Ashford and St. Peter's Hospitals NHS
NHS Foundation Trust

WOMEN'S HEALTH AND PAEDIATRICS
MATERNITY UNIT

GENITAL HERPES - GUIDELINES FOR THE MANAGEMENT OF WOMEN PRESENTING TO THE LABOUR WARD

Amendments			
Date	Page(s)	Comments	Approved by
Nov 2014		Complete document review	Women's Health Guidelines Group
March 2018		Complete document review – no changes	Women's Health Guidelines Group

Compiled by: Sandra Newbold, Consultant Obstetrician

In Consultation with: Obstetric and Anaesthetic Consultants and Senior Midwives

Ratified by: Women's Health Guidelines Group

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Target Audience: Staff working within maternity services

Impact Assessment Carried Out By: Women's Health Guidelines Group

Comments on this document to: Women's Health Guidelines Group

GENITAL HERPES - GUIDELINES FOR THE MANAGEMENT OF WOMEN PRESENTING TO THE LABOUR WARD

Neonatal herpes is a serious viral infection with a high morbidity and mortality, however, it is rare in the UK. Surveillance by the British Paediatric Surveillance Unit from 2004 to 2006 identified 86 cases in the three-year period (BPSU 2006 – 2007)). Neonatal herpes may be caused by herpes simplex virus (HSV) type 1 or type 2 as either viral type can cause genital herpes in the mother. Most cases of neonatal herpes occur as a result of direct contact with infected maternal secretions, although in 25% of cases a possible source of postnatal infection was identified. Postnatal infection may occur as a result of exposure to oro-labial herpes infection.

If practical a woman with suspected genital herpes should be referred to the Blanche Heriot Unit for diagnosis by viral polymerase chain reaction (PCR), advice on management and screening for other sexually transmitted infections. Treatment, however, should not be delayed if prompt GUM review cannot be arranged, in which case viral swabs should be taken from the vulval lesions before commencing treatment.

Management of the woman should be in line with her clinical condition and will usually involve the use of oral (or intravenous for disseminated HSV) aciclovir (400 mg three times daily, usually for 5 days) if the woman is symptomatic. The use of aciclovir is associated with a reduction in the duration and severity of symptoms and a decrease in the duration of viral shedding. Aciclovir is not licensed for use in pregnancy but is considered safe (BASSH/RCOG 2014)

Paracetamol and topical lidocaine 2% gel can be offered as symptomatic relief.

Urine output must be monitored as some women will go into retention, and require catheterisation, with acute genital herpes.

First or second trimester genital Herpes (up to 27+6 weeks of gestation):

Providing that delivery does not ensue within the next 6 weeks, the pregnancy should be managed expectantly and vaginal delivery planned.

Third trimester genital Herpes:

Once the woman has completed 5 days of treatment with Aciclovir treatment should then continue with daily suppressive aciclovir 400 mg three times daily until delivery.

Caesarean section should be the recommended mode of delivery for all women developing a first episode of genital herpes in the third trimester as the risk of neonatal transmission of HSV is very high at 41% (BASHH/RCOG 2014). The neonatal team should be made aware of the indication for caesarean section by documentation in the paediatric section of the woman's hand-held notes AND her planned delivery should be discussed at the 'Mother and Baby meeting (this can be arranged via the Midwife in charge of the antenatal clinic)

For women presenting with a first episode of genital herpes in the third trimester, particularly within 6 weeks of expected delivery, type specific HSV antibody testing (IgG antibodies to HSV-1 and HSV-2) may influence the advice given about mode of delivery since these tests can identify the women in whom this apparent first episode of genital herpes is in fact a recurrent episode. These tests will be arranged by the Blanche Heriot Unit, however, it may take 2–3 weeks for the results of this test to become available.

Recurrent genital herpes:

Women with recurrent genital herpes should be informed that the risk of neonatal herpes is low, even if lesions are present at the time of delivery (0–3% for vaginal delivery).

Vaginal delivery should be planned in the absence of other obstetric indications for caesarean section.

There is no increased risk of preterm labour, preterm prelabour rupture of membranes or fetal growth restriction associated with recurrent herpes.

Management of women with genital herpes lesions at the onset of labour or with ruptured membranes:

Management of a woman with genital herpes at the onset of labour will be based on clinical assessment as there will not be time for confirmatory laboratory testing.

Take a viral swab from the lesion(s) since the result may influence management of the neonate.

From the woman's history determine whether this is likely to be a primary or recurrent episode.

The woman's management must be promptly discussed with the labour ward, or on-call, consultant.

If this is a primary episode urgent delivery by caesarean section should be advised because if the baby is delivered vaginally, the risk of neonatal herpes is estimated to be 41% (BASHH/RCOG 2014). Ideally delivery should occur less than 4 hours after rupture of membranes, but there may be some benefit in performing a caesarean section even after this time interval.

If a woman with primary herpes declines caesarean section give intravenous aciclovir to the mother (5 mg/kg every 8 hours) and subsequently to the neonate. However, the woman must be informed that it is not known whether intrapartum aciclovir reduces the risk of neonatal HSV infection from the estimated 41%.

Although vaginal delivery should be avoided if possible, in women who labour in the presence of primary genital herpes lesions, invasive procedures (application of fetal scalp electrodes, fetal blood sampling, artificial rupture of membranes and/or instrumental deliveries) should be avoided (BASHH/RCOG 2014).

Women who present with recurrent genital herpes lesions at the onset of labour should be advised that as vaginal delivery does not pose a significant risk for neonatal herpes (0–3% for vaginal delivery, BASHH/RCOG 2014) caesarean section will only be advised if required for other reasons.

If the mother requests a caesarean section solely because of recurrent genital herpes lesions then the risks and benefits of caesarean section must be carefully discussed with the mother. This discussion must be documented in the mother's notes.

If invasive procedures (application of fetal scalp electrode, fetal blood sampling, artificial rupture of membranes or operative vaginal delivery) are required in a woman labouring with recurrent genital herpes lesions, they should be performed (BASHH/RCOG 2014).

Although there is no evidence to guide the management of women with spontaneous rupture of membranes at term and recurrent genital herpes lesions, in this maternity unit we advise early augmentation of labour in an attempt to minimise the duration of potential exposure of the fetus to HSV.

If a woman presents with genital herpes lesions AND preterm pre-labour rupture of membranes her management should be guided by multidisciplinary team discussion involving a consultant obstetrician and consultant neonatologists and (if possible) a consultant genitourinary medicine physician and will depend on the gestation that PPROM occurred and whether this is a primary or recurrent episode of herpes.

Management of the baby:

The neonatal team must be informed when a woman with herpes lesions
(primary or recurrent) is on the labour ward and likely to deliver, or if vaginal delivery is planned (or has occurred unexpectedly) in a woman who has had primary herpes within the last 6 weeks.

Any baby at high risk of herpes infection (see above) must be reviewed by the neonatal registrar soon after birth. Mother must remain on the labour ward until the baby has been reviewed.

The registrar must discuss the baby's management with a neonatal consultant.

Breast feeding is not contraindicated even if the mother is taking acyclovir, unless the mother has active herpetic lesions around the nipples.

Prevention of postnatal transmission:

The mother should practice careful hand hygiene.

Monitoring:

Compliance with this guideline will be monitored by reviewing all cases. Where monitoring has identified deficiencies, recommendations and an action plan will be developed

References:

British Association for Sexual Health and HIV /Royal College of Obstetricians and Gynaecologists. *Management of Genital Herpes in Pregnancy*. London: BASHH/RCOG; October 2014.

British Paediatric Surveillance Unit. *BPSU 21st Annual Report 2006-2007.* London: British Paediatric Surveillance Unit/Royal College of Paediatrics and Child Health; 2007.

EQUALITY IMPACT ASSESSMENT TOOL

Name: GENITAL HERPES - GUIDELINES FOR THE MANAGEMENT OF WOMEN PRESENTING TO THE LABOUR WARD

Policy/Service: Women's Health and Paediatrics

Background • Description of the aims of the policy • Context in which the policy operates • Who was involved in the Equality Impact Assessment
To ensure consistent high standard of evidence base care Women's Health Guideline Group
Methodology • A brief account of how the likely effects of the policy was assessed (to include race and ethnic origin, disability, gender, culture, religion or belief, sexual orientation, age) • The data sources and any other information used • The consultation that was carried out (who, why and how?)
Policy widely circulated for comments within the Multidisciplinary Maternity Team.
Key Findings • Describe the results of the assessment • Identify if there is adverse or a potentially adverse impacts for any equalities groups
Accepted and understand the relevance of high standards of evidence based practice. Principles of equality have been adhered to.
Conclusion • Provide a summary of the overall conclusions
Improvement and consistency of maternity care provision
Recommendations • State recommended changes to the proposed policy as a result of the impact assessment • Where it has not been possible to amend the policy, provide the detail of any actions that have been identified • Describe the plans for reviewing the assessment
none

Guidance on Equalities Groups

Race and Ethnic origin (includes gypsies and travellers) (consider communication, access to information on services and employment, and ease of access to services and employment)	**Religion or belief** (include dress, individual care needs, family relationships, dietary requirements and spiritual needs for consideration)
Disability (consider communication issues, access to employment and services, whether individual care needs are being met and whether the policy promotes the involvement of disabled people)	**Sexual orientation including lesbian, gay and bisexual people** (consider whether the policy/service promotes a culture of openness and takes account of individual needs
Gender (consider care needs and employment issues, identify and remove or justify terms which are gender specific)	**Age** (consider any barriers to accessing services or employment, identify and remove or justify terms which could be ageist, for example, using titles of senior or junior)
Culture (consider dietary requirements, family relationships and individual care needs)	**Social class** (consider ability to access services and information, for example, is information provided in plain English?)

If further assessment is required please see the Integrated Single Equality Scheme.

For advice in respect of answering the above questions, please contact, HR Manager, on extension 2552.

PROFORMA FOR RATIFICATION OF POLICIES AND GUIDELINES BY RATIFYING COMMITTEE

Policy/Guidelines Name: Policy	GENITAL HERPES - GUIDELINES FOR THE MANAGEMENT OF WOMEN PRESENTING TO THE LABOUR WARD
Name of Person completing form:	Dianne Casey
Date:	Nov 2014

Author(s)	Sandra Newbold
Name of author or sponsor to attend ratifying committee when policy/guideline is discussed	Dianne Casey
Date of final draft	Nov 2014
Has this policy/guideline been thoroughly proof-read to check for errors in spelling, typing, grammar and consistency?	Yes
By whom:	Women's Health Guidelines Group
Is this a new or revised policy/guideline?	revised

Describe the development process used to generate this policy/guideline.
Women's Health Guidelines Group, Labour Ward Forum, Obs & Gynae Consultants, Supervisors of Midwives
Who is the policy/guideline primarily for?
Health Professionals working within the maternity service
Is this policy/guideline relevant across the Trust or in limited areas?
Maternity Services
How will the information be disseminated and how will you ensure that relevant staff are aware of this policy/guideline?
Intranet, newsletters,
Describe the process by which adherence to this policy/guideline will be monitored.
See *monitoring section of policy*
Is there a NICE or other national guideline relevant to this topic? If so, which one and how does it relate to this policy/guideline?
See *reference section of policy*
What (other) information sources have been used to produce this policy/guideline?
See *reference section of policy*
Has the policy/guideline been impact assessed with regard to disability, race, gender, age, religion, sexual orientation?
No impact
Other than the authors, which other groups or individuals have been given a draft for comment?
All obstetric Consultants, Women's Health Guidelines Group, SOM's
Which groups or individuals submitted written or verbal comments on earlier drafts?
Any comments received considered by Women's Health Guidelines Group
Who considered those comments and to what extent have they been incorporated into the final draft?
All comments considered
Have financial implications been considered?
Yes