Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

Genital Herpes Simplex Virus

Cause

- Herpes is caused by Herpes simplex viruses types 1 and 2

Overview

- Genital Herpes Simplex Virus (HSV) is highly stigmatised and poorly understood in the community.
- Patient education to address both clinical and psychosocial concerns is required at time of diagnosis.
- Other conditions can cause genital ulceration: syphilis, other human herpes viruses (herpes zoster virus [VZV] Epstein-Barr virus [EBV], systemic viral infections including Covid, MPX and HIV, aphthous ulcers and blistering dermatoses. (See genital ulcers)
- A sexual health check including syphilis & HIV serology is recommended (see sexual health check).
- Initial episodes may be severe, and treatment should never be delayed while waiting for a test result.
- Most HSV is asymptomatic or mild enough that diagnosis is never sought. If symptoms do appear, it can be days or years after HSV was first acquired.
- More than 50% of primary genital infections are caused by HSV–1 in young people.
- Recurrences are more common in the first year with HSV–2.
- Severe and frequent recurrences may be treated with continuous

suppressive or episodic antivirals.

Clinical presentation

Symptoms
Primary episodes may be severe with extensive anogenital ulceration and systemic features of viremia
Recurrent ulcers or blisters on the anogenitals, lower back, buttocks, thighs and pubis
Recurrent genital fissures
Erythema with itching and tingling
Cervicitis, often with visible ulcers, blisters or erosions in primary episodes, vaginal discharge
Proctitis, tenesmus
Psychosexual stress – very common
Neonatal infection – extremely rare complication
Urethritis, including urethral discharge
Very rare – central nervous system (CNS) involvement, including meningitis, transverse myelitis or sacral radiculopathy
Extra-genital lesions – frequently located on the lower back, buttock, groin or thigh. The fingers and eyes can be involved

Diagnosis

Site/specimen	Test	Consideration
Swab of base of ulcer or deroofed vesicle	*HSV NAAT	Positive – HSV infection Negative – may not exclude HSV infection – see genital ulcers section

*HSV NAAT – Nucleic Acid Amplification Test; a very sensitive and specific test; it is rare but false positives and false negatives may occur.

Self-collection of NAAT specimens at first onset of recurrent symptoms may be useful to confirm diagnosis in patients who have failed to have confirmation when attending clinical services.

Serology: do not screen asymptomatic people with serological tests for HSV types 1 or 2. Use of serology is limited to specific situations where results will provide meaningful clinical information (e.g. an asymptomatic pregnant partner of a newly diagnosed person) and should be done in conjunction with a sexual health specialist.

Management

Principal treatment options		
Situation	**Recommended**	**Alternative**
Initial episode	Valaciclovir 500mg PO, BD for 7 days or longer if new lesions appear or healing is incomplete	Aciclovir 400mg PO, TDS for 7 days or longer if new lesions appear or healing is incomplete
Recurrence: episodic therapy *Should be self-initiated at the first hint of symptoms*	Valaciclovir 500mg PO, BD for 3 days	Aciclovir 800mg TDS for 2 days
Recurrence: suppressive therapy *It is advisable to have virologic confirmation of diagnosis before commencing suppression*	Valaciclovir 500mg PO, daily for 12 months followed by a break of 3 months to see if recurrences are still frequent and/or distressing	Aciclovir 400mg BD for 12 months followed by a break of 3 months to see if recurrences are still frequent and/or distressing
Suppression in pregnancy (see below for details)*	Valaciclovir 500mg PO, BD from 36 weeks until birth	Aciclovir 400mg TDS from 36 weeks until birth

*In the case of immunocompromise, herpes proctitis or use of antivirals in pregnancy, specialist discussion/referral is recommended.

Other immediate management

- Written information and support (www.herpes.org.nz)
- Regular analgesia
- Topical lignocaine to reduce pain from erosions, fissures and ulcers

- Urinating in a bath or shower relieves superficial dysuria
- Neuropathic bladder requires urgent catheterisation and referral
- Avoid intimate contact with partners until symptoms have resolved
- Routine sexual health screening
- Use of barriers i.e., waterproof dressings.

HSV is not a notifiable disease.

Contact tracing is not recommended, but patients may need support if they wish to disclose to current or future sexual partners.

Treatment advice

- Seek specialist advice regarding patients living with human immunodeficiency virus (HIV) or immunosuppression.
- Treatment should not be delayed for those presenting with moderate-to-severe episodes, particularly initial episodes.
- Initial episodes may require a 10-day course of treatment if symptoms are slow to resolve.
- Choice of suppressive therapy, episodic therapy or no therapy depends on clinical features including frequency and severity of recurrences and psychosexual complications of the diagnosis (e.g. fear of transmitting the infection to intimate partners).
- Review the need for suppressive therapy 6 monthly as recurrences usually become less frequent and less severe with time.
- Ongoing symptoms, despite antiviral treatment, should prompt consideration of other causes of genital symptoms (see genital ulcers and genital skin lesions). Specialist discussion/referral may be indicated.

Psychosocial impact of diagnosis

- This can be profound but is often based on misinformation.
- Providing facts about high community prevalence (70%-80% HSV-1 and 12-15% HSV-2) and largely mild clinical effect is important for reducing stigma.
- Concerns about a current relationship may be addressed with knowledge that transmission can occur from someone unaware they have the infection and symptoms can also occur for the first

time some days or years after acquisition.

- Patients should be reassured that there are multiple strategies to avoid transmission to future partners. https://www.herpes.org.nz/herpes-patient-info/living-with-genital-herpes
- Refer to a psychologist for support with patients who are unable to accept the diagnosis, are significantly distressed by the diagnosis, or anxious about having the infection when tested negative.

Special treatment situations

Special situations

- Seek specialist advice before treating any complicated presentation.
- Talk to people with HSV about suppressive therapy to reduce transmission to their partner before or during pregnancy.

Pregnancy	Neonatal transmission may occur in pregnancy, during the delivery or via skin-to-skin transmission in post-natal period (via oro-labial HSV transmission). The greatest risk of sequelae for the baby is when HSV is acquired in the third trimester or close to the time of delivery. Routinely commence HSV suppression from 36 weeks gestation in people who know they have genital herpes (with or without lesions). Commence at an earlier gestation in people with multiple recurrent lesions during pregnancy.	
First episode of genital herpes during first or second trimester *Inform and liase with the Lead maternity carer (LMC) and suppress from 36 weeks (or earlier if recurrent episodes)*	**Recommended** Valaciclovir 1g PO, BD for 7 days or longer if new lesions appear or healing is incomplete	**Alternative** Aciclovir 400mg PO, TDS for 7 days or longer if new lesions appear or healing is incomplete
Symptomatic recurrences in 1st and 2nd trimester *Inform and liase with the Lead maternity carer (LMC) and suppress from 36 weeks (or earlier if recurrent episodes)*	**Recommended** Valaciclovir 500mg PO, BD for 3 days	**Alternative** Aciclovir 800mg PO, TDS for 2 days

First episode of genital herpes in the 3rd trimester	Seek specialist advice.
Allergy to principal treatment choice	Seek specialist advice.

Contract tracing

- Contact tracing is not recommended for HSV infections.

Follow up

Review a week after commencing treatment for the first time to:

- Undertake evaluation of the response to treatment
- Complete sexual health testing if unable to do so at time of initial presentation because of severity of symptoms
- Provide further sexual health education and prevention counselling
- Provide further support and information as required
- Obtain copies of previous results, if possible, if tested at another clinic. Microbiological confirmation of diagnosis (NAAT) is desirable but need not delay treatment.

Test of cure and retesting

Not required.

Auditable outcomes

- 100% of patients presenting with initial episode of genital herpes will be offered treatment.

Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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