Genital Herpes

MANAGEMENT SUMMARY

TEST IF

- Patient presents with genital ulcers, sores or fissures.

RECOMMENDED SAMPLE FOR GENITAL HERPES

Female and male:

- Viral swab for herpes simplex virus testing.
- Base of lesions should be rubbed firmly to maximise yield.
- Sexual health check at first or subsequent visit.

Treat immediately if patient symptomatic and clinical suspicion of genital herpes.

TREATMENT

- Aciclovir 400mg po 3 times daily for 7 days.
- 2% lignocaine gel or other analgesia.
- Skin care (see First Episode Genital Herpes guideline on page 2).
- Avoid sexual intercourse.
- Information leaflet and discussion regarding probable diagnosis.

PARTNER NOTIFICATION

- Not necessary, however may be useful for partners to have a clinical review and sexual health check
- Advise patients that partners should be informed of diagnosis (see www.herpes.org.nz for further information).

LABORATORY RESULTS

Positive: Confirmed diagnosis.

Negative: Does not exclude diagnosis – consider retesting when next symptoms and serology.

FOLLOW-UP

- At one week, give results and information on genital herpes.
- Check psychological well-being – offer counselling if required.
- Note: negative result does not exclude infection – consider re-testing when next symptomatic and possibly serology if continued negative tests (see guidelines).
- Sexual health check if not already done.
- Discuss management of future recurrences (see guidelines).

Further guideline information – www.nzshs.org or phone the local sexual health service.

This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health

NZSHS THE NEW ZEALAND SEXUAL HEALTH SOCIETY SEXUAL HEALTH FOR ALL

Introduction

Aetiology and epidemiology

- First episode disease caused by herpes simplex virus HSV-2 (~60%), or HSV-1 (~40%).
- On a clinical basis it is not possible to distinguish:
  - infection with HSV-1 or HSV-2
  - whether the infection is recently acquired, or past asymptomatic infection with new clinical manifestations.
- Recurrent genital herpes is usually due to HSV-2 (see Recurrent Genital Herpes guideline on page 4).

Symptoms and signs

Symptoms

- Blisters or ulcers in the anogenital region (including buttocks, sacral area and upper thigh).
- Groin, leg/buttock pain.
- Vaginal and/or urethral discharge (with cervical or urethral lesions).
- Fever, malaise, myalgia, headache.

Signs

- Anogenital blisters or ulcers.
- Inguinal lymphadenopathy.
- Cervicitis, urethritis, proctitis.

Note: Herpes zoster may present in the genital region.

Complications

- Urinary retention, constipation (more common in females than males).
- Fungal super-infection (bacterial super-infection very uncommon).
- Post herpetic neuralgia.
- Rarely disseminated infection (pregnancy or immune suppression), labial adhesions, meningitis.

Diagnosis

- Diagnosis is based on history, clinical findings and the results of appropriate tests.
- Virological confirmation and typing should be attempted in all patients.

Diagnostic tests

Which test is used depends on local laboratory availability.

1. **Nucleic acid amplification tests (NAAT) e.g. PCR or SDA.**
   - More sensitive than culture.
   - Typed as HSV-1 or HSV-2.
2. **Culture** (available in some laboratories).
   - Highest yield with blisters or early ulceration.
   - Reported as positive culture and typed as HSV-1 or HSV-2.
3. **Serology** (see Serology for Genital Herpes guideline on page 6).
4. Sexual health check at initial assessment unless not possible due to pain.

Recommended specimens

- Use viral swab – vesicular fluid optimal. Rub firmly on base of lesion to maximize yield.
- Store at 4°C and transport chilled (for culture only).

Management

General points

- Offer antiviral therapy at initial assessment, as well as counselling, support, and written information.
- Skin care, e.g. salt bathing daily to avoid development of adhesions.

Uncomplicated first episode genital herpes

- Aciclovir 400mg po 3 times daily for 7 days ± 2% lignocaine gel.
- Oral analgesia if necessary.

Pregnant or breastfeeding

- As above.
- **Note:** Aciclovir is not licensed for use in pregnancy, although it has been extensively used in pregnancy without significant adverse events (pregnancy category B3).
- All pregnant women with first episode genital herpes require review by a sexual health physician or an obstetrician as specific counselling regarding the management of the pregnancy and delivery is required (for more detailed guidelines refer to www.herpes.org.nz).

Complicated first episode genital herpes

- e.g. proctitis, severe infection, immunosuppression, disseminated infection – specialist referral recommended.

Management of sexual partners

- Partners with symptoms should be seen and evaluated.
- Asymptomatic partners may be seen for a routine sexual health check and/or counselling, as deemed appropriate by clinician.

Follow-up

- Patients should be reviewed in one week for counselling and discussion of results.
- **Note: A negative diagnostic test does not rule out the diagnosis** – if clinical suspicion of genital herpes repeat testing with further symptoms is required.
- Patients who did not have a sexual health check performed at the initial visit should be offered a sexual health check at follow-up.

Referral guidelines

Referral to a specialist sexual health service is recommended for:

- Recurrent lesions suspicious of genital herpes but negative on diagnostic testing.
- Suspected herpes proctitis.
- Suspected complications of primary genital herpes.
- Genital herpes in pregnancy or in immune suppressed individuals.
- Patients requiring additional psychological support.

Further information

Further guideline information is available at www.nzshs.org or www.herpes.org.nz or phone the local sexual health service.

This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health

NZSHS THE NEW ZEALAND SEXUAL HEALTH SOCIETY SEXUAL HEALTH FOR ALL

Introduction

- Recurrent genital herpes is mostly due to herpes simplex virus HSV-2 ,as HSV-1 reactivates less frequently.
- Of those who are HSV-2 seropositive 25% have clinical recurrent disease and 75% have unrecognised symptomatic disease or are asymptomatic.
- Treatment options should be discussed with all patients experiencing genital herpes recurrences and include:
  - Suppression
  - Episodic treatment
  - Conservative management with topical analgesia.

Suppression (continuous treatment)

- 80% of recipients of suppressive therapy for recurrent genital herpes will remain asymptomatic for the duration of treatment.
- Suppressive therapy does not result in cure, nor does it significantly alter the rate of recurrences following cessation of therapy.
- Asymptomatic shedding is reduced substantially, therefore transmission risk is substantially reduced but not eliminated.

Suggested criteria for commencement of suppressive treatment of HSV

- Positive diagnostic test.
- At patient request following discussion of potential benefits vs inconvenience of daily medication.
- Particularly indicated if:
  - At least 6 attacks per year.
  - Infrequent but very severe/neurological complications.
  - Significant psychosocial issues. In the latter case counselling should be strongly encouraged.

Management

- Aciclovir 400mg twice daily.
- Aciclovir 400mg 3 times daily if used in pregnancy.
- A treatment break is suggested at the end of 1-2 years as, due to the variable natural history of recurrences, frequency may have diminished and ongoing suppression may not be necessary.
- Side effects are uncommon – nausea or dizziness are the most common of these.
- Care should be taken with patients with renal disease.
- There are no known adverse effects of long term therapy.

At follow-up visits

- Breakthrough episodes – uncommon but may occur.
  - Patients should be examined to determine if symptoms are due to genital herpes.
  - If verified, valaciclovir may be applied for under Special Authority from MOH. This may offer an advantage over aciclovir in this situation, due to more favourable pharmacokinetics.
- Review adherence.
- Acknowledge and address psychosocial issues.

Pregnancy

- Routine prophylaxis for symptomatic control is not recommended in pregnancy but may be considered at clinician discretion.
- All pregnant women with recurrent genital herpes in pregnancy should be reviewed by a sexual health physician or an obstetrician as specific counselling regarding the management of the pregnancy and delivery is required.
- Full recommendations for the management of genital herpes in pregnancy are available at www.herpes.org.nz.

Episodic Treatment

- Useful for patients who have relatively infrequent episodes and who have a defined prodrome.
- Commencement of treatment during the prodrome or within one day of lesion onset may be effective at ameliorating or aborting the episode.

Management

- Aciclovir 800mg 3 times daily for 2 days OR
- Aciclovir 400mg 3 times daily for 5 days
- To start with the first symptoms of prodrome.

Referral guidelines

Referral to a specialist sexual health service is recommended for:

- Suspected breakthrough episodes on therapy.
- Suspected allergy/intolerance to aciclovir.
- Recurrent genital herpes in pregnancy or immune suppressed individuals.

Further information

Note: An in-depth guideline for the management of genital herpes has been produced by the Professional Advisory Board of the Sexually Transmitted Infection Education Foundation. This is available in printed form or online at www.herpes.org.nz.

Further guideline information – www.nzshs.org or phone the local sexual health service.

This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health

Screening

Testing as part of a routine sexual health check is not appropriate and there are very few clinical situations in which serological testing is indicated.

- False positive or false negative HSV-2 results are relatively common in the general population and confirmatory testing of positives is not available in New Zealand.
- No curative therapy is available.
- Provision of suppressive treatment for asymptomatic seropositive patients in order to reduce transmission is not cost effective.
- The psychosocial impact on the patient may be significant.

Epidemiology

- Approximately 70% of the adult population are seropositive for HSV-1.
- Approximately 22% of women and 15% of men in New Zealand are seropositive for HSV-2 by their 30s.

Appropriate situations for use of HSV serology

Situations in which HSV serology may be appropriate are as follows:

- Recurrent genital lesions which are repeatedly negative for HSV by diagnostic testing.
  Note: Positive serology in this setting confirms the presence of HSV but does not necessarily mean that the observed genital lesions are caused by HSV.
- Clinically discordant couples in a long-term relationship.
- Pregnant women with a partner who has confirmed genital herpes – to inform ongoing management of pregnancy.
- Pregnant women with a first episode of genital herpes after reaching foetal viability.

Note: Guidelines for management of genital herpes in pregnancy are available at www.herpes.org.nz.

Pre-test and post-test counselling

Pre-test and post-test counselling is essential.

- Interpretation of possible result combinations should be discussed with the patient before testing.
- Both partners of a couple should be offered testing.
- Results should be given in person.

Diagnostic tests

- Availability of serology depends on the local laboratory.
- ELISA – specific for HSV-1 and HSV-2 antibodies.
- Sensitivity and specificity are approximately 96-98% – false negatives and false positives may occur, particularly in a low prevalence population.
- Window period between infection and seroconversion is on average 6 weeks, but may take up to 6 months.
- Seroreversion (loss of antibodies) may occur.

Interpretation of test results

1. **HSV-1 and HSV-2 seronegative**
   - Implies no infection with either HSV-1 or HSV-2. Note could be false negative or seroreversion.
   - Note window period.
2. **HSV-1 and HSV-2 seropositive**
   - Implies infection with both HSV-1 and HSV-2. Note possible false positive HSV-2.
   - Usually this would suggest orolabial HSV-1 and genital HSV-2.

   Note:
   - ***HSV-1 infection may be genital, ophthalmic, or extragenital, e.g. Whitlow.***
   - ***HSV-2 may occasionally cause extragenital infections.***
   - ***Dual genital infection with HSV-1 and HSV-2 is possible.***

3. **HSV-1 seropositive, HSV-2 seronegative**
    - Implies infection with HSV-1.
    - History of orolabial lesions would suggest this as a site of infection.

    Note:
    - ***Up to 40% of genital infection is due to HSV-1.***
    - ***Dual orolabial and genital infection with HSV-1 is possible.***
4. **HSV-1 seronegative, HSV-2 seropositive:**
    - Implies infection with HSV-2. Note possible false negative HSV-1.
    - Usually this is due to genital infection.

    Note:
    - ***Occasionally HSV-2 will infect non-genital sites.***

Management

- Treatment decisions should be based on clinical findings.

Referral guidelines

Referral to a specialist sexual health service is recommended for:

- Above clinical situations if the clinician requires management advice.

Further information

Note: An in-depth guideline for the management of genital herpes has been produced by the Professional Advisory Board of the Sexually Transmitted Infection Education Foundation. This is available online at www.herpes.org.nz.

Further guideline information – www.nzshs.org or phone the local sexual health service.

This Best Practice Guide has been produced by NZSHS, and is adapted from the CMDHB Best Practice Guideline.
Every effort has been taken to ensure that the information in this guideline is correct at the time of publishing (July 2012).

Produced with funding by the Ministry of Health

NZSHS
THE NEW ZEALAND SEXUAL HEALTH SOCIETY
SEXUAL HEALTH FOR ALL