Approved by Quality & Patient Safety Committee
20/6/13

HERPES SIMPLEX IN PREGNANCY AND BIRTH

This LOP is developed to guide clinical practice at the Royal Hospital for Women. Individual patient circumstances may mean that practice diverges from this LOP.

1. AIM

- Appropriate management of pregnant woman with Herpes simplex (HSV) infection

2. PATIENT

- Pregnant woman with primary and secondary HSV infection

3. STAFF

- Registered Midwives
- Medical Staff
- Registered Nurses
- Student midwives

4. EQUIPMENT

- Nil

5. CLINICAL PRACTICE

- Refer woman presenting with their first episode of genital herpes to a medical staff member. Offer screening for other sexually transmitted infections and confirmation of herpes diagnosis by obtaining HSV serology (type specific) and HSV genital culture. Ideally test the serum in parallel with first antenatally collected sample to define the episode as primary (no previous HSV infection) or first episode
- Treat primary infection with oral or intravenous aciclovir or valaciclovir in standard doses
- Recommend caesarean section for all women presenting with a primary episode of genital herpes lesions at the time of birth unless the membranes have been ruptured for more than 6 hours
- Consider caesarean section for all women with primary episode genital herpes within 6 weeks of delivery. In women who develop their primary episode of genital herpes lesions within six weeks of birth and who opt for vaginal birth, water birth and invasive procedures such as fetal scalp electrode application, fetal blood sampling, instrumental delivery should be avoided if possible

Recurrent herpes infection in pregnancy

- Offer women who have a history of recurrent HSV lesions and are planning a vaginal birth, daily suppressive therapy of Aciclovir 400mg three times a day
- Do not recommend caesarean section for recurrent episodes of herpes infection where no lesions are present at delivery
- Consider caesarean section for women with active lesions of recurrent genital herpes who present in labour, if the membranes have been ruptured for less than 6 hours

General

- Inform neonatal team about women who are giving birth with active herpes lesions with either primary or recurrent episodes
- Inform female partners of men with genital herpes, who have no history of genital herpes themselves, about reducing their risk of acquiring this infection
- Avoid direct contact with the neonate and herpes lesions in healthcare workers and family members with active HSV Infection such as orofacial herpes or herpetic whitlow

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HERPES SIMPLEX IN PREGNANCY AND BIRTH cont'd

6. DOCUMENTATION

- Yellow Card
- Integrated Clinical Notes
- Medication Chart

7. EDUCATIONAL NOTES

- Intravenous aciclovir given intrapartum to the mother and subsequently to the neonate may reduce the risk of neonatal herpes in women with active primary genital herpes lesions
- Recurrent episodes of genital herpes with active lesions in labour are associated with 1-3% transmission rate to the neonate
- Studies report an increase in risk of neonatal herpes as being dependant on whether the woman has experienced a primary herpes lesion within 4–6 weeks of birth rather than recurrent genital HSV
- The aciclovir pregnancy registry documented 1234 pregnancies where aciclovir was used prospectively, with no increase in birth defects. Valaciclovir is broken down to aciclovir in the body and safety data can be extrapolated from acyclovir
- In a Cochrane review of studies, women who received antiviral prophylaxis were significantly less likely to have a recurrence of genital herpes at delivery (relative risk (RR) 0.28, 95% CI 0.18 to 0.43). The corresponding number of women who would need to receive antiviral prophylaxis from 36 weeks until delivery to prevent a recurrence at delivery would be 10. Suppressive therapy options include Aciclovir 400mg three times a day or Valaciclovir 500mg twice a day from 36 weeks gestation. Valaciclovir is significantly more expensive.
- Where there is clinical uncertainty contact the on-call virologist
- A Patient Information Leaflet can be obtained from: http://www.fpnsw.org.au/189826_8.html

8. RELATED POLICIES / PROCEDURES / CLINICAL PRACTICE LOP

- Care in Normal Labour
- Sexually Transmitted Infections (STI) / blood borne viruses antenatal screening and treatment guideline

9. REFERENCES

1 SOGC Guidelines for the Management of Herpes Simplex Virus in Pregnancy. J Obstet Gynaecol Can 2008; 30(6): 514-519

2 Australian Herpes Management Forum. Guidelines for Clinicians Herpes Simplex in Pregnancy. 2009. http://www.ahmf.com.au/sites/default/files/Clinical_guidelines/200904/AHMF_Herpes_Simplex_Pregnancy.pdf

3 Royal College of Obstetricians and Gynaecologists, (2007) Green-top Guideline no. 30 *Management of genital herpes in pregnancy*

4 Hollier LM, Wendel GD. Third trimester antiviral prophylaxis for preventing maternal genital herpes simplex virus (HSV) recurrences and neonatal infection. *Cochrane Database of Systematic Reviews* 2008, Issue 1. Art. No.: CD004946

5 Management of Perinatal Infections. Edited By Dr Pamela Palasanthiran, Dr Mike Starr, And Dr Cheryl Jones. Australasian Society For Infectious Diseases 2002

REVISION & APPROVAL HISTORY

Maternity Services Clinical Committee 14/9/04 – Approved Quality Council 20/9/04
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