Royal Cornwall Hospitals
NHS Trust

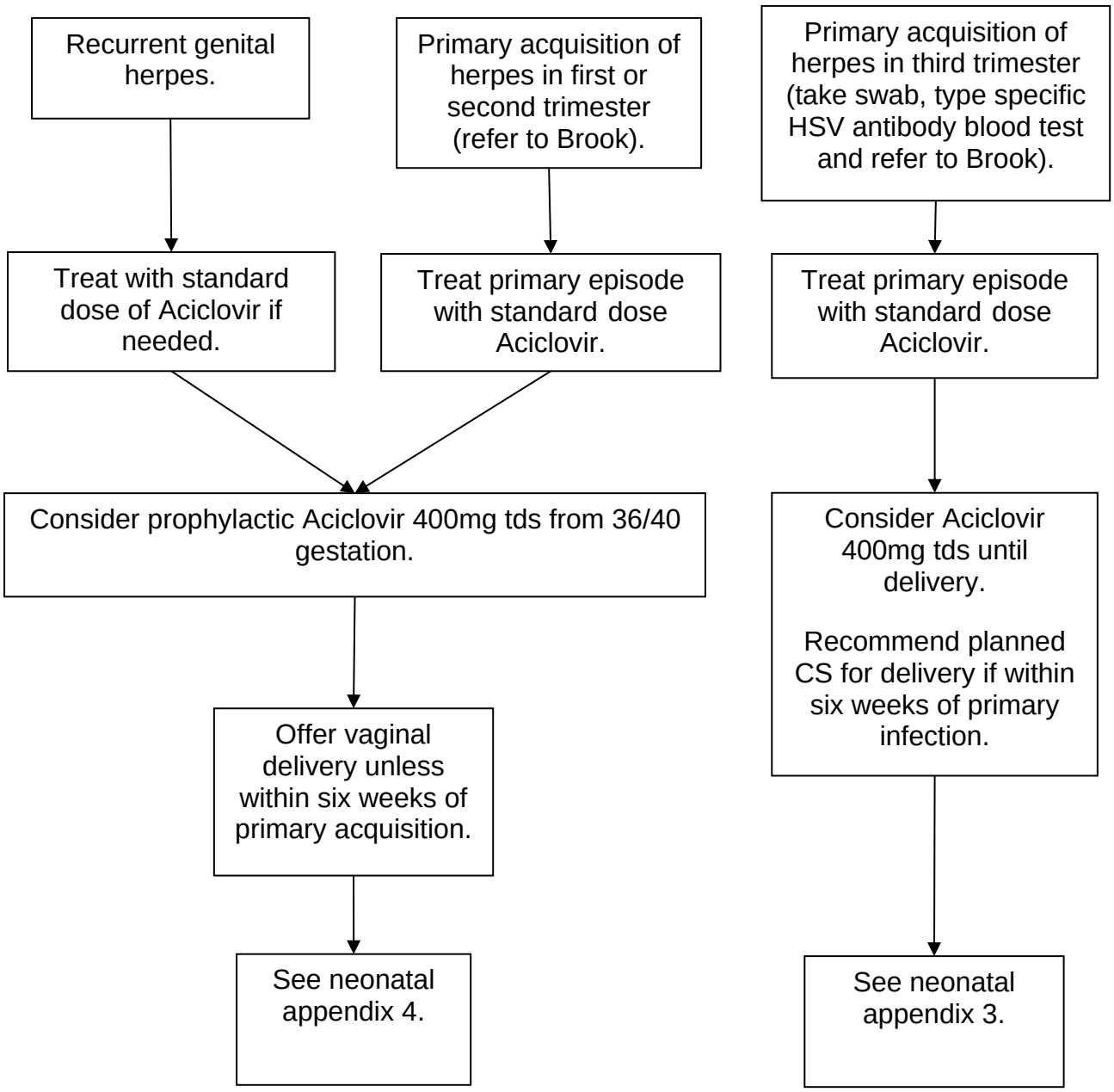
Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline

V3.3

April 2024

Summary

Algorithm for management of herpes in pregnancy and care of neonate



1. Aim/Purpose of this Guideline

1.1. The aim of the guideline is to reduce maternal morbidity and to prevent neonatal herpes, which is a rare but serious viral infection. The average reported incidence is 1 in 15,000 live births but there is considerable variation between populations with rates of up to 1 in 7,500 in certain deprived inner-city populations. Incidence appears to be increasing, possibly due to increase in prevalence of sexually transmitted infections, demographic and social change, and improvements in diagnostic tests.

1.2. **Transmission**

Factors associated with increased transmission risk include primary herpes in the mother, lack of transplacental maternal neutralising antibodies, prolonged rupture of membranes and immunosuppression in the mother.

Disseminated herpes is more common in preterm infants and occurs almost exclusively as a result of primary infection in the mother. Although recurrent genital herpes is associated with a very low risk of neonatal herpes, recurrent herpes at the time of delivery, which is commonly asymptomatic or unrecognised, may cause the localised forms of neonatal herpes: both local CNS disease and skin, eye, and mouth infection.

It may be difficult to distinguish clinically between recurrent and primary genital HSV infections, as many first episode HSV infections are not true primary infections. Careful history and use of type specific serology can help.

1.3. **Disseminated herpes infection in the mother**

Disseminated herpes, which may present with encephalitis, hepatitis, disseminated skin lesions or a combination of these conditions, is rare in adults. However, it has been more commonly reported in pregnancy, particularly in the immunocompromised. The maternal mortality associated with this condition is high.

All immunocompromised women, such as those infected with the HIV virus, are at increased risk of more severe and frequent symptomatic recurrent episodes of genital herpes during pregnancy and of asymptomatic shedding of HSV at term.

For more detailed information on the diagnosis and management of HSV infection in the mother, please refer to the most up to date version of the BASHH guideline on the management of genital herpes.

For more information on presentation of neonatal herpes, on epidemiology and virology and for references please refer to the original document.

1.4. This guideline makes recommendations for women and people who are pregnant. For simplicity of language the guideline uses the term women throughout, but this should be taken to also include people who do not identify as women but who are pregnant, in labour and in the postnatal period. When discussing with a person who does not identify as a woman, please ask them their preferred pronouns, and then ensure this is clearly documented in their notes to inform all health care professionals.

1.5. This version supersedes any previous versions of this document.

Data Protection Act 2018 (UK General Data Protection Regulation – GDPR) Legislation

The Trust has a duty under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 to ensure that there is a valid legal basis to process personal and sensitive data. The legal basis for processing must be identified and documented before the processing begins. In many cases we may need consent; this must be explicit, informed, and documented. We cannot rely on opt out, it must be opt in.

Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the Data Protection Act 2018 and UK General Data Protection Regulations 2016/679 please see the Information Use Framework Policy or contact the Information Governance Team

Royal Cornwall Hospital Trust rch-tr.infogov@nhs.net

2. The Guidance

2.1 Management of Pregnant Women with First Episode of Genital Herpes.

2.1.1 First or second trimester acquisition (until 27+6 weeks of gestation)

2.1.1.1. Women with suspected genital herpes should be referred to the Brook by calling 03003030714.

2.1.1.2. If the woman is an inpatient, she can be referred to the HIV service by calling ext 8419.

2.1.1.3. Treatment should not be delayed. 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 in standard doses (400 mg three times daily, usually for 5 days). 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 and has not been associated with an increased incidence of birth defects. Transient neonatal neutropenia has been reported but no clinically significant adverse maternal or neonatal effects have been reported. Aciclovir is well tolerated in pregnancy.

2.1.1.4. If not the referrer, the obstetrician should be informed and should be involved in discussions around treatment, mode of delivery and risk to baby.

2.1.1.5. Paracetamol and topical lidocaine 2% gel can be offered as symptomatic relief. There is no evidence that either is harmful in pregnancy in standard doses.

2.1.1.6. Providing that delivery does not ensue within the next six weeks, the pregnancy should be managed expectantly, and vaginal delivery anticipated. There is no evidence that HSV acquired in pregnancy is associated with an increased incidence of congenital abnormalities.

2.1.1.7. Following first or second trimester acquisition, daily suppressive Aciclovir 400mg three times daily from 36 weeks of gestation reduces HSV lesions at term and hence the need for delivery by caesarean section. It has also been shown to reduce asymptomatic viral shedding.

2.1.2. **Third trimester acquisition (from 28 weeks of gestation)**

2.1.2.1. There is some evidence of increased perinatal morbidity (preterm labour and low birthweight), together with stillbirth, however the data are conflicting, so no additional monitoring of such pregnancies is recommended.

2.1.2.2. Treatment should not be delayed. 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 in standard doses (400mg three times daily, usually for five days). In the third trimester, treatment will usually continue with daily suppressive Aciclovir 400mg three times daily until delivery.

2.1.2.3. Caesarean section should be the recommended mode of delivery for all women developing first episode genital herpes in the third trimester, particularly those developing symptoms within six weeks of expected delivery, as the risk of neonatal transmission of HSV is very high at 41%. The caesarean section should be performed within four hours of rupturing membranes in women who are greater than 37+0 to prevent the risk of transmission and need for treatment of the neonate.

2.1.2.4. It can be difficult to distinguish clinically between primary and recurrent genital HSV infections. In up to 15% of cases where a woman presents with a first episode of clinical HSV infection, it will actually be a recurrent infection. For women presenting with first episode genital herpes in the third trimester, particularly within six weeks of expected delivery, type-specific HSV antibody testing (immunoglobulin G [IgG] antibodies to HSV-1 and HSV-2) should be taken. For these women, characterising the infection will influence the advice given regarding mode of delivery and risk of neonatal herpes infection. The presence of antibodies of the same type as the HSV isolated from genital swabs would confirm this episode to be a recurrence rather than a primary infection and elective

caesarean section would not be indicated to prevent neonatal transmission.

2.1.2.5. However, it should be noted that it may take two–three weeks for the results of this test to become available. It is therefore recommended that an initial plan of delivery should be based on the assumption that all first episode lesions are primary genital herpes. This plan can then be modified if HSV antibody test results subsequently confirm a recurrent, rather than primary, infection. As interpretation of serology can be complicated, results should be discussed with a virologist and/or genitourinary medicine consultant.

2.2. Management of Pregnant Women with Recurrent Genital Herpes.

2.2.1. 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).

2.2.2. Although there is no evidence that Aciclovir is unsafe in early pregnancy, the majority of recurrent episodes of genital herpes are short-lasting and resolve within seven–ten days without antiviral treatment. Supportive treatment measures using saline bathing, Vaseline, and analgesia with standard doses of paracetamol alone will usually suffice.

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

2.2.4. Daily suppressive Aciclovir 400 mg three times a day should be considered from 36 weeks gestation. There is insufficient evidence to determine whether this reduces the incidence of neonatal herpes; however, it reduces viral shedding and recurrences at delivery so may reduce the need for caesarean section. Limited information exists regarding the neonatal safety of prophylaxis. The risks, benefits and alternatives to daily suppressive therapy should be discussed and prophylaxis initiated for women who desire intervention.

2.2.5. This increase from the standard suppressive dose of 400 mg twice daily is recommended in view of the greater volume of distribution of the drug during pregnancy.

2.2.6. Sequential PCR culture during late gestation to predict viral shedding at term, or at delivery to identify women who are asymptomatically shedding HSV, is not indicated. There is no increased risk of preterm labour, preterm prelabour rupture of membranes or fetal growth restriction associated with women seropositive for HSV. The incidence of congenital abnormalities is not increased in the presence of recurrent genital herpes infection.

2.3. Management of women with genital lesions at the onset of labour

2.3.1. 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.

2.3.2. The clinician must take a history in order to ascertain whether this is a primary or recurrent episode.

2.3.3. A viral swab from the lesion(s) should nonetheless be taken since the result may influence management of the neonate.

2.3.4. The neonatologist should be informed.

2.3.5. **Management of women with primary genital lesions at the onset of labour**

2.3.5.1. Caesarean section should be recommended to all women presenting with primary episode genital herpes lesions at the time of delivery, or within six weeks of the expected date of delivery, in order to reduce exposure of the fetus to HSV which may be present in maternal genital secretions.

2.3.5.2. There is some evidence to suggest that the benefit of caesarean section reduces if the membranes have been ruptured for greater than four hours. However, there may be some benefit in performing a caesarean section even after this time interval. If membranes have been ruptured for greater than four hours prior to caesarean section the neonate will get empirical treatment regardless of the mode of delivery, see appendix 3.

2.3.5.3. Intravenous Aciclovir given intrapartum to the mother (5 mg/kg every 8 hours) and subsequently to the neonate (intravenous Aciclovir 20 mg/kg every 8 hours) may be considered for those mothers opting for vaginal delivery. It is unknown whether intrapartum Aciclovir reduces the risk of neonatal HSV infection.

2.3.5.4. Where primary episode genital herpes lesions are present at the time of delivery and the baby is delivered vaginally, the risk of neonatal herpes is estimated to be 41%.

2.3.5.5. The risk of perinatal transmission depends on the timing of maternal acquisition of HSV, with the highest risk in infants born to women who have not completed HSV seroconversion during pregnancy (most commonly in the third trimester, within six weeks of delivery).

2.3.5.6. Although vaginal delivery should be avoided, if possible, in women who deliver vaginally 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.

2.3.6. **Management of women with recurrent lesions at the onset of labour**

2.3.6.1. Women presenting with recurrent genital herpes lesions at the onset of labour should be advised that the risk to the baby of neonatal herpes is low (0–3% for vaginal delivery).

2.3.6.2. Evidence from the Netherlands shows that a conservative approach, allowing vaginal delivery in the presence of an anogenital lesion, has not been associated with a rise in the number of neonatal HSV cases.

2.3.6.3. Vaginal delivery should be offered to women with recurrent genital herpes lesions at the onset of labour. A caesarean section delivery can be considered but the risk to the mother and future pregnancies should be set against the small risk of neonatal transmission of HSV with recurrent disease (0–3% for vaginal delivery).

2.3.6.4. The final choice of vaginal delivery versus caesarean section should be made by the mother, who should base her decision on the very low risk of transmission set against any other obstetric risk factors and the risks associated with caesarean section.

2.3.6.5. It has been reported that invasive procedures (fetal blood sampling, application of fetal scalp electrodes, artificial rupture of membranes and/or instrumental deliveries) increase the risk of neonatal HSV infection. However, given the small background risk (0–3%) of transmission in this group, the increased risk associated with invasive procedures is unlikely to be clinically significant so they may be used if required.

2.3.6.6. Women should be managed in accordance with standard National Institute for Health and Care Excellence (NICE) intrapartum guidelines. There is no evidence to guide the management of women with spontaneous rupture of membranes at term, but many clinicians will advise expediting delivery in an attempt to minimise the duration of potential exposure of the fetus to HSV.

2.3.6.7. Women should not labour or birth in water.

2.4. **Genital herpes in preterm pre-labour rupture of membranes (PPROM): before 37+0 weeks of gestation**

2.4.1. **PPROM with primary herpes**

2.4.1.1. There is limited evidence to inform best obstetric practice when PPROM is complicated by primary HSV infection. Management should be guided by multidisciplinary team discussion involving the obstetricians, neonatologists and genitourinary medicine physicians and will depend on the gestation that PPROM occurred. If the decision is made for

immediate delivery, then the anticipated benefits of caesarean section will remain.

2.4.1.2. If there is initial conservative management, the mother should be recommended to receive intravenous Aciclovir 5 mg/kg every 8 hours. Prophylactic corticosteroids should be considered to reduce the implications of preterm delivery upon the infant. If delivery is indicated within six weeks of the primary infection, delivery by caesarean section may still offer some benefit despite the prolonged rupture of membranes.

2.4.2. **PPROM with recurrent herpes**

2.4.2.1. When PPROM is encountered in the presence of recurrent genital herpes lesions, the risk of neonatal transmission is very small and may be outweighed by the morbidity and mortality associated with premature delivery.

2.4.2.2. In the case of PPROM before 34 weeks there is evidence to suggest that expectant management is appropriate, including oral Aciclovir 400mg three times daily for the mother. After this gestation, it is recommended that management is undertaken in accordance with relevant RCOG guidelines on PPROM and antenatal corticosteroid administration to reduce neonatal morbidity and mortality and is not materially influenced by the presence of recurrent genital herpes lesions.

2.5. **Management of HIV positive women with HSV infection in pregnancy**

2.5.1. HIV-positive women with primary genital HSV infection in the last trimester of pregnancy should be managed according to the recommendations for all women with primary genital HSV infection.

2.5.2. Women who are HIV antibody positive and have a history of genital herpes should be offered daily suppressive Aciclovir 400 mg three times daily from **32 weeks of gestation** to reduce the risk of transmission of HIV infection, especially in women where a vaginal delivery is planned. Starting therapy at this earlier gestation than usual should be considered in view of the increased possibility of preterm labour in HIV-positive women.

2.5.3. The mode of delivery should be in line with the British HIV Association (BHIVA) HIV in pregnancy guideline recommendations according to obstetric factors and HIV parameters such as HIV viral load.

2.5.4. There is currently no evidence to recommend daily suppressive treatment of HSV for HIV antibody positive women who are HSV-1 or -2 seropositive but have no history of genital herpes.

2.6. **Management of the neonate**

For neonatal management please see flow charts in Appendix 3 and Appendix 4.

2.7. Prevention of postnatal transmission

In 25% of cases a possible source of postnatal infection is responsible, usually a close relative. Efforts to prevent postnatal transmission of HSV are therefore important. The mother and all those with herpetic lesions who may be in contact with the neonate, including staff, should practice careful hand hygiene. Those with oral herpetic lesions (cold sores) should not kiss the neonate.

3. Monitoring compliance and effectiveness

Information Category	Detail of process and methodology for monitoring compliance
Element to be monitored	Numbers of pregnant women treated with antiviral medication in pregnancy. When a herpes antiviral drug is used against a previously undiagnosed genital herpes episode, a swab for herpes PCR should be sent – target 100%. Documentation in the clinic notes regarding discussion with patient of mode of delivery - target 100%. Where a first episode diagnosis of genital herpes is made in the third trimester, the woman's case should be discussed between the obstetrician and neonatologist with documentation of the agreed management – target 100%. Pregnant women with genital herpes should be provided with written information on genital herpes in pregnancy (e.g., the RCOG patient information leaflet) – target 90%. Cases of proven or suspected neonatal herpes – these should all be subject to an investigation to ensure management of the mother was in keeping with the guideline. Investigation to be led by Obstetric lead with input from both neonatal and sexual health teams. (i.e., Brooke, HIV Team).
Lead	Audit Midwife.
Tool	Annual audit of case notes. Immediate audit of notes of any child with proven or suspected neonatal herpes.
Frequency	3 yearly reports. Immediate Datix and investigation of any cases of neonatal herpes with sharing of any learning between the three disciplines.
Reporting arrangements	Report to be discussed at relevant specialty governance meetings and the learning to be taken to the specialty board meetings and then disseminated to staff. Outcomes to be documented in the meeting minutes.

Information Category	Detail of process and methodology for monitoring compliance
Acting on recommendations and Lead(s)	Departmental audit and governance leads will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes. Required actions will be identified and completed in a specified timeframe.
Change in practice and lessons to be shared	Required changes to practice will be identified and actioned within three months. A lead member of the team will be identified to take each change forward where appropriate. Lessons will be shared with all the relevant stakeholders.

4. Equality and Diversity

4.1. This document complies with the Royal Cornwall Hospitals NHS Trust service Equality and Diversity statement which can be found in the Equality Diversity And Inclusion Policy or the Equality and Diversity website.

4.2. Equality Impact Assessment

The Initial Equality Impact Assessment Screening Form is at Appendix 2.

Appendix 1. Governance Information

Information Category	Detailed Information
Document Title:	Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V3.3
This document replaces (exact title of previous version):	Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V3.2
Date Issued/Approved:	March 2024
Date Valid From:	April 2024
Date Valid To:	April 2026
Directorate / Department responsible (author/owner):	Dr Sophie Haynes (Obstetric consultant) Dr Chris Bell (Neonatal consultant)
Contact details:	01872 258477
Brief summary of contents:	Guideline described the antenatal, intrapartum and postnatal care of women with suspected or proven genital herpes. It also described the management of the neonate in these cases. The aim is to minimise the risk of neonatal herpes which is a potentially life-threatening infection.
Suggested Keywords:	Genital Herpes, antenatal, neonatal
Target Audience:	**RCHT:** Yes **CFT:** No **CIOS ICB:** No
Executive Director responsible for Policy:	Chief Medical Officer
Approval route for consultation and ratification:	Obstetrics guidelines group, neonatal guidelines group.
Manager confirming approval processes:	Caroline Chappell
Name of Governance Lead confirming consultation and ratification:	Tamara Thirlby
Links to key external standards:	None required.
Related Documents:	Reference and Associated documents

Information Category	Detailed Information
Training Need Identified?	No
Publication Location (refer to Policy on Policies – Approvals and Ratification):	Internet and Intranet
Document Library Folder/Sub Folder:	Clinical / Midwifery and Obstetrics

Version Control Table

Date	Version Number	Summary of Changes	Changes Made by
7 July 2016	1.0	New Guideline	Dr Lisa Haddon, Consultant in Sexual Health
5 September 2019	2.0	2.1.2.3. and 2.3.5.2. caesarean section should be performed within 4 hours of rupturing membranes if >37 weeks gestation. Add in neonatal care pathways as appendices and change text to support this.	Sarah-Jane Pedler, Practice Development Midwife
March 2023	V3.0	Amendment of referral to Brook for women with primary HSV. Addition of new Trust template.	Tamara Thirlby, Patient Safety Midwife
September 2023	V3.1	Amendments to appendix A and B.	Catherine Wills, Maternity Guidelines Midwife
January 2024	V3.2	Amendments throughout to update sexual health service contacts.	Catherine Wills, Maternity Guidelines Midwife
March 2024	V3.3	Clarification on swab taking noted in summary flow chart and 2.1.2.4.	Clare Gray, Patient Safety Midwife

All or part of this document can be released under the Freedom of Information Act 2000.

All Policies, Strategies and Operating Procedures, including Business Plans, are to be kept for the lifetime of the organisation plus 6 years.

This document is only valid on the day of printing. Controlled Document.

This document has been created following the Royal Cornwall Hospitals NHS Trust The Policy on Policies (Development and Management of Knowledge Procedural and Web Documents Policy). It should not be altered in any way without the express permission of the author or their Line Manager.

Appendix 2. Equality Impact Assessment

Section 1: Equality Impact Assessment (EIA) Form

The EIA process allows the Trust to identify where a policy or service may have a negative impact on an individual or particular group of people.

For guidance please refer to the Equality Impact Assessment Policy (available from the document library) or contact the Equality, Diversity, and Inclusion Team rcht.inclusion@nhs.net

Information Category	Detailed Information
Name of the strategy / policy / proposal / service function to be assessed:	Genital Herpes in Pregnancy Clinical Guideline V3.3
Directorate and service area:	Obstetrics and Gynaecology
Is this a new or existing Policy?	Existing
Name of individual completing EIA (Should be completed by an individual with a good understanding of the Service/Policy):	Dr Sophie Haynes (Obstetric consultant)Dr Chris Bell (Neonatal consultant)
Contact details:	01872 258477

Information Category	Detailed Information
1. Policy Aim - Who is the Policy aimed at? (The Policy is the Strategy, Policy, Proposal or Service Change to be assessed)	To minimise the risk of neonatal herpes in infants born to women presenting in pregnancy with proven or suspected genital herpes.
2. Policy Objectives	To minimise the risk of neonatal herpes in infants born to women presenting in pregnancy with proven or suspected genital herpes.
3. Policy Intended Outcomes	To minimise the risk of neonatal herpes in infants born to women presenting in pregnancy with proven or suspected genital herpes.
4. How will you measure each outcome?	Monitoring tool – see section 3.0.
5. Who is intended to benefit from the policy?	All pregnancy women who have or acquire genital herpes in pregnancy.

Information Category	Detailed Information
6a. Who did you consult with? (Please select Yes or No for each category)	• Workforce: Yes • Patients/ visitors: No • Local groups/ system partners: No • External organisations: No • Other: No
6b. Please list the individuals/groups who have been consulted about this policy.	**Please record specific names of individuals/ groups:** Maternity Guidelines Group
6c. What was the outcome of the consultation?	Agreed
6d. Have you used any of the following to assist your assessment?	**National or local statistics, audits, activity reports, process maps, complaints, staff, or patient surveys:** No

7. The Impact

Following consultation with key groups, has a negative impact been identified for any protected characteristic? Please note that a rationale is required for each one.

Where a negative impact is identified without rationale, the key groups will need to be consulted again.

Protected Characteristic	(Yes or No)	Rationale
Age	No	
Sex (male or female)	No	
Gender reassignment (Transgender, non-binary, gender fluid etc.)	No	
Race	No	
Disability (e.g. physical or cognitive impairment, mental health, long term conditions etc.)	No	
Religion or belief	No	
Marriage and civil partnership	No	

Protected Characteristic	(Yes or No)	Rationale
Pregnancy and maternity	No	
Sexual orientation (e.g. gay, straight, bisexual, lesbian etc.)	No	

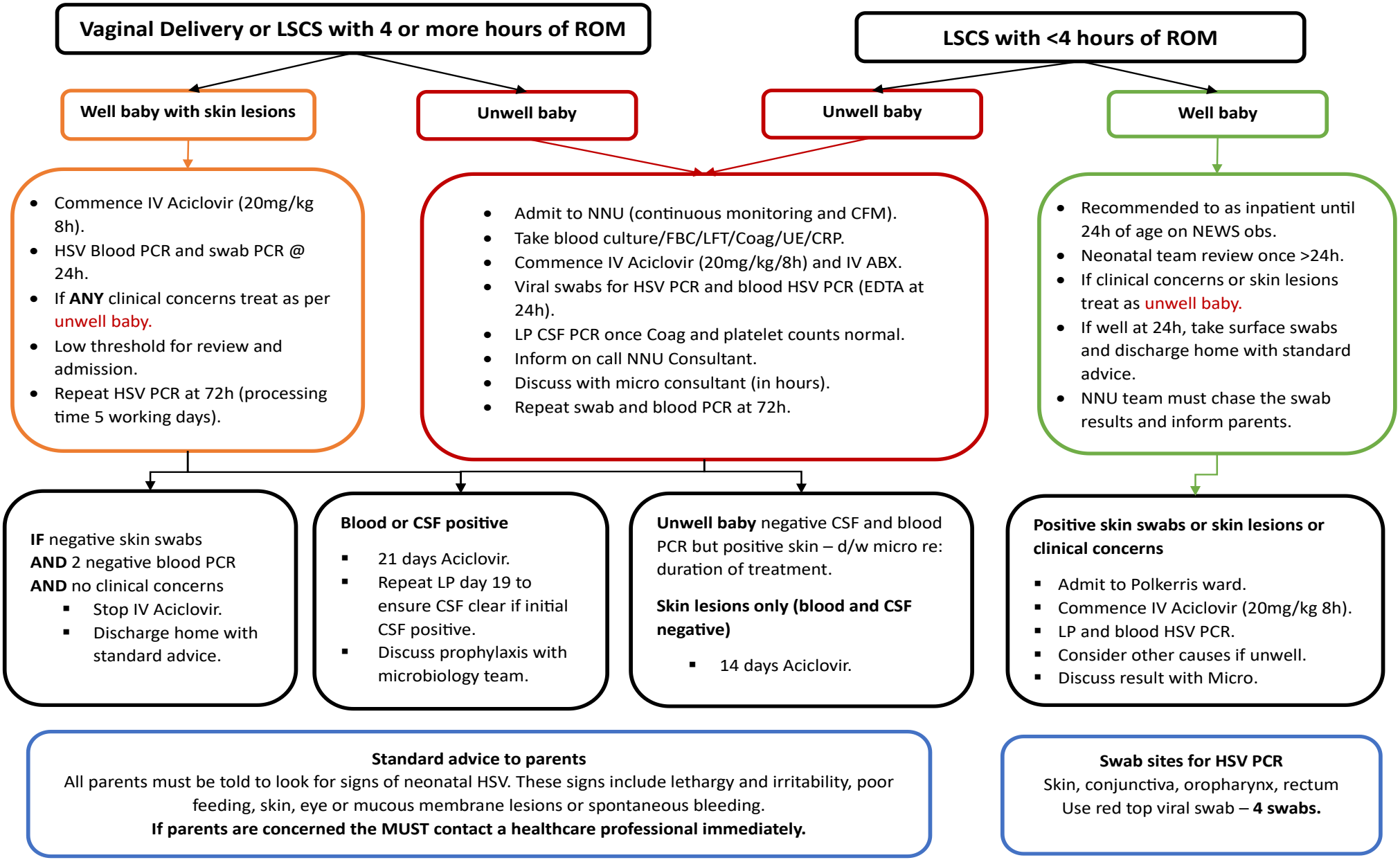
A robust rationale must be in place for all protected characteristics. If a negative impact has been identified, please complete section 2. If no negative impact has been identified and if this is not a major service change, you can end the assessment here.

I am confident that section 2 of this EIA does not need completing as there are no highlighted risks of negative impact occurring because of this policy.

Name of person confirming result of initial impact assessment: Catherine Wills, Maternity Guidelines Midwife

If a negative impact has been identified above OR this is a major service change, you will need to complete section 2 of the EIA form available here:
Section 2. Full Equality Analysis

Appendix 3. Primary Herpes in 6 weeks prior to delivery in this pregnancy



Appendix 4. Primary Herpes more than 6 weeks prior to delivery in this pregnancy OR Herpes recurrence in this pregnancy

Delivery – with or without lesions: SVD and

Well baby with skin lesions

- Commence IV Aciclovir (20mg/kg 8h).
- HSV Blood PCR and swab PCR @ 24h.
- If **ANY** clinical concerns treat as per unwell baby.
- Low threshold for review and admission.
- Repeat HSV PCR at 72h (processing time 5 working days).

Unwell baby

- Admit to NNU (continuous monitoring and CFM).
- Take blood culture/FBC/LFT/Coag/UE/CRP.
- Commence IV Aciclovir (20mg/kg/8h) and IV ABX.
- Viral swabs for HSV PCR and blood HSV PCR (EDTA at 24h).
- LP CSF PCR once Coag and platelet counts normal.
- Inform on call NNU Consultant.
- Discuss with micro consultant (in hours).
- Repeat swab and blood PCR at 72h.

Well baby

- Recommended to as inpatient until 24h of age on NEWS obs.
- Neonatal team review once >24h.
- If clinical concerns or skin lesions treat as unwell baby.
- If well at 24h, take surface swabs and discharge home with standard advice.
- NNU team must chase the swab results and inform parents.

IF negative skin swabs
AND 2 negative blood PCR
AND no clinical concerns

- Stop IV Aciclovir.
- Discharge home with standard advice.

Blood or CSF positive

- 21 days Aciclovir.
- Repeat LP day 19 to ensure CSF clear if initial CSF positive.
- Discuss prophylaxis with microbiology team.

Unwell baby negative CSF and blood PCR but positive skin – d/w micro re: duration of treatment.

Skin lesions only (blood and CSF negative)

- 14 days Aciclovir.

Positive skin swabs or skin lesions or clinical concerns

- Admit to Polkerris ward.
- Commence IV Aciclovir (20mg/kg 8h).
- LP and blood HSV PCR.
- Consider other causes if unwell.
- Discuss result with Micro.

Standard advice to parents

All parents must be told to look for signs of neonatal HSV. These signs include lethargy and irritability, poor feeding, skin, eye or mucous membrane lesions or spontaneous bleeding.

If parents are concerned the MUST contact a healthcare professional immediately.

Swab sites for HSV PCR

Skin, conjunctiva, oropharynx, rectum
Use red top viral swab – **4 swabs.**