

# Genital Herpes – Summary of Guidelines

Taken from: **Guidelines for the Management of Genital Herpes in New Zealand 11th Edition - 2015**

[www.herpes.org.nz](http://www.herpes.org.nz)

## Genital Herpes – Key Management Points

- Genital herpes is under-recognised and under-treated. Minor lesions are common; any recurring localised anogenital symptoms or lesions should be investigated as possible genital herpes.
- Oral antiviral treatment of the first clinical episode (**without waiting for results**) should always be offered, regardless of the time of symptom onset. **The '72 hour' herpes zoster rule does NOT apply to first episode genital herpes infection.**
- Antiviral therapy of recurrent genital herpes may be suppressive or episodic.
- Many patients prefer suppressive antiviral therapy. It is particularly recommended for those with frequent and/or severe recurrences or associated psychosocial morbidity. Adherence to suppressive treatment reduces but does not eliminate transmission.
- For those choosing episodic antiviral therapy, it is more effective when patients start therapy themselves at the first signs of a recurrence; this requires anticipatory prescribing ("pill-in-the-pocket" antibiotic prescription).
- Neonatal HSV infection needs specialist advice on management for women with a history of genital herpes and active lesions at term and especially in the high risk situation of a first episode up to 6 weeks prior to delivery.
- Neonatal HSV infection is a rare but potentially fatal disease of babies, occurring within the first 4–6 weeks of life. Symptoms are non-specific and a high index of suspicion is required. Most neonatal HSV infections are acquired at birth, generally from mothers with an unrecognised first genital herpes infection acquired during pregnancy.

## What's new since 2013

### Valaciclovir (Valtrex™)

The special authority and Hospital Medicines List restriction will be removed from 1 March 2016 (Pharmac).

**From 1 March 2016 this is recommended first line treatment.**

### Treatment of first episode genital herpes

- Oral aciclovir 400mg 3 times daily (8 hourly) for 7 days.
- From 1 March 2016, valaciclovir 1g bd for 7/7.

### Treatment of recurrent genital herpes

#### Episodic Treatment

- Oral aciclovir 800mg (2 x 400mg) 3 times daily for 2 days.
- From 1 March 2016, valaciclovir 500mg bd for 3/7.

Prescribe enough tablets for patients to be able to self-initiate treatment at onset of symptoms.

#### Suppressive therapy

**Given daily to prevent recurrences and reduce asymptomatic shedding. Recommended for people with confirmed HSV-2. Suggest prescribing for minimum of 12–18 months, followed by a break of 3 months at their convenience to see if recurrences are still frequent and/or bothersome.**

- Oral aciclovir 400mg twice daily.
- From 1 March 2016, valaciclovir 500mg daily (increase to 500mg BD on individual basis of clinical presentation and/or having breakthrough recurrences on 500mg daily).

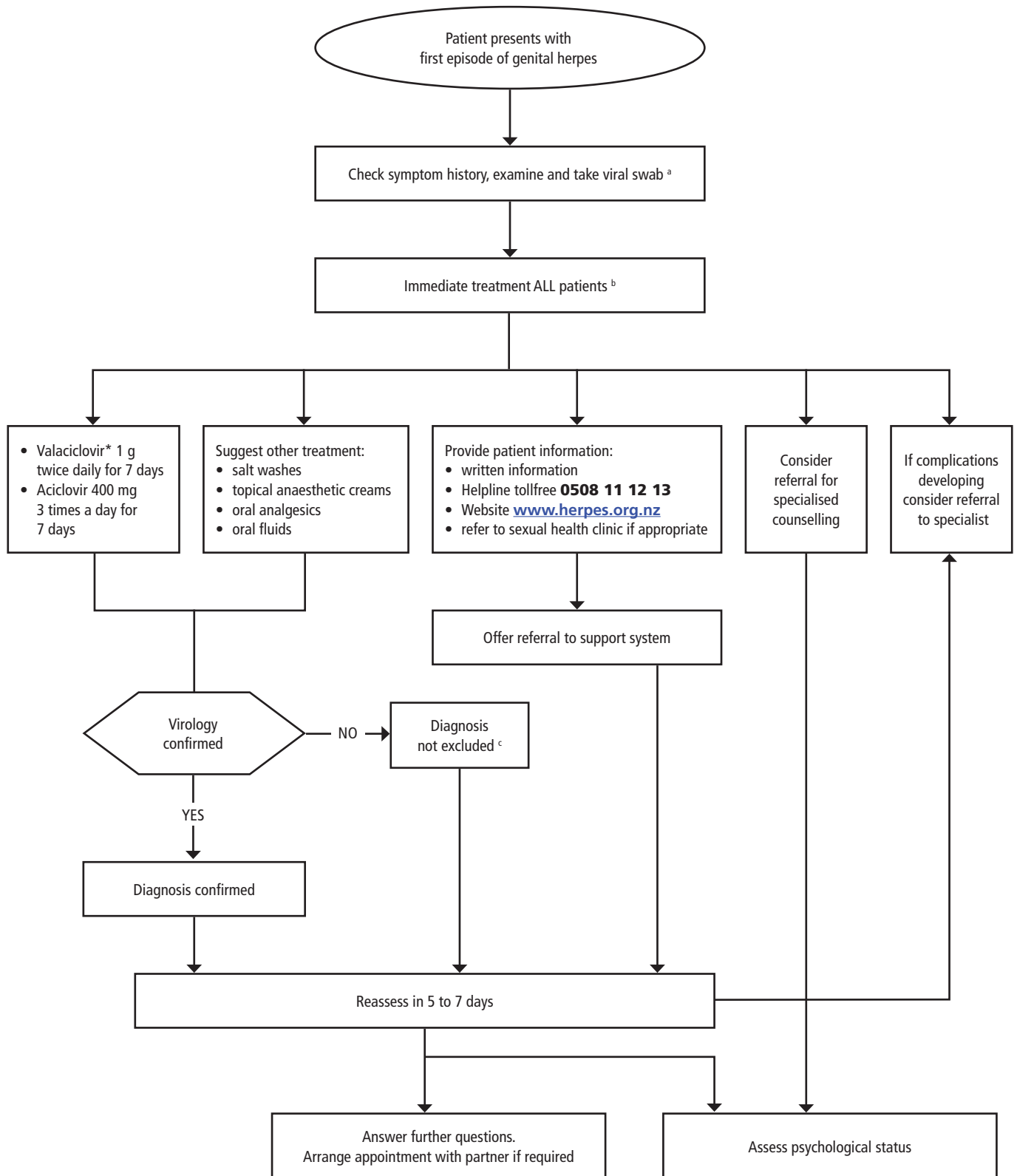
### Treatment of HSV in people with HIV

HSV episodes in those with HIV can be successfully treated with standard antiviral regimens as for non-HIV infected individuals. However there is a higher rate of resistance to standard anti-herpes drugs.

## Epidemiology

- As many as one in five adults in New Zealand have genital herpes due to HSV-2, but most will have asymptomatic or unrecognised disease.
- Genital herpes due to HSV-1 (through oral to genital transmission) has also become common; HSV-1 is a frequent cause of primary genital herpes.
- The natural history of genital HSV-1 infection involves significantly fewer clinically apparent recurrences and less subclinical shedding than HSV-2.

# Management of First Episode of Genital Herpes



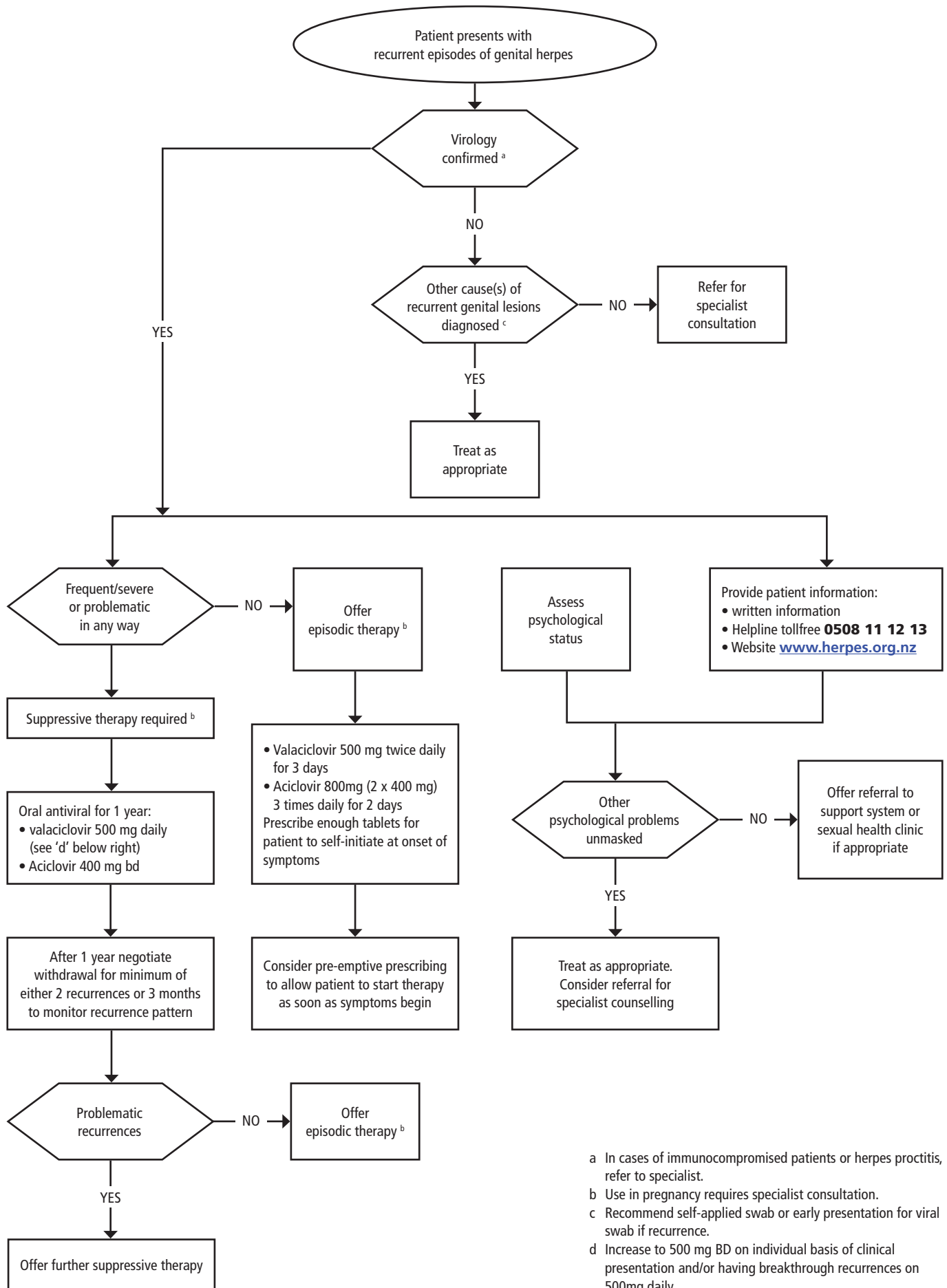
\* Available from 1 March 2016.

a In cases of immunocompromised patients or herpes proctitis, refer to specialist.

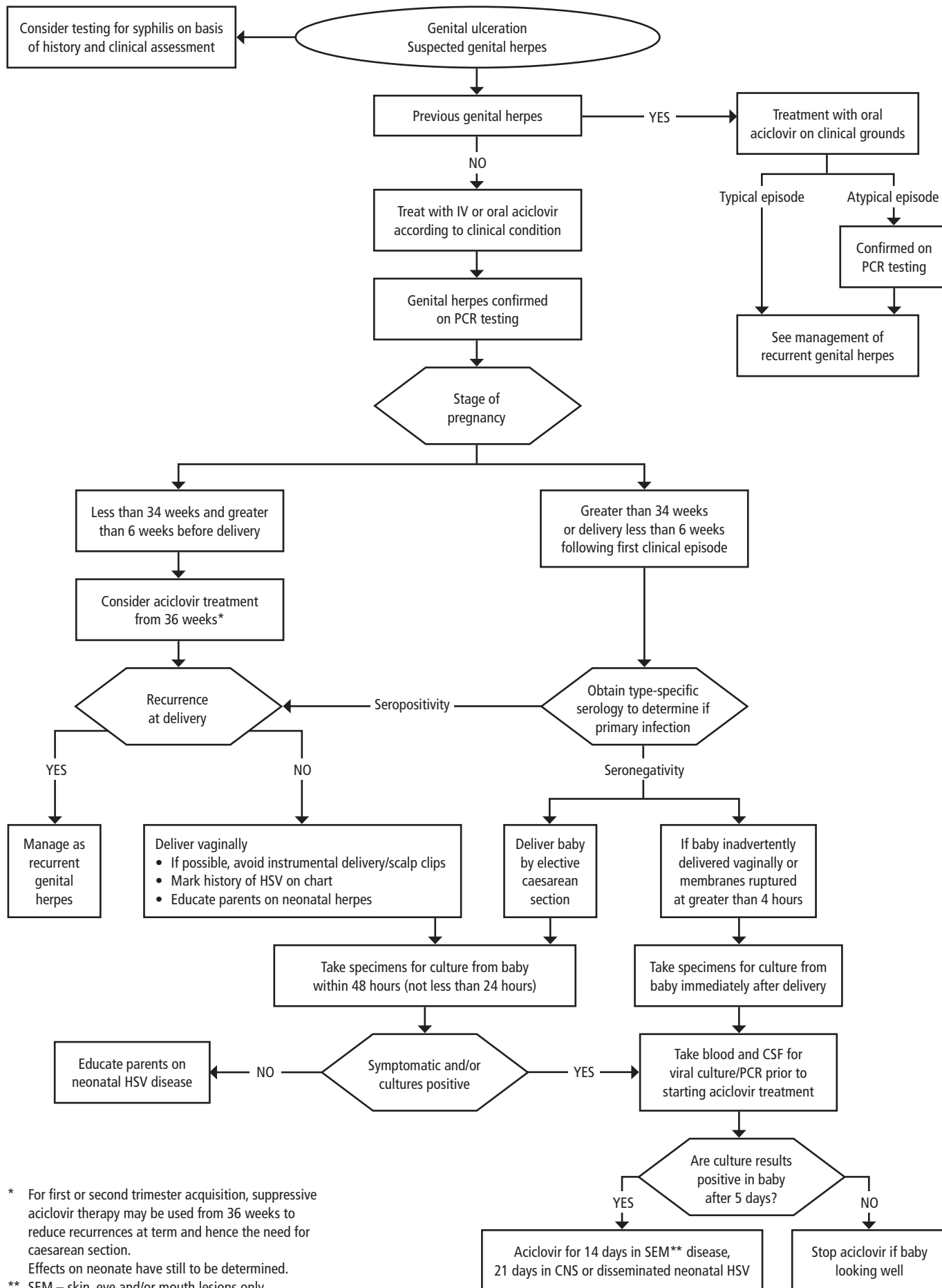
b Use in pregnancy requires specialist consultation.

c Recommend early presentation for viral swab if recurrence.

# Management of Recurrent Episodes of Genital Herpes



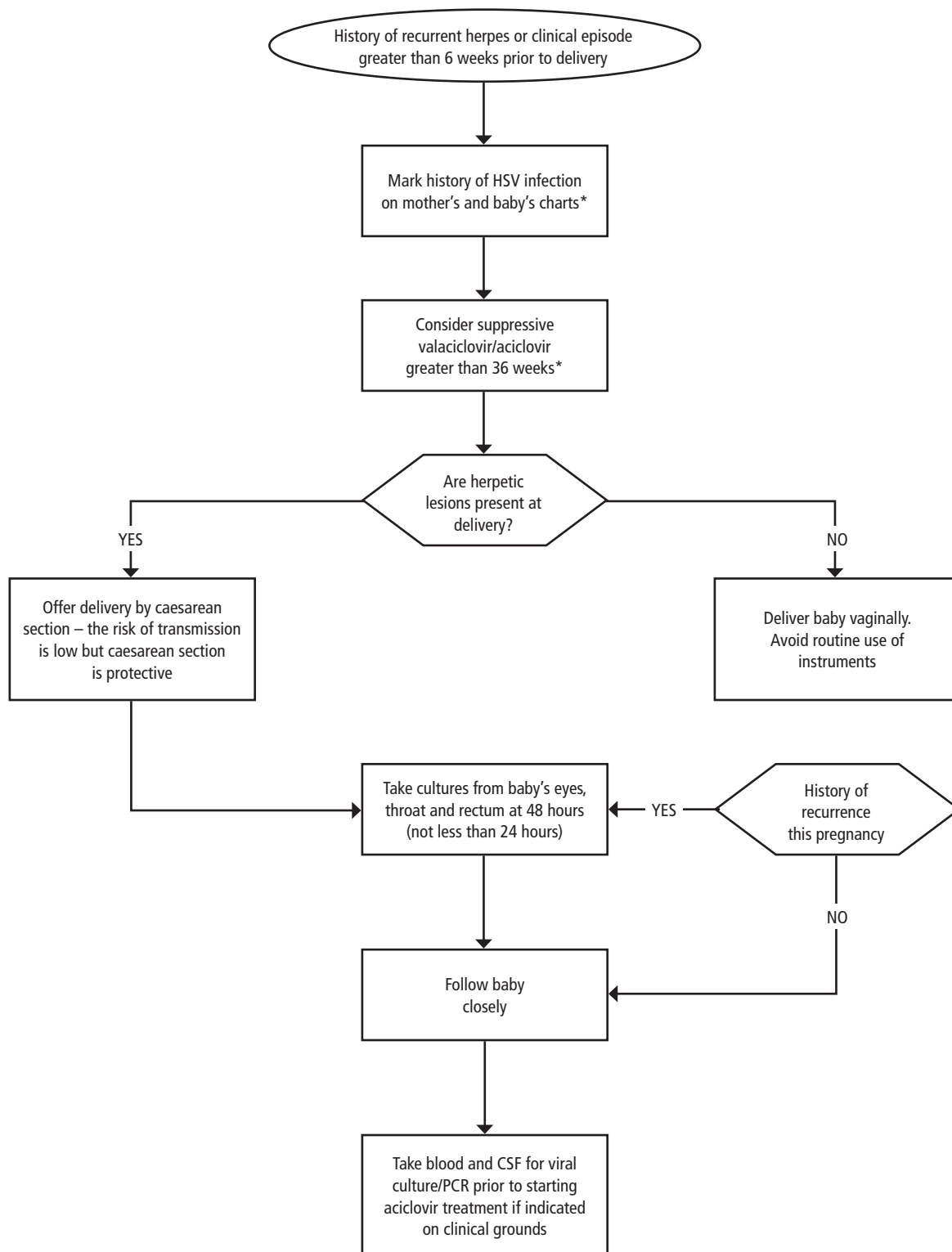
# Management of women with suspected genital herpes in pregnancy (in consultation with a specialist)



\* For first or second trimester acquisition, suppressive aciclovir therapy may be used from 36 weeks to reduce recurrences at term and hence the need for caesarean section. Effects on neonate have still to be determined.

\*\* SEM – skin, eye and/or mouth lesions only.

# Management of women with history of genital herpes prior to pregnancy and women with first clinical episode greater than 6 weeks prior to delivery (in consultation with a specialist)



\* For women with recurrences during pregnancy, suppressive aciclovir therapy can be considered to reduce recurrence at term and hence the need for caesarean section. Effects on the neonate have still to be determined.

## Key Information to provide patients on diagnosis – available on [www.herpes.org.nz](http://www.herpes.org.nz) - 3 minute PowerPoint tool home page

- Up to one in three people have genital herpes, but only 20% of them experience symptoms. (This includes genital herpes caused by both HSV-1 and HSV-2.)
- Most people (80%) who become infected with genital herpes will not have any symptoms, or have such mild symptoms that they will not be recognised or diagnosed as genital herpes. 75% of herpes is acquired from partners unaware they have it.
- For most people who experience symptoms, genital herpes is a sometimes-recurring 'cold sore' on the genitals. It does not affect your overall health or longevity of life.
- A small percentage of people who get genital herpes may experience problematic recurrences. If this happens there is effective treatment available.
- People who experience a first episode of genital herpes will get better, lesions will heal and there will be no evidence of the initial lesions left.
- Most people who experience a first episode of HSV-2 will have recurrences, but they are generally milder than the first episode. HSV-1 tends to cause fewer recurrences than HSV-2.
- Getting genital herpes in a long-term relationship does not mean that the other partner has been unfaithful. However, a full sexual health screen may be reassuring.
- Where both partners in a long-term relationship have the virus, use of condoms is not necessary as they cannot reinfect each other. However, it is advisable to avoid skin-to-skin contact when lesions are present, as friction may prolong the healing.
- Oral to genital transmission of HSV-1 is very common through oral sex. This can happen when 'cold sores' are not causing symptoms.
- Genital herpes does not affect your fertility or stop you having children. Vaginal delivery is usual for most women with a history of genital herpes.
- Genital herpes does not stop you having sex.
- Anybody with genital herpes, whether they get symptoms or have never had symptoms, may shed the virus from time to time with no symptoms present.
- There is no evidence that genital herpes causes cancer of the cervix.
- Condoms reduce the risk of transmission. The use of condoms in a long-term relationship should be a matter of discussion between the individuals. It is advisable to avoid genital-to-genital contact, even with a condom, until any lesions are completely healed.
- Even if the virus is passed on, the most likely outcome is that the person will never experience symptoms.
- Ensure patients have access to the NZHF patient pamphlets and/or **TOLL FREE 0508 11 12 13** or visit [www.herpes.org.nz](http://www.herpes.org.nz)