

Valley Midwifery Group

Herpes Simplex Virus (HSV) – Genital Herpes

Genital herpes is one of the most common sexually transmitted infections in the Canada. About 20-60% of sexually active men & women have the virus. Significant portions of those who are infected or vulnerable to infection are women of childbearing age with 2% to 4% acquiring the infection during pregnancy¹⁻³. Newborns acquire herpes through the birth process. There is a low risk of infection for babies born to mothers with recurrent HSV-2 infection, while there is a higher risk if the mother experiences primary infection during pregnancy, especially during the third trimester⁵. Babies born to mothers with primary herpes infections are at up to 40-50% risk of infection even if the mother has no symptoms. Among newborns, HSV infection can be truly dangerous and can result in high morbidity and mortality. Infections are classified as skin/eye/mouth (SEM), central nervous system (CNS), or disseminated disease, according to the extent of the disease at presentation. A complicating factor in managing genital herpes in pregnant women (and their partners) to prevent transmission to their newborns is the often-invisible nature of the disease. New findings have shown that asymptomatic and unrecognized infections are much more common than clinical disease and initial infections are often without symptoms.

Knowledge and guidelines regarding the optimum management of infected pregnant women is continuing to evolve. Preventive strategies include cesarean delivery if active lesions or prodromal symptoms are present at term, serologic screening of pregnant women, and prophylactic antiviral therapy (for the woman and her partner) starting at 36 weeks.

Antiviral therapy decreases the risk of viral shedding at the time of delivery and may decrease the need for cesarean delivery². A randomized, double-blind, placebo-controlled trial of suppressive valacyclovir (500 mg once daily for 8 months) in 1494 monogamous, heterosexual couples with one partner that was seropositive for HSV-2 and one HSV-2 seronegative showed that valacyclovir use significantly reduced HSV transmission between partners⁶. Treatment with an antiviral agent should be considered for all women who develop a first episode of genital herpes in pregnancy and should be discussed as a means of suppression therapy for women (and their partners) with recurrent infections to reduce risk of transmission to babies. Although there are a variety of effective nucleoside analogues available for treating genital herpes, including acyclovir, famciclovir, and valacyclovir, at this time only acyclovir has been used extensively in pregnant women and neonates⁵. Treatment of first-episode genital herpes reduces the duration and severity of symptoms and decreases the duration of viral shedding. Acyclovir has been used extensively during pregnancy, and is well tolerated in late pregnancy. Currently, there is no clinical or laboratory evidence of maternal or fetal toxicity from use of acyclovir either in late pregnancy or in the first trimester⁷.

Prepared by Trang Duong ND RM

¹ Fleming DT, McQuillan GM, Johnson RE, et al. Herpes simplex virus type 2 in the United States, 1976 to 1994. *N Engl J Med.* 1997;337:1105-1111.

² Brown, ZA, Selke S, Zeh J, et al. The acquisition of herpes simplex virus during pregnancy. *N Engl J Med.* 1997;337:509-515.

³ Rudnick CM, Hoekzema GS. Neonatal herpes simplex virus infections. *Am Fam Physician.* 2002;65:1138-1142.

⁴ BCRCPC Obstetric Guideline 3, July 2003.

⁵ Baker DA, Warren TJ, Mac Low, C. Preventing Herpes in the Pregnant Woman and the Neonate. Medscape, 2003

⁶ 2002 Interscience Conference on Antimicrobial Agents and Chemotherapy (ICAAC) in San Diego, California

⁷ Reiff-Eldridge R, Heffner CR, Ephross SA, Tennis PS, White AD, Andrews EB. Monitoring pregnancy outcomes after prenatal drug exposure through prospective pregnancy registries: a pharmaceutical company commitment. *Am J Obstet Gynecol.* 2000;182:159-163.