

## Introduction

### Aetiology and Epidemiology:

- First episode disease caused by - **HSV-2 (70%)**, or **HSV-1 (30%)**.
- **Recurrent** disease - mostly **HSV-2** as HSV-1 reactivates less frequently
- Of those who are **HSV-2 seropositive 25% have clinical recurrent disease** and **75% have unrecognised symptomatic disease** or are asymptomatic
- At presentation with first episode disease - 50% primary, 25% first episode non-primary (usually HSV-1 seropositive and new HSV-2 infection), 25% recurrent (seropositive already for type affecting genitals)
- No way to clinically distinguish these

### Symptoms:

- Painful genital ulcers, itching, external dysuria,
- Groin, leg/buttock pain
- Vaginal and /or urethral discharge (with cervical or urethral lesions)
- Systemic - fever, malaise, myalgia, headache
- First episode disease caused by - **HSV-2 (70%)**, or **HSV-1 (30%)**.

### Note:

**May get proctitis and have rectal symptoms (not necessarily related to AI)**

### Signs:

- Genital blisters or ulcers
- Inguinal lymphadenopathy
- Cervicitis – necrotic

**Note: May have atypical appearance e.g. fissures, may also occur in extra-genital sites e.g. buttocks, sacral area, thigh**

### Complications - primary disease:

- Meningitis
- Sacral radiculopathy - urinary retention, constipation (relatively common F>M)
- Transverse myelitis
- Disseminated infection – pregnancy (rare)
- Labial adhesions
- Fungal super-infection (bacterial v. uncommon)

## Diagnosis

Diagnosis is based on history, clinical findings and the results of appropriate tests as below

- **Virological confirmation** and typing should be attempted **in all patients**

## Tests

1. **Culture and serotyping** - routine for evaluation of genital ulcers
  - Highest yield with blisters or early ulceration
  - Reported as positive culture and typed as HSV-1 or HSV-2
2. PCR maybe useful in certain situations e.g. Recurrent lesions with repeated negative culture
3. **Serology** (see separate section)

## Specimen collection

- Use **green top viral swab – vesicular fluid optimal**. Otherwise rub firmly on base of lesion to maximise isolation
- Store at 4° C and transport chilled (not frozen)
- DML sends all viral swabs to LabPlus ADHB for culture

### Note:

**Negative culture does not rule out diagnosis**

**A separate swab is required if PCR requested and for each site ( first need approval from lab)**

## Management

### General Points:

- Patients should be **offered antiviral therapy** if they present **within 72 hrs** of development of symptoms
- Antiviral therapy may still be appropriate if patient presents >72 hrs of development of symptoms, depending on clinical situation e.g. severe disease, new lesions developing
- Patients with a diagnosis of genital herpes should be offered counselling, support, and written information

### Male & Female:

- **Aciclovir 400mg po 3 x daily for 10 days ± 2% lignocaine gel**

**HIV positive/ immunosuppressed:**

- **Aciclovir 400mg 3x daily for 10 days ± lignocaine gel**

**Pregnancy:**

- **Aciclovir 400mg 3x daily for 10 days ± 2% lignocaine gel**

**Note:**

**Aciclovir is not licensed for use in pregnancy although it has been extensively used in pregnancy without significant adverse events**

All **pregnant women** with first episode genital herpes **in the third trimester of pregnancy require urgent review** by a sexual health physician or an obstetrician as this situation is high risk for neonatal transmission and requires specialist management. All pregnant women **with first episode genital herpes in the first or second trimester require non-urgent review** by a sexual health physician or an obstetrician. This is a low risk situation for neonatal transmission, but specific counselling and management is required

**Note:**

**Suppressive therapy** should be offered to all **patients with more than six recurrences annually** (see Recurrent Genital Herpes).

## **Partner notification and management of sexual partners**

- Not necessary
- Partners with symptoms should be seen and evaluated
- Asymptomatic partners may be seen for routine sexual health screening and/or counselling as deemed appropriate by clinician

## **Follow-up**

- Patients should be given an appointment in 1-2 weeks for review, appropriate counselling and discussion of results
- Patients who did not have a sexual health screen performed at the initial visit should be offered a sexual health screen at follow-up

## **Referral guidelines**

**Referral to a Specialist Sexual Health Service is recommended for:**

1. Recurrent lesions **suspicious of genital herpes but negative on culture**
2. Suspected **herpes proctitis**
3. Suspected **complications of primary infection** unable to be managed in primary care
4. **Pregnancy issues** if appropriate

# **First Episode Genital Herpes**

5. In immunosuppressed consider referral to Sexual Health Specialist

## Further information

An in-depth guideline for the management of Genital Herpes has been produced by the Professional Advisory Board of the Viral Sexually Transmitted Infection Education Foundation. This is available in printed form or online at : [www.herpes.org.nz](http://www.herpes.org.nz)

# First Episode Genital Herpes