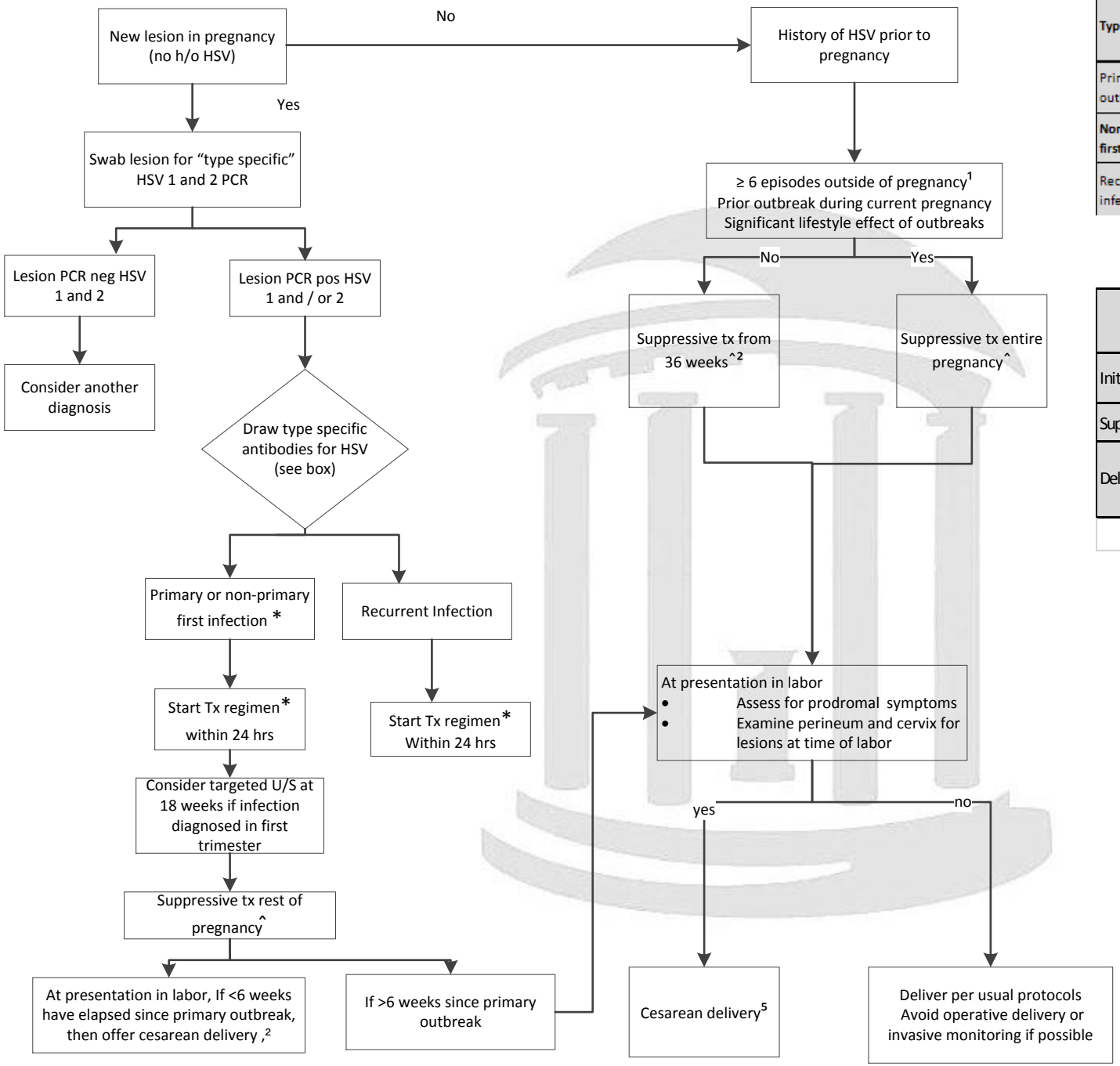
Gential Herpes: HSV



Type Specific Antibodies		Lesion PCR result	
		HSV 1+	HSV 2+
Primary outbreak	Serum antibodies	HSV 1 IgG neg HSV 2 IgG neg	HSV 1 IgG neg HSV 2 IgG neg
Non-primary first	Serum antibodies	HSV 1 IgG neg HSV 2 IgG pos	HSV 1 IgG neg HSV 2 IgG pos
Recurrent infection	Serum antibodies	HSV 1 IgG pos HSV 2 IgG neg/pos	HSV 1 IgG neg/pos HSV 2 IgG pos

	Primary Infection or non-primary first ≠	Recurrent Ω
Initial diagnosis	Treat with antivirals 10 days	Treat with antivirals 5 days
Suppressive tx	same	same
Deliver by C/S	-Active lesions labor or prodromal sx - <6 wks since diagnosis	-Active lesions in labor or prodromal sx

PPROM[4] · Give antenatal steroids & antibiotics per usual hospital protocols · Treat with appropriate antiviral · If primary infection and <6 weeks since outbreak, deliver by cesarean

Treatment Options*
First Episode:
Acyclovir 400 mg TID x 7-10 days
Valacyclovir 1 g BID x 7-10 days

Suppressive Options^
Acyclovir 500 mg BID
Valacyclovir 500mg or 1000 mg once a day

HSV references

1. Centers for Disease Control and Prevention. Sexually Transmitted Disease Treatment Guidelines. **MMWR Morb Mortal Wkly** Rep 2002; 51:14.

   Suppressive therapy reduces the frequency of genital herpes recurrences by 70-80% among patients who have frequent recurrences (e.g. ≥ 6 recurrences per year)

2. Sheffield JS, Hollier LM, Hill JB, Stuart GS, Wendel GD. Acylovir prophylaxis to prevent herpes simplex virus recurrence at delivery: a systematic review. Am J Obstet Gynecol 2003; 102: 1396-403

   --Prophylactic acyclovir beginning at 36 weeks gestation reduces the risk of clinical HSV recurrence at delivery, cesarean delivery for recurrent genital herpes and the risk of HSV viral shedding at delivery.

   --Reduced clinical HSV recurrence at time of delivery (RR0.28, 95% CI 0.18-0.43)

   --Asymptomatic viral shedding at delivery (OR 0.14, 95% CI 0.05-0.39)

   --Cesarean delivery for clinically recurrent genital herpes (RR 0.3, 95% 0.2-0.45)

3. Royal College of Obstetrician Gynecologists-- Green Top Guideline #30
   "For women presenting with a first-episode HSV infection in the third trimester, type specific HSV antibodies are advisable. C/S should be recommend to all women with primary genital episode within 6 weeks of expected date of delivery"

   Brown ZA, Wald A, Morrow RA, Selke S, Zeh J, Corey L. Effect of serologic status and abdominal deliveries on transmission rates of herpes simplex virus from mother to infant. JAMA 2003;289: 203–9

   --7046 women in Seattle, USA, the risk of neonatal herpes was highest in infants born to women who had not completed HSV seroconversion during pregnancy (most commonly in the third trimester, within 6 weeks of delivery).

   Bryson YJ, Dillon M, Lovett M, Acuna G, Taylor S, Cherry JD, et al. Treatment of first episodes of herpes simplex virus infection with oral acyclovir. A randomized double-blind controlled trial in normal subjects. N Engl J Med 1983; 308: 916-21.

   --Women with primary herpes that is untreated have a mean duration of viral shedding of 15 days.

4. ACOG Practice Bulletin Management of Herpes in Pregnancy June 2007 (Reaffirmed 2012)-
"Cesarean delivery is indicated in women with active genital lesions or prodromal symptoms, such as vulvar pain or burning at delivery, because these symptoms may indicate an impending outbreak"

Brown ZA, Wald A, Morrow RA, Selke S, Zeh J, and Corey L. Effect of serologic status and cesarean delivery on transmission rates of herpes simplex virus from mother to infant. JAMA. 2003; 289 (2): 203-9.

--Among women with HSV detected at delivery, neonatal herpes occurred in 1.2% of infants delivered by cesarean delivery compared with 7.7% of infants delivered vaginally

5. ACOG Practice Bulletin Management of Herpes in Pregnancy June 2007 (Reaffirmed 2012)
"In a patient with preterm premature rupture of membranes and active HSV, the risks of prematurity should be weighed against the risk of neonatal HSV disease in considering expectant management. In pregnancies remote from term, especially in women with recurrent disease, there is increasing support for continuing the pregnancy to gain benefit from time and use of corticosteroids "

Majors CA, Towers CV Lewis DF, Garite TJ. Expectant management of preterm premature rupture of membranes complicated by active recurrent genital herpes. Am J Obstet Gynecol 2003;188:1551–4;discussion 1554–5

--29 patients with PPROM and recurrent active genital HSV were expectantly monitored. Mean latency period was 13.2 days from PPROM to delivery. No cases of neonatal herpes developed in the newborn period

Effect of corticosteroids for fetal maturation on perinatal outcomes, February 28–March 2, 1994. National Institutes of Health. Consensus Development Conference Statement. Am J Obstet Gynecol 1995;173:246–52.

Revision: 1/16/18 ES

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