NEW ZEALAND HERPES FOUNDATION

Genital Herpes

SUMMARY OF GUIDELINES

Taken from: **Guidelines for the Management of Genital Herpes in New Zealand** 13th Edition - 2024

www.herpes.org.nz

The Ministry of Health supports the use of these clinical guidelines, developed by clinical experts and professional associations to guide clinical care.

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.
- Diagnosis is made by HSV PCR swab testing of lesions. Blood tests for herpes simplex type specific antibodies are NOT recommended for diagnosing or screening for 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.**
- Antiviral therapy of recurrent genital herpes may be suppressive or episodic.
- Suppressive therapy helps reduce recurrences, transmission and alleviates psychological morbidity. For those on episodic antiviral therapy, maximal effectiveness is achieved when the medication is started at the first signs of a recurrence; this requires anticipatory prescribing (“back-pocket” antiviral prescription). Any patient diagnosed with genital HSV should have the option of suppressive treatment discussed with them.
- A diagnosis can cause distress. It is helpful to ensure the patient has access to information on www.herpes.org.nz and/or the toll free number 0508 111 213 (from a landline) or (09) 433 6526 (from a mobile).
- Specialist advice is recommended for management of pregnant people 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 nonspecific 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 in the 2024 guidelines

Suppressive Therapy

Antiviral suppressive therapy should be offered as an option to patients who have problematic recurrences, those who are adversely psychologically impacted by herpes recurrences and patients who wish to decrease the risk of transmission to their sexual partners.

Suppressive prescriptions should be reviewed after 12 months to see if patients' circumstances have changed and to explore if patients would like to come off suppressive therapy. Withdrawal of suppressive therapy should take place for a period that is sufficient to establish whether the pattern of recurrence has changed or at least 2 recurrences.

Herpes Proctitis management

HSV can cause severe proctitis, usually without external herpetic lesions. If a patient presents with proctitis symptoms clinicians should obtain a HSV PCR swab, treat with antivirals and make an urgent referral to a Sexual Health Clinic for review and ongoing management.

HSV proctitis treatment:

Oral valaciclovir 500mg bd OR aciclo for 7-10 daysvir 400 mg orally tds 7 -10 days

Pharmacy prescribing

There is now a capacity for Pharmacists to provide repeat scripts under standing orders for episodic treatment of patients with known genital herpes.

Genital Herpes Management flowcharts

The Genital Herpes management flow charts have been updated to reflect treatment guidelines with the addition of a new flow chart created for the management of Genital Herpes at the time of delivery.

Treatment of first episode genital herpes

- Oral valaciclovir 500mg bd for 7 days or longer (up to 10 days) if new lesions appear during treatment.
- *Alternative*: oral aciclovir 400mg tds (8 hourly) for 7 days.
- *Immunocompromised patients (under specialist guidance):* oral valaciclovir 1g bd for 10 days.

Treatment of recurrent genital herpes

Episodic Therapy

- Oral valaciclovir 500mg bd for 3 days.
- *Alternative*: oral aciclovir 800mg tds for 2 days.
- *Immunocompromised patients (under specialist guidance):* oral valaciclovir 500mg bd for 5 days

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

Suppression Therapy

- Oral valaciclovir 500mg daily (increase to 500mg bd if having breakthrough recurrences).
- *Alternative*: oral aciclovir 400mg twice daily (increase to 400mg tds if having breakthrough recurrences).
- *Immunocompromised patients (under specialist guidance):* oral valaciclovir 500mg bd.

Epidemiology

- As many as one in five adults in New Zealand are serologically positive with HSV-2, most will have asymptomatic or unrecognised disease.
- It is estimated that 80% of New Zealanders are serologically positive for HSV-1. Genital herpes due to HSV-1 is also common and now accounts for almost half of first episode presentations. The natural history of genital HSV-1 infection involves significantly fewer clinically apparent recurrences and less subclinical shedding than HSV-2.
- Only 10–25% of individuals who are HSV-2 seropositive report a diagnosis of genital herpes, which suggests that most have unrecognised symptomatic or completely asymptomatic infections.[2] However, after being told that they are HSV-2 seropositive, more than 60% of individuals are able to identify clinically symptomatic recurrences that they may have previously been thought to be due to other conditions. See Figure 2 for a visual aid of these statistics.

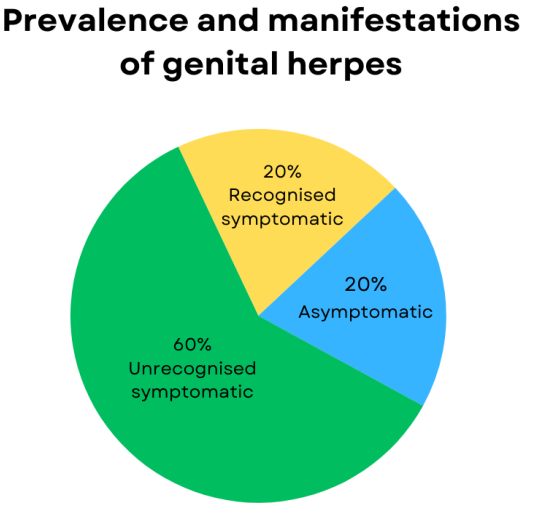
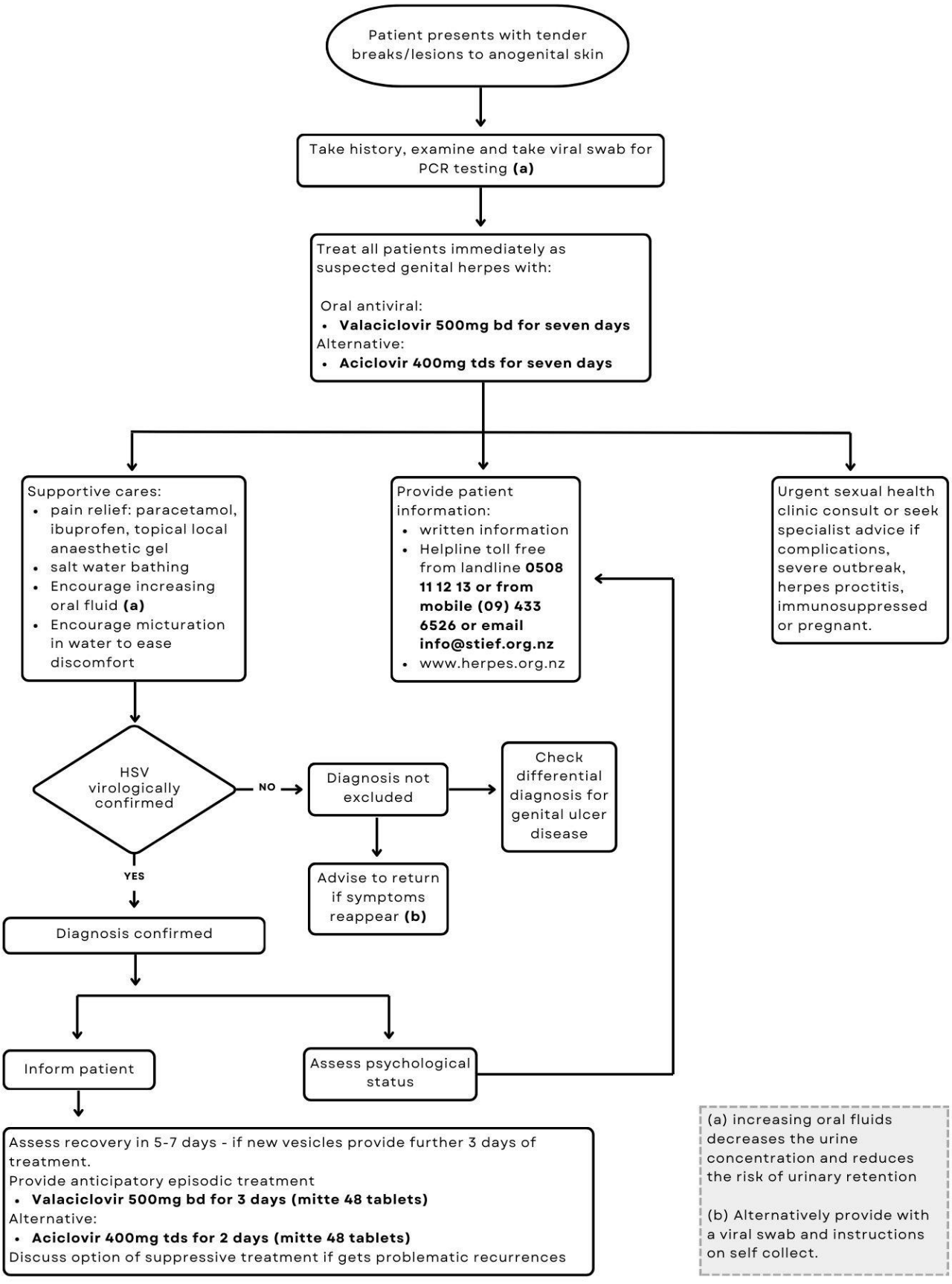


Figure 2. The percentage of people who are serologically positive for genital herpes HSV-2 and their clinical manifestations.

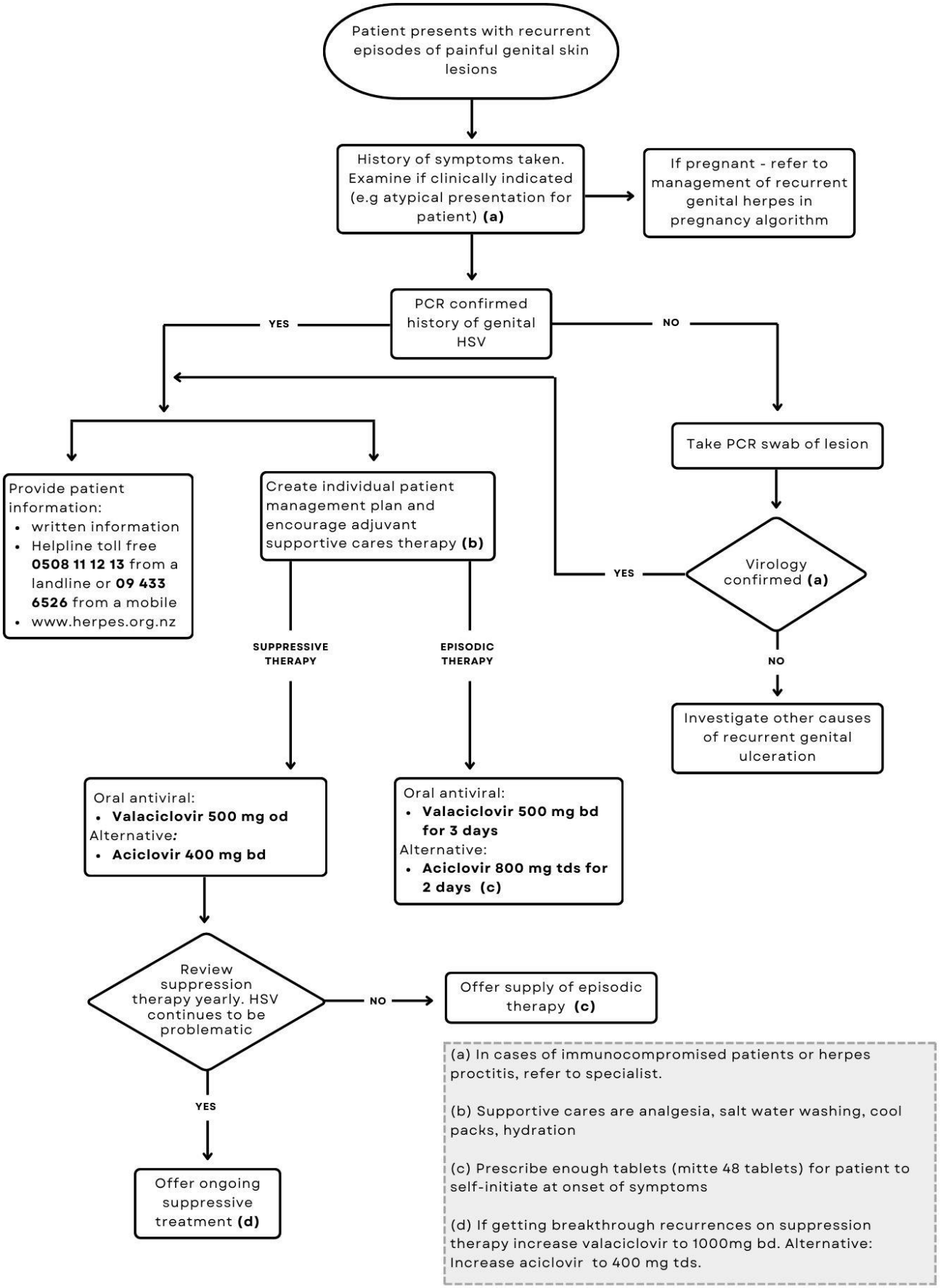
Management of First Episode of Genital Herpes



(a) increasing oral fluids decreases the urine concentration and reduces the risk of urinary retention

(b) Alternatively provide with a viral swab and instructions on self collect.

Management of Recurrent Genital Herpes



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

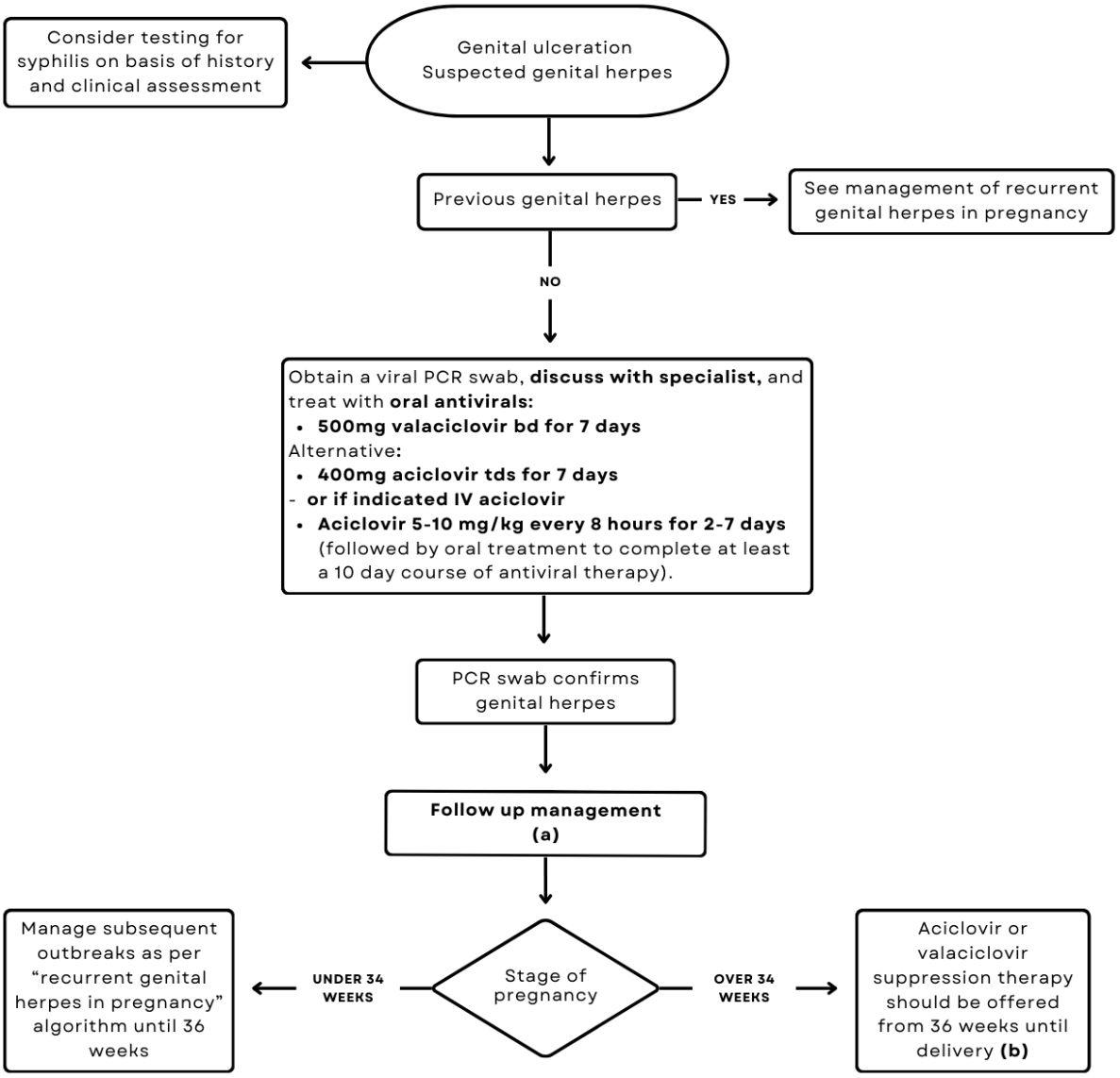
(b) Supportive cares are analgesia, salt water washing, cool packs, hydration

(c) Prescribe enough tablets (mitte 48 tablets) for patient to self-initiate at onset of symptoms

(d) If getting breakthrough recurrences on suppression therapy increase valaciclovir to 1000mg bd. Alternative: Increase aciclovir to 400 mg tds.

Management of Suspected Genital Herpes in Pregnancy

(In consultation with a specialist)

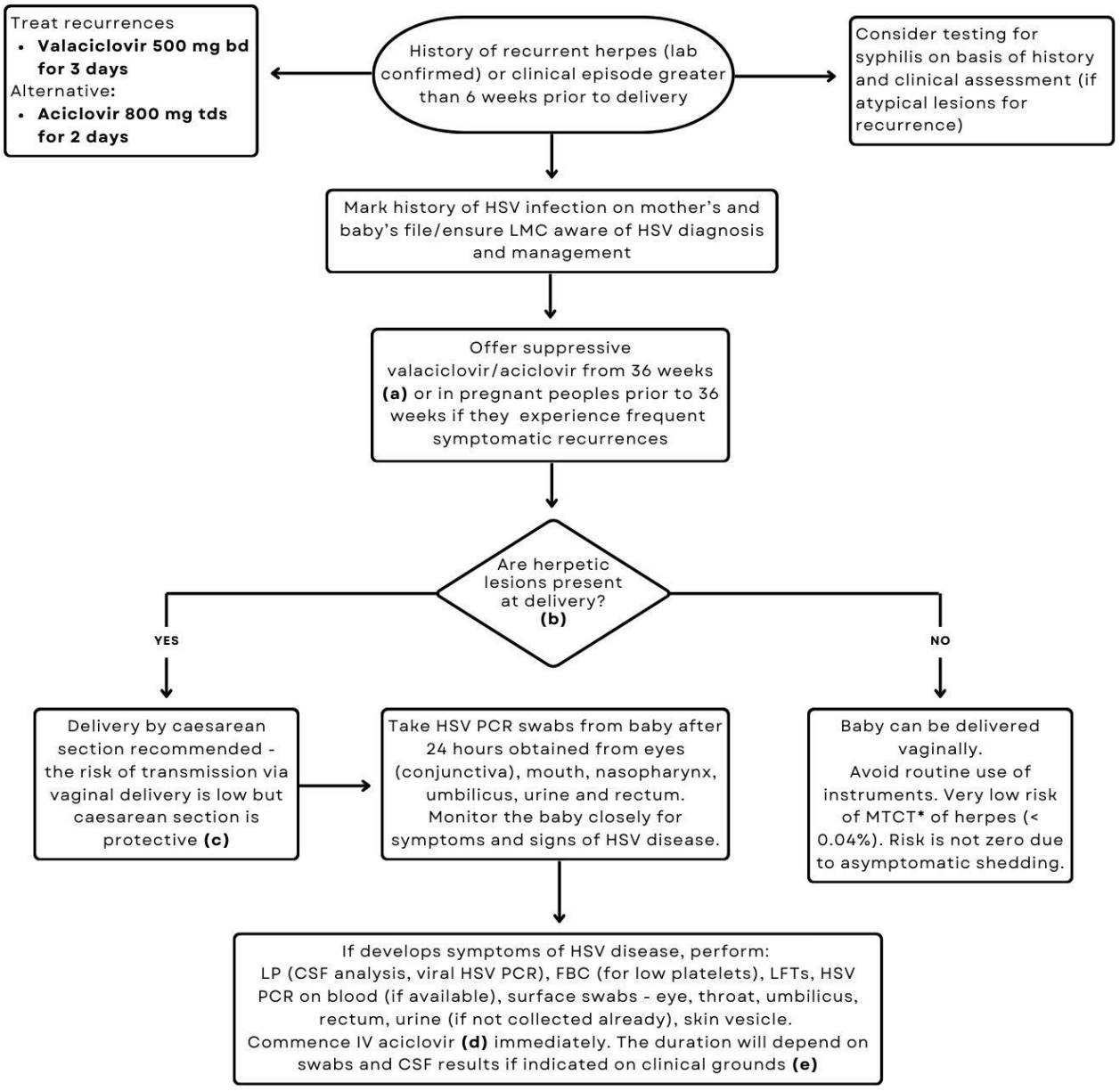


(a) Ensure LMC is aware of HSV diagnosis and management.

(b)Valaciclovir 500 mg bd until delivery or aciclovir 400 mg tds until delivery. For first or second trimester acquisition, suppressive aciclovir or valaciclovir therapy can be used to treat symptomatic recurrences. From 36 weeks, treatment can be considered to reduce the chance of a recurrence at term and hence the need for caesarean section. Effects on the neonate have not been fully determined. However, aciclovir (and to a lesser extent valaciclovir, which is a pro-drug of aciclovir) has been widely used in pregnancy without reported adverse consequences.

Management of Known Recurrent Genital Herpes in Pregnancy

(in consultation with a specialist)



(a) For women with recurrences during pregnancy, suppressive aciclovir or valaciclovir therapy can be used to treat symptomatic recurrences. From 36 weeks treatment can be considered to reduce the chance of a recurrence at term and hence the need for caesarean section. Effects on the neonate have not been fully determined. However, aciclovir (and to a lesser extent valaciclovir, which is a pro-drug of aciclovir) has been widely used in pregnancy without reported adverse consequences.

(b)All patients with a known hx of genital HSV should be examined visually when they present for labour management (consideration of speculum exam to rule out cervical lesions).

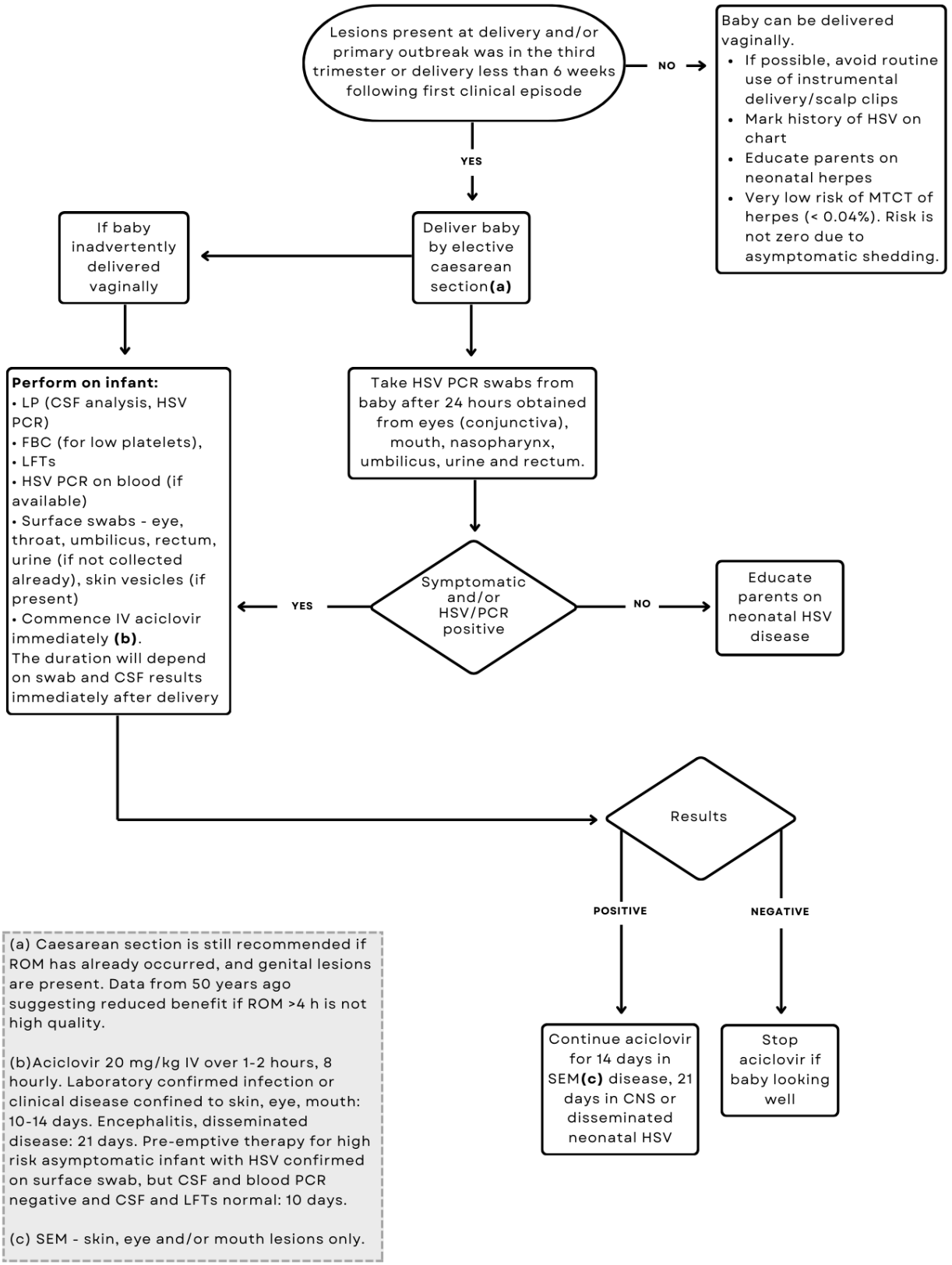
(c)The low risk of MTCT of HSV after vaginal delivery in women with recurrent genital herpes lesions need to be balanced against the risks of caesarean section.

(d) Aciclovir 20 mg/kg IV over 1-2 hours, 8 hourly.
(e) Laboratory confirmed infection or clinical disease confined to skin, eye, mouth: 10-14 days. Encephalitis, disseminated disease: 21 days. Pre-emptive therapy for high risk asymptomatic infant with HSV confirmed on surface swab, but CSF and blood PCR negative and CSF and LFTs normal: 10 days.

*Mother-to-Child Transmission

Management of Genital Herpes at Time of Delivery

(in consultation with a specialist)



(a) Caesarean section is still recommended if ROM has already occurred, and genital lesions are present. Data from 50 years ago suggesting reduced benefit if ROM >4 h is not high quality.

(b)Aciclovir 20 mg/kg IV over 1-2 hours, 8 hourly. Laboratory confirmed infection or clinical disease confined to skin, eye, mouth: 10-14 days. Encephalitis, disseminated disease: 21 days. Pre-emptive therapy for high risk asymptomatic infant with HSV confirmed on surface swab, but CSF and blood PCR negative and CSF and LFTs normal: 10 days.

(c) SEM - skin, eye and/or mouth lesions only.

Key information to provide patients on a diagnosis of genital herpes

- Herpes simplex virus (HSV) is a very common infection, nearly always medically insignificant, and most of us (80%) will eventually have it.
- There are two strains of HSV. HSV-1 is most commonly associated with ora/facial herpes, called “cold sores”, and responsible for approximately 50% of genital herpes. HSV-1 is commonly transmitted to a partner’s genitals through oral to genital contact. HSV-2 is more commonly transmitted through genital to genital contact.
- One in three sexually active people in New Zealand will have genital herpes.
- Most people (80%) who have genital herpes will not have any symptoms, or have such mild symptoms that they will not be recognised or diagnosed as genital herpes. More than 50% 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.
- There is effective oral antiviral treatment available, which will significantly reduce recurrences and the risk of transmission.
- People who experience a first episode of genital herpes will get better, lesions will heal and there will be no scarring.
- Most people who experience a first episode of HSV-2 will have recurrences, but they are generally milder than the first episode. Eventually the virus tends to “fizzle out” causing less or no recurrences.
- With a first episode of genital HSV-1 there is a 43% chance of no further recurrences after the first year or an average of one a year.
- Getting genital herpes in a long-term relationship does not mean that the other partner has been unfaithful. They are very likely to have the virus but be unaware because they have no symptoms.
- Where both partners in a long-term relationship have the virus, use of condoms is not necessary as they cannot reinfect each other. If there is one partner who has HSV in the relationship and the other does not, the decision to use condoms or not becomes a mutual discussion.
- Genital herpes does not affect your fertility or stop you having children. Vaginal delivery is usual and safe 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. It is not a virus you can choose “not to get” or “not to pass on” because for most people it is invisible.
- Even if the virus is passed on, the most likely outcome is that the person will never experience symptoms.
- Condoms may reduce the risk of transmission. The use of condoms in any sexual 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 healed.
- Ensure patients have access to the NZHF patient pamphlets and/or the HELPLINE TOLLFREE number 0508 111 213 (from a landline) or (09) 433 6526 (from a mobile) or via email info@stief.org.nz or visit www.herpes.org.nz.