommended to perform weekly surveillance cultures to detect asymptomatic reactivation of viral shedding.
- 5) Women with a history of genital herpes should have a thorough internal and external exam for genital lesions on presentation to labor and delivery. Asymptomatic patients without an obvious genital lesion or prodromal symptoms may attempt a vaginal birth.
- 6) Patients with an active genital lesion or prodromal symptoms should be delivered by cesarean delivery regardless of duration of ROM.
- 7) Suppressive therapy starting at 35 weeks should be offered to women with a history of recurrent genital herpes.
- 8) Presence of nongenital lesions does not preclude a vaginal delivery. If nongenital lesions (buttocks, thigh, etc.) are present they should be covered with an occlusive dressing and a thorough exam for the presence of genital lesions should be performed. If no genital lesions are present the patient may deliver vaginally.
- 9) The table below is a recommended guideline for the treatment and suppression of genital herpes during pregnancy.

PROTOCOL #11 - Maternal Fetal Medicine, University of New Mexico

Table 1

Indication	Acyclovir	Valacyclovir
Primary infection	400 mg PO, three times daily, for 7-10 days	1 gram PO, twice daily, for 7-10 days
Symptomatic recurrent infection	400 mg PO, three times daily, for 5 days or 800 mg PO, twice daily, for 5 days	500 mg PO, twice daily, for 3 days, or 1 gram, PO daily, for 5 days
Daily suppression	400 mg PO, three times daily, from 36 weeks gestational age to delivery	500 mg PO, twice daily, from 36 weeks gestational age to delivery
Severe or disseminated disease	5-10 mg/kg. IV, every 8 hours for 2-7 days, then PO therapy for primary infection to complete 10 day course	

Adapted from ACOG technical bulletin #82

CONSULTATION: Twenty-four hour consultation is available by calling the Maternal Fetal Medicine service at the University of New Mexico Hospital. 1-888-866-7257.

Selected References

ACOG Practice Bulletin Number 82, June 2007. Management of Herpes in Pregnancy
CDC Sexually Transmitted Diseases Treatment Guidelines 2006.