Gential Herpes: HSV

**New lesion in pregnancy (no h/o HSV)**
- No
- Swab lesion for "type specific" HSV 1 and 2 PCR
  - Lesion PCR neg HSV 1 and 2:
    - Consider another diagnosis
  - Lesion PCR pos HSV 1 and / or 2:
    - Draw type specific antibodies for HSV (see box)
      - Primary or non-primary first infection *
        - Start Tx regimen within 24 hrs
          - Consider targeted U/S at 18 weeks if infection diagnosed in first trimester
          - Suppressive tx rest of pregnancy
    - Recurrent Infection:
      - Start Tx regimen Within 24 hrs
      - At presentation in labor:
        - Assess for prodromal symptoms
        - Examine perineum and cervix for lesions at time of labor
      - Suppressive tx entire pregnancy
      - ≥ 6 episodes outside of pregnancy:
        - Prior outbreak during current pregnancy
        - Significant lifestyle effect of outbreaks
        - History of HSV prior to pregnancy
          - Lesion PCR result
            - HSV 1+ HSV 2+
              - Primary Outbreak:
                - Serum antibodies:
                  - HSV 1 IgG neg
                  - HSV 2 IgG neg
              - Non-primary first:
                - Serum antibodies:
                  - HSV 1 IgG neg
                  - HSV 2 IgG pos
              - Recurrent infection:
                - Serum antibodies:
                  - HSV 1 IgG pos
                  - HSV 2 IgG neg/pos
                  - HSV 1 IgG pos
  - ≥ 6 episodes outside of pregnancy:
    - 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 in labor or prodromal sx
        - < 6 wks since diagnosis
        - Active lesions in labor or prodromal sx
  - At presentation in labor:
    - If < 6 weeks have elapsed since primary outbreak, then offer cesarean delivery.
    - If > 6 weeks since primary outbreak:
      - Cesarean delivery
      - Deliver per usual protocols
        - Avoid operative delivery or invasive monitoring if possible

**PPROM**
- 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 400 mg BID
  - Valacyclovir 500mg or 1000 mg once a day
HSV references

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


   --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”


   --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).


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


--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

“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 “


--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


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These algorithms are designed to assist the primary care provider in the clinical management of a variety of problems that occur during pregnancy. They should not be interpreted as a standard of care, but instead represent guidelines for management. Variation in practices should take into account such factors as characteristics of the individual patient, health resources, and regional experience with diagnostic and therapeutic modalities. The algorithms remain the intellectual property of the University of North Carolina at Chapel Hill School of Medicine. They cannot be reproduced in whole or in part without the expressed written permission of the school.

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