West of Scotland Sexual Health Managed Clinical Network

NHS Ayrshire & Arran | NHS Dumfries & Galloway | NHS Forth Valley | NHS Greater Glasgow and Clyde | NHS Lanarkshire

West of Scotland Guideline *Approved January 2023*

GENITAL HERPES

What's New

Standard letter now on NASH which can be used to send to GPs for patients starting suppressive treatment

Mpox may present with similar symptoms in GBMSM – please refer to local guidance.

Introduction

Genital herpes is caused by infection with the herpes simplex viruses (HSV) of which where are two types (types 1 and 2). HSV infection may cause ulceration but may also be asymptomatic.

Genital herpes is a lifelong infection and some people may experience recurrent infection. Following initial infection, HSV remains dormant in sensory ganglia of nerves and can reactivate with varying frequency.

Natural History

- Only a third of individuals appear to develop recognisable symptoms at the time of acquisition. Incubation of infection from acquisition to first clinical signs and symptoms in this minority ranges from 2 days to 2 weeks.
- Disease episodes may be initial or recurrent and symptomatic or asymptomatic.
- Prior infection with HSV-1 modifies the clinical manifestations of the first infection by HSV-2.
- After childhood, symptomatic primary infections with HSV-1 are equally likely to be acquired in the genital or oral areas.
- The majority of first episode infections of genital herpes in adults are due to HSV-1.
- Following primary infection, the virus becomes latent in local sensory ganglia, periodically reactivating to cause symptomatic lesions or asymptomatic (but infectious) viral shedding. Virus can be shed from the external genitalia, the anorectum, the cervix and urethra.
- The median rate for recurrence after a symptomatic first episode is 0.34 recurrence/month for HSV-2 (and is four times the recurrence rate for HSV-1). Recurrence rates decline with time in most individuals, although this pattern is variable.
- In some individuals the number of days when the virus is shed asymptomatically exceeds the number of days of symptomatic shedding.
- Asymptomatic shedding probably plays a significant role in onward transmission.

Clinical features

Signs and Symptoms

- The patient may be asymptomatic and the disease unrecognised.
- Local symptoms may consist of
    - blisters or painful ulceration of external genitalia or perianal region
    - dysuria
    - vaginal or urethral discharge (please note this may not need immediate testing for other causes of discharge)
    - Proctitis – check for HSV in all cases
- Blisters and ulceration may also involve the cervix and / or rectum.
- Systemic symptoms of fever and myalgia are more common in those who present with a first episode with either HSV I or HSV II and no pre existing antibodies to either type than those with a first episode with either HSV I or HSV II with pre existing antibodies to the other type or those who present with recurrent disease.
- Lesions and lymphadenitis are usually bilateral in first episodes.
- It is usual for lesions to affect favoured sites in recurrent disease. They may alternate between sides but are usually unilateral for each episode.
- Lesions of recurrent episodes may be small and may resemble non-specific erythema, erosions or fissures.
- Recurrent episodes are limited to the infected dermatome.

Complications

- superinfection of lesions with candida or streptococcal species
- urinary retention (result of severe pain or autonomic neuropathy)
- autoinoculation to fingers and adjacent skin e.g. thighs
- aseptic meningitis

Diagnosis

Virus Detection & Characterisation

Confirmation and typing of the infection is essential for diagnosis and counselling on prognosis, transmission and management. Laboratory diagnosis is based on direct detection of HSV from genital lesions; in the West of Scotland the HSV detection test used is PCR, which yields the highest sensitivity of all available tests and also allows virus typing. The quality of sample is crucial.

Specimens should be collected using the swab recommended by the testing laboratory. Ideally sample from a vesicle or, alternatively, directly from the base of an ulcer. Material from several lesions should be taken, to maximise diagnostic yield.

Poorly taken swabs and swabs from old lesions or taken from patients already on anti-virals may result in a false negative report.

In the West of Scotland samples tested for herpes are also tested for T.pallidum. (syphilis).

Ensure that the virology request form includes appropriate information about lesions and risk-behaviour groups (eg genital ulcer and MSM). If dark ground microscopy is available this may be appropriate in certain cases.

Herpes Serology - Generic and Type Specific

Herpes serology has a very limited role in overall herpes management.

The appropriateness of serology testing should be discussed with a senior colleague and local virology services as this may be available in certain circumstances from Colindale, London.

Management

First Episode Genital Herpes

Antivirals

Patients presenting within 5 days of the start of the episode, or while new lesions are still forming, should be given oral antiviral drugs.

There is no evidence of benefit for greater than 5 days but it can be considered if new vesicles are forming or systemic symptoms are persisting.

Aciclovir is the preferred treatment choice as there is no evidence of additional benefit from newer, more expensive antivirals.

Antiviral therapy does not alter the natural history of the disease in that the frequency or severity of subsequent recurrences remains unaltered.

Therapy may be continued beyond five days if new lesions are still appearing, systemic symptoms still present or complications have occurred.

Immunocompetent: aciclovir 400 mg three times daily for 5 days

***HIV+:** aciclovir 400mg five times daily for 10 days or valaciclovir 500mg to 1g twice daily for 10 days

Refer all clients presenting with genital herpes with HIV (or immunosuppression)* URGENTLY to a senior clinician experienced in the management of genital herpes in people with HIV or the immunosuppressed (**do not delay initiating therapy**)

*See later section 'Management of Genital Herpes in People with HIV (or immunosuppression)'

Testing for other STIs

All clients should be encouraged to have tests for other STIs. As a minimum this should include tests for chlamydia, gonorrhoea, syphilis and HIV. It may be preferable to do a lower vaginal swab for chlamydia and gonorrhoea NAAT testing rather than doing a speculum examination. If chlamydia, gonorrhoea, HIV and syphilis tests are not done at the initial visit or are done but are within the incubation or window period arrangements should be made for them to be done or repeated at an appropriate follow up visit.

Supportive measures

- Saline bathing and the application of yellow soft paraffin ('Vaseline') to lesions as required.
- Appropriate analgesia.
- Topical anaesthetic agents eg 5% lidocaine ointment may be useful to apply especially prior to micturition. Although the potential for sensitisation exists in the use of topical anaesthetic agents, lidocaine is a rare sensitiser.
- Consider referral of clients with first diagnosis HSV to the sexual health advisers for information, partner notification and counselling/support.

Management of complications

Hospital admission may be required for:

- severe pain or constitutional symptoms
- meningism
- urinary retention
- severe secondary infection or cellulitis

Recurrent Genital Herpes

Recurrences of genital herpes are generally self-limiting and usually cause minor symptoms. Management strategies include

1. supportive therapy only
2. episodic antiviral therapy
3. suppressive antiviral therapy.

The most appropriate strategy for managing an individual patient will vary over time, dependent upon

- the patient's psychological coping strategies
- recurrence frequency and duration
- symptom severity
- other factors such as relationship status, relationship difficulties and concerns of onward transmission.

Patients should be seen by an experienced clinician, where all relevant clinical and psychosocial issues can be addressed.

1. Supportive therapy only

Analgesia, 5% lidocaine ointment, saline baths and use of yellow soft paraffin in the absence of specific antiviral treatment are suitable for patients with short, infrequent recurrences with minimum pain or distress.

2. Episodic antiviral treatment

- Oral aciclovir, valaciclovir and famciclovir are effective at reducing the duration and severity of recurrent genital herpes.
- The reduction in duration is a median of 1-2 days.
- Aborted lesions have been documented in up to one third of patients with early treatment.
- Patients who experience infrequent episodes which cause distress because of their severity and / or duration may benefit from episodic treatment.
- Patients with the occasional but prolonged episode (> 7 days) or those very concerned that episodes will occur during special events, holidays etc may be particularly suitable for this approach.
- Some patients who would appear to be more suitable for suppressive therapy may also choose this option as they wish to avoid continuous use of medication.
- To ensure prompt treatment, consideration should be given to providing patients with the appropriate treatment in advance. Treatment started early (including during prodromal symptoms) in an episode and prior to the development of papules is likely to be of greatest benefit.

The regimen recommended is:-

Aciclovir 800mg three times daily for 2 days

Clients with genital herpes with HIV (or immunosuppression) should be managed by a senior clinician experienced in the management of genital HSV in people with HIV or the immunosuppressed. Treatment regimes may vary.

*See later section 'Management of Genital Herpes in People with HIV (or immunosuppression)'

3. Suppressive therapy

Patients with virologically confirmed genital herpes and a recurrence rate of more than six episodes of genital herpes annually are likely to experience a substantial reduction in recurrence frequency on suppressive therapy. All patients in this category, especially those with prolonged and / or painful recurrences should therefore be given full information on the advantages and disadvantages of suppressive therapy, within the context of their overall clinical care.

Patients with lower rates of recurrences will probably also have fewer recurrences with treatment. The decision to start suppressive therapy is a subjective one, balancing the costs and inconvenience of treatment.

Experience with suppressive therapy is most extensive with aciclovir. Safety and resistance data on patients taking long term therapy now extend to over 20 years of continuous surveillance.

The regimen recommended is:-

Aciclovir 400 mg twice daily

Clients with genital herpes with HIV (or immunosuppression) should be managed by a senior clinician experienced in the management of genital HSV in people with HIV or the immunosuppressed. Treatment regimes may vary.

*See later section 'Management of Genital Herpes in People with HIV (or immunosuppression)'

If breakthrough recurrences occur on standard treatment, the daily dose should be increased to aciclovir 400mg three times daily.

Sexual health services should supply an initial one month supply and local procedures will determine where the patient accesses on going supplies with appropriate correspondence if this is intended to be from their GP.

Suppressive treatment should be provided for a minimum of six months and a trial of discontinuation should be considered after one year of continuous therapy, to reassess recurrence frequency. Most patients will have an episode soon after stopping suppressive treatment therefore the minimum period of assessment should include two recurrences. Patients who continue to have unacceptably high rates of recurrence or problematic disease may restart treatment.

Prevention of transmission

- Condoms can reduce but not completely prevent transmission.
- Infected persons should be informed that male condoms when used consistently and correctly might reduce the risk of genital herpes transmission. The protective effect appears greater for women.
- Aciclovir and valaciclovir suppress symptomatic and asymptomatic viral shedding. These drugs in clinical trials have been shown to reduce (not eliminate) asymptomatic HSV shedding by about 80-90%.
- Suppressive antiviral therapy with valaciclovir 500mg once daily reduces the rate of acquisition of HSV-2 infection and clinical symptomatic genital herpes in serodiscordant couples. Other antivirals may be effective but efficacy has not been proven in clinical trials.

Counselling & Support

- Diagnosis often causes considerable distress.
- Most people with recurrent genital HSV infection adjust over time, but antiviral treatment can reduce anxiety, assist adjustment and improve quality of life.
- Care must be taken in all consultations to ensure the appropriate language is used and that alarmist terms (incurable, chronic, attacks) are avoided.
- Counselling should be as practical as possible and address the individual's particular personal situation; for instance, issues for someone in a long term relationship are likely to be different from those for someone seeking a partner.
- Disclosure is often a difficult issue for patients but is more likely to happen in the context of an ongoing relationship. The legal responsibility and requirements in serodiscordant relationships is currently unclear. However it is important that the clinician raises the issue and advises that disclosure is advised in all relationships since this is associated with lower transmission risks and may be protection against legal action. **Discussions around disclosure should be documented.**
- There is no evidence that failure by the patient to control everyday stresses affects recurrences.
- For most patients, one or two counselling sessions, with an invitation to return in case of difficulty, should be enough. Patients who have failed to adjust to the diagnosis within a year merit review for the consideration of more intensive counselling interventions. Consider referring to sexual health advisers for this detailed work.

- Counselling should cover the following topics and should be documented:

  - The natural history.
  - The use of antivirals for symptoms control.
  - The risks of transmission.
  - Uncertainties exists about the impact of suppressive therapy on infectivity but suppressive therapy appears to reduce the rate of acquisition of symptomatic genital herpes in serodiscordant couples.
  - Disclosure is recommended in all relationships.
  - Abstinence from sexual contact during lesion recurrences or prodromes.
  - Transmission may occur as a result of asymptomatic shedding.
  - The possible benefit of male condoms in reducing transmission, emphasising that their use cannot completely prevent transmission.
  - Reassurance regarding transmission by fomites, eg towels, bedding, etc and autoinoculation after the first infection is over.
  - Evidence for reinfection of source patients at genital or distant sites is limited although some work does suggest it is more likely than previously thought and maybe greatest for those who are immunocompromised or have HSV – I.
  - Partners with infection should understand the importance of not transmitting a new infection to someone who is pregnant. Strategies aimed at reducing the risk of transmission should be explicitly stated:
    - Conscientious use of condoms during pregnancy, especially in the last trimester as this can prevent transmission to a seronegative pregnant partner.
    - Abstaining from sex at the time of lesion recurrence and in the last six weeks of pregnancy can also prevent transmission to a seronegative pregnant partner.
    - If there is a history of oro-facial HSV, oro-genital transmission to pregnant women should be considered and strategies to avoid transmission discussed.

Partner Notification

Although there is no evidence on which to base recommendations for partner notification at a population level, the clarification of whether a partner is co-infected or not may help to relieve anxiety about transmission and/or reinforce the need to reduce the risk of transmission between individuals. However, given the limitations of current type-specific serology and the non-specific clinical features of genital HSV infection, confirmation of the status of partners is often imprecise.

Although there is no definitive evidence that either antiviral treatment or patient education/counselling alters transmission rates of HSV at a population level, it seems logical to increase awareness of the diagnosis in partners when appropriate, with the aim of preventing onward transmission

Supportive Organisations and Materials

See Appendix 1

Management of Genital Herpes In Pregnancy

See West of Scotland Guideline
Pregnancy - STIs, Vaginal Infections and Group B streptococcal colonisation.

Management of Genital Herpes In People with HIV (or immunosuppression)

Refer all clients presenting with herpes with HIV (or immunosuppression) to a senior clinician experienced in the management of genital HSV in people with HIV or the immunosuppressed. (Do not delay initiation of treatment).

The following are key points only for the management of genital herpes in people with HIV. Refer to BASHH guidelines.

- Genital herpes is the most common STI in HIV positive heterosexuals in the UK.
- Herpes simplex infections activate HIV replication and may facilitate onward HIV transmission to sexual partners.
- The natural history of genital herpes in untreated people with HIV is significantly different from that in HIV-negative individuals. The most important risk factor for herpes reactivation is the degree of HIV associated immunosuppression.
- In the absence of HIV therapy, primary genital herpes may be severe and prolonged with risk of progressive, multifocal and coalescing mucocutaneous anogenital lesions. Moreover, serious and potentially life-threatening systemic complications, such as fulminant hepatitis, pneumonia, neurological disease and disseminated infection have been reported. Prompt initiation of therapy is recommended if herpes is suspected clinically. In severe cases initiation of IV therapy may be necessary.

- Suppressive treatment of HSV-2 infection with valaciclovir has been shown to reduce HIV shedding in women not on antiretroviral treatment.
- Genital herpes, including chronic erosive lesions may occur as a manifestation of the immune reconstitution inflammatory syndrome following combination antiretroviral therapy.
- Refer to BASHH Guidelines for recommended treatment schedules for episodic and suppressive therapy.

Aciclovir resistance

Refer to BASHH guidelines. Resistance to antiherpes drugs is more common in those with HIV co-infection and is associated with treatment failure of genital herpes. Resistance testing is available in Birmingham and Colindale.

References

2023 BASHH HSV Update 13th January 2023

2014 UK National Guideline for the Management of Anogenital Herpes
Clinical Effectiveness Group (British Association for Sexual Health and HIV)
Patel R, Green J, Clarke E, Seneviratne K Abbt N, Evans C, Bickford J, Nicholson M , O'Farrell N, Barton S, FitzGerald M, Foley E.
http://www.bashh.org/documents/HSV_2014%20IJSTDA.pdf [accessed 1st May 2022].

Appendix 1

The British Association of Sexual health and HIV produces a patient leaflet which is available on line in a printer friendly version.

http://www.bashh.org/documents/HSV%20PIL%202015%20Printer-friendly.pdf

The Family Planning Association (FPA) produces on line information and a leaflet on genital herpes Infection which provides comprehensive patient information.

http://www.fpa.org.uk/sexually-transmitted-infections-stis-help/genital-herpes

http://www.fpa.org.uk/sites/default/files/genital-herpes-information-and-advice.pdf

NHS Health Scotland leaflet

http://www.healthscotland.com/uploads/documents/9880-WhatdoYouKnowAboutGenitalHerpes.pdf

Herpes Virus Association

- Helpline 0845 123 2305 – weekdays
- Email: info@herpes.org.uk
- www.herpes.org.uk

Appendix 2

Letter to be sent to GP when starting suppressive HSV therapy - "*HSV Suppressive Therapy*" on NaSH:

This patient has been diagnosed with genital herpes simplex virus type -----. They have had frequent recurrences and are suitable for suppressive therapy as per national guidelines.

They have been given Aciclovir 400mg twice daily for --- months, which they can increase to three times daily for 5 days if symptoms occur on suppressive therapy.

Please would you kindly continue to prescribe this for up to one year, after which they will stop therapy and assess symptom recurrence. At this time, if they have persistent symptoms, we would be happy to review again in the sexual health service.

Many thanks for your help in this patient's management.

Yours sincerely

Sexual Health Service