Royal Berkshire NHS
NHS Foundation Trust

Genital Herpes in Pregnancy (GL849)

Approval

Approval Group	Job Title, Chair of Committee	Date
Maternity & Children's Services Clinical Governance Committee	Chair, Maternity Clinical Governance Committee	10th April 2015

Change History

Version	Date	Author, job title	Reason
1.0	2004	Pat Street (Consultant Obstetrician), U Khopkar (Gynae Staff Grade)	Trust requirement
2.0	2006	Pat Street (Consultant Obstetrician), U Khopkar (Gynae Staff Grade)	Reviewed
3.0	January 2010	Pat Street (Consultant Obstetrician), U Khopkar (Gynae Staff Grade)	Reviewed
4.0	June 2013	Pat Street (Consultant Obstetrician)	Reviewed
5.0	January 2015	F Ajibade (Obs & Gynae Staff Grade), P Street (Consultant Obstetrician)	Review due

Overview: *Women developing a primary Herpes Simplex Virus (HSV) infection in late pregnancy or in labour, with either intact membranes or membranes having been ruptured for less than 4 hrs, should be offered delivery by Caesarean section and treatment with Acyclovir.*

The HSV's are DNA viruses that are widespread in nature. Two types are known

- HSV 1 commonly causes oro-labial herpes (cold sore)
- HSV 2 commonly causes genital lesions

However, both can cause either lesion. This guideline relates to genital herpes in pregnancy.

HSV infection is either

- Primary - the first exposure to the virus having occurred during pregnancy
- Secondary - which can either be a re-activation of an endogenous, latent virus or a re-infection by exogenous virus

You need to be aware that primary infection in pregnancy may present with skin lesions or disseminated herpes infection (encephalitis, hepatitis and disseminated skin lesions). This must be managed with joint multidisciplinary team involving GU medicine.

Neonatal effects

In the UK, the incidence of neonatal herpes is around 1.65 per 100,000 deliveries annually and there are, 10 cases of neonatal herpes per year. Passive immunisation from recurrent maternal HSV infection may confer protection. Primary HSV infection in the mother within 6 weeks of delivery or at the time of labour is known to transmit the virus to the baby in up to 41% of cases. As a result they may suffer fulminating systemic infection with a mortality of 70-90%. Symptoms vary and range from neuro-developmental impairment to meningo-encephalitis and even multi-organ failure, with eventual death.

Recommendation

Women developing a primary HSV infection during the first or second trimesters should be referred to the genito-urinary physicians

- Treat with oral Acyclovir 400mg 3 times daily for 5 days is associated with reduction in symptoms .. Topical lidocaine 2% gel may offer symptomatic relief.
- Following primary infection in first and second trimester daily suppressive therapy from 36 weeks gestation till delivery reduces HSV lesion at term and reduces risk of delivery by caesarean section
- Caesarean section should be the recommended mode of delivery for all women developing first episode in third trimester particularly symptomatic patient within 6 weeks of delivery.

- Women with first episode of genital herpes in third trimester, type specific HSV antibody (IgG) testing is advisable by liaising with GU medicine department to avoid unnecessary caesarean section. Viral swab to confirm diagnosis by PCR is advised
- If diagnosed in third trimester continue oral Acyclovir (400mg t.d.s) treatment until delivery
- If primary infection is diagnosed in third trimester continue oral acyclovir (400m t.d.s) treatment till delivery. Women developing a primary HSV infection after 34 weeks, in labour with either intact membranes or membranes having been ruptured for less than 4 hrs, should be offered delivery by Caesarean section. However If SROM more than 4 hrs there is still a slight benefit from performing C/section after this time interval. This most be discussed with the patient. If the patient want vaginal delivery treatment with IV acyclovir 5mg/kg every 8 hours and must inform the paediatrician.

invasive procedures such as fetal scalp electrode application, fetal blood sampling to be avoided and they should be offered intravenous acyclovir intrapartum at 5mg/kg every 8 hrs and the neonate must be treated with acyclovir 20mg/kg 8hrly if this invasive procedures are used In situations where vaginal delivery is unavoidable intrapartum iv acyclovir most be administered and paediatricians most be informed

In patient with primary genital herpes with preterm pre-labour rupture of membrane (PPROM) multidisciplinary management. If decision for conservative management IV acyclovir 5mg/kg treatment with steroid is recommended

Recurrent genital herpes

- Women who have acute symptoms or visible lesions over the vulva or cervix in early labour have a minimal chance (<3%) of transmitting the disease to the baby, and the risks to the baby of neonatal herpes, should be set against the risks to the mother of caesarean section.
- Women with recurrent genital herpes can be offered daily suppressive acyclovir 400mg three times daily from 36 weeks gestation
- Women with history of recurrent genital herpes & confirmed ruptured membrane at term should be advised about expediting delivery.
- If rupture membrane before 34 weeks expectant management is appropriate with oral acyclovir three time daily
- Inform paediatricians

References

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