Frimley Health
NHS Foundation Trust

Genital Herpes in Pregnancy

Key Point

- This guideline is based on the consensus guideline between the RCOG and British Association of Sexual Health and HIV (BASHH) on the Management of Genital Herpes in Pregnancy (2014).
- Caesarean section should be advised to women with a primary HSV infection in the 6 weeks leading up to the time of birth or at the time of onset of labour.
- Women with a recurrent HSV infection can have a vaginal birth.

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Abbreviations

ARM	Artificial rupture of membranes
FBS	Fetal blood sampling
FSE	Fetal scalp electrode
GUM	Genito-urinary medicine
HSV	Herpes simplex virus
STI	Sexually transmitted infection

1. INTRODUCTION

- For an outline of the types of HSV, how HSV is transmitted, the signs & symptoms of primary and of recurrent infections, the risk of transmission to the neonate and management of the neonate and how to diagnose both primary and recurrent infection, please refer to the BASHH guideline of Herpes in Pregnancy:

  https://www.bashh.org/resources/24/herpes_in_pregnancy_2014/

2. PREVENTION OF ACQUISITION OF GENITAL HERPES DURING PREGNANCY

- A history should be taken at booking to see if a woman or her partner has, or has ever had genital herpes, or if her partner has ever had cold sores.
- Partners of pregnant women who have active genital herpes should be advised to avoid any genital contact during a recurrence.
- Women should also be informed of the risk of transmission through orogenital contact if their partner has an active cold sore. (However, viral shedding and transmission can also occur from an asymptomatic infection).
- Use of condoms reduces the risk, but does not completely prevent transmission,

3 MANAGEMENT OF WOMEN WITH GENITAL HERPES IN PREGNANCY

3.1 General Advice

For a primary attack or painful recurrence:

- Bathing and passing urine in the bath can ease pain and dysuria.
- Regular analgesia, e.g., Paracetamol.
- Topical anaesthetic agents, e.g., lidocaine gel applied to the ulcers (caution should be exercised as may cause sensitisation).
- The Herpes Virus Association “herpes.org.uk” can be used as a further resource for general Herpes-related advice.
- Referral to the GU medicine service for a full STI screen and contact tracing if this is a primary attack.
- Women who develop a primary episode or have a history of recurrent genital herpes should be referred to an obstetrician and women should have a clear plan for mode of birth documented in the notes.

3.2 Antiviral therapy

If oral antiviral therapy is started within 5 days of the start of symptoms it can decrease the severity, duration and viral shedding. It is not licensed for use during pregnancy but there is evidence to support its safety [8,9,10, 11]. First line treatment is:

- Aciclovir 400mg TDS for 5 days (10 days if the patient is HIV positive).

For those who have more than three recurrences in pregnancy, or if over 36 weeks gestation consider prophylactic suppressive therapy for the rest of the pregnancy. [12, 25] A dose of Aciclovir 400 mg three times daily may be appropriate because of the altered pharmacokinetics of the drug in late pregnancy [2].

- For women with a history of recurrent genital herpes and who would request a LSCS if they had a recurrent episode at the onset of labour, consider daily suppressive Aciclovir 400 mg TDS from 36 weeks of gestation until delivery. There is insufficient evidence to determine if this reduces the risk of neonatal herpes; however, it can reduce the

likelihood of HSV lesions and asymptomatic viral shedding at term, and so reducing the potential need for caesarean section[8].

- The majority of recurrent episodes of genital herpes are short lasting and resolve within 7–10 days without antiviral treatment. Supportive treatment measures using saline bathing and analgesia alone will suffice.
- Regular viral swabs and cultures in late pregnancy do not predict viral shedding at term and are not recommended.

3.3 Management of complications

- Disseminated infection, which may present with encephalitis, hepatitis, disseminated skin lesions or a combination of these conditions, is rare in adults but has been more commonly reported in pregnancy, particularly in the immuno-compromised. The maternal mortality associated with this condition is high. This carries the greatest risk of intrauterine transmission and associated early pregnancy complications. It therefore requires hospital admission and treatment with IV Aciclovir.
- If in urinary retention, the patient should be catheterised (consider suprapubic if this will give better symptom control) or if suffering with severe generalised symptoms, admit and give IV Aciclovir.

4. MODE OF BIRTH

4.1 Primary genital herpes

If <u>not</u> in labour, or if has <u>not</u> had a primary episode within the last 6 weeks:

- Plan for normal birth [2, 26].

If <u>in</u> labour, or if <u>has</u> had a primary episode within the last 6 weeks regardless of gestation:

A caesarean section is recommended *for women who have developed primary genital herpes within six weeks of delivery [3]. Around 70% of neonatal infections result from asymptomatic HSV shedding during delivery [4].*

- **Offer caesarean section if:**
- In labour with intact membranes.
- In labour with membranes ruptured less than 4 hours prior [13, 26].
- The benefits of caesarean section may reduce if the membranes have been ruptured > 4 hours, however, there may be some benefit even after this time interval.
- If caesarean section is declined or if membranes have been ruptured for more than 4 hours, it could be considered to plan for normal birth, give IV Aciclovir (5mg/kg 8 hourly) to the woman and to the neonate (20mg/kg 8 hourly) [31, 32]. It is unknown if intrapartum IV Aciclovir reduces the risk of neonatal HSV infection.
- Avoid FSE, FBS, ARM and instrumental delivery [2,15, 26].
- It is advisable to have delivery expedited by the appropriate means and labour should be augmented without delay if membranes have ruptured.
- Inform the paediatric team.
- When caesarean section is recommended, women should avoid vaginal seeding.

4.2 Recurrent genital herpes

- Caesarean section is not routinely recommended for women with recurrent genital herpes lesions at the onset of labour. The mode of delivery should be discussed with the woman and individualised according to the clinical circumstances and the woman's preferences.

- Discuss the maternal risk of LSCS and the low risk of neonatal transmission (0-3%) even if lesions are present at the time of delivery [19, 20, 25].
- Plan for vaginal birth [21, 22, 26] but avoid prolonged rupture of membranes. Women with recurrent genital herpes lesions and confirmed rupture of membranes at term should be advised to have delivery expedited by the appropriate means, e.g., augmentation of labour.
- Invasive procedures such as FSE, FBS and instrumental delivery may be used if required:
- Inform the paediatric team.

5. PRETERM PRELABOUR RUPTURE OF MEMBRANES (PPROM)

5.1 Primary genital herpes

- There is limited evidence to inform best practice when PPROM is complicated by primary HSV infection. Management should be guided by MDT discussion involving a consultant obstetrician, a GUM physician and neonatologist.
- If immediate delivery is decided, the anticipated benefits of caesarean section remain.
- If there is initial conservative management, it is recommended to give IV Aciclovir to the woman (5mg/kg 8 hourly).
- Steroids should be considered as usual in line with our regional steroid guideline.
- Manage otherwise as per the trust guidelines for PPROM.
- If delivery is indicated within 6 weeks of primary infection, delivery by caesarean section may still offer some benefit despite prolonged rupture of membranes.

5.2 Recurrent genital herpes

- The risk of neonatal transmission is very small and may be outweighed by the risk associated with preterm delivery.
- When PPROM occurs before 34 weeks gestation, manage conservatively and offer oral Aciclovir 400mg TDS [23].
- Beyond 34 weeks gestation, the management should be in accordance with Trust Preterm prelabour rupture of membranes (PPROM) and our regional guideline on steroid use.

6. MANAGEMENT OF HIV-POSITIVE WOMEN WITH HSV INFECTION

6.1 Primary genital herpes

- HIV-positive women with primary HSV infection in the last trimester of pregnancy should be managed in accordance with recommendations for managing all women with primary genital HSV infection.

6.2 Recurrent genital herpes

- There is some evidence that women with HIV and HSV ulceration in pregnancy are more likely to transmit HIV infection independent of other factors.
- Women with HIV and a history of previous genital HSV infection can be offered oral Aciclovir 400mg TDS **from 32 weeks** gestation, especially when vaginal delivery is planned, to reduce the risk of HIV transmission.

- Mode of delivery should be in line with Trust HIV in pregnancy and BASHH HIV in pregnancy guideline recommendations.
- There is no evidence to recommend daily suppressive treatment of HSV to women with HIV who are HSV-1 or -2 seropositive with no history of genital herpes.

7. PREVENTION OF POSTNATAL HSV TRANSMISSION

Healthcare workers and family members with active HSV infection, e.g., cold sores or herpetic whitlows on fingers, should avoid direct contact between the lesion and the neonate [23, 24].

Breastfeeding is recommended for women with both primary and recurrent genital herpes infection, unless the woman has herpetic lesions around the nipples.

In cases where a woman has herpetic lesions on her breast, the woman should temporarily refrain from breastfeeding her infant from the affected breast or feeding her infant expressed breast milk from the affected breast. She should discard expressed breast milk from the affected side until the lesions have healed. A woman may breastfeed her infant or express milk from the unaffected breast but should ensure that the lesions on the affected breast are completely covered to avoid transmission. Women should also follow appropriate hand hygiene practices to avoid transmission of herpes to her infant. This will need to be referenced to reference 35: https://www.cdc.gov/breastfeeding/breastfeeding-special-circumstances/maternal-or-infant-illnesses/herpes.html

8. MONITORING

This guideline will be monitored by individual case review via the maternity risk management group.

9. COMMUNICATION

If there are communication issues (e.g., English as a second language, learning difficulties, blindness/partial sightedness, deafness) staff will take appropriate measures to ensure the patient (and her partner if appropriate) understands the actions and rationale behind them.

10. EQUALITY AND DIVERSITY ASSESSMENT

This guideline has been subject to an equality impact assessment.

REFERENCE

1 https://www.bashh.org/resources/24/herpes_in_pregnancy_2014/

Full version control record

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This guideline has been registered with the trust. However, clinical guidelines are guidelines only. The interpretation and application of clinical guidelines will remain the responsibility of the individual clinician. If in doubt, contact a senior colleague or expert. Caution is advised when using guidelines after the review date.

This guideline is for use in Frimley Health Trust hospitals only. Any use outside this location will not be supported by the Trust and will be at the risk of the individual using it.

Version Control Sheet

Version	Date	Guideline Lead(s)	Status	Comment
1.0	Oct 2020	K Barot, M Van de Venne, D Vijeratman	Final	
2.0	July 2024	K Barot, M Van de Venne	Final	Scheduled review.

Related Documents

None