Summary

Algorithm for management of herpes in pregnancy and care of neonate

- **Recurrent genital herpes**
  - Treat with standard dose of aciclovir if needed
  - Consider prophylactic Aciclovir 400mg tds from 36/40 gestation
  - Offer vaginal delivery unless within 6 weeks of primary acquisition
  - See neonatal appendix B

- **Primary acquisition of herpes in first or second trimester (refer to GUM)**
  - Treat primary episode with standard dose aciclovir

- **Primary acquisition of herpes in third trimester (refer to GUM)**
  - Treat primary episode with standard dose aciclovir
  - Consider Aciclovir 400 mg tds until delivery
  - Recommend planned CS for delivery if within 6 weeks of primary infection
  - See neonatal appendix A

Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V2.0
Page 2 of 17
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.

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.

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.

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

1.3. Data Protection Act 2018 (General Data Protection Regulation – GDPR) Legislation
2. The Guidance


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

2.1.1.1. If not presenting to sexual health, women with suspected genital herpes should be referred to the Sexual Health Clinic by telephone to the secretarial team on extension 8477. The woman will be seen by a genitourinary medicine physician who will confirm or refute the diagnosis by viral polymerase chain reaction (PCR), advise on management of genital herpes and arrange a screen for other sexually transmitted infections.

2.1.1.2. 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 (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.

2.1.1.3. 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.

The Trust has a duty under the DPA18 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 can't rely on Opt out, it must be Opt in.

DPA18 is applicable to all staff; this includes those working as contractors and providers of services.

For more information about your obligations under the DPA18 please see the ‘information use framework policy’, or contact the Information Governance Team rch-tr.infogov@nhs.net
2.1.1.6. Providing that delivery does not ensue within the next 6 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 400 mg 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 (400 mg three times daily, usually for 5 days). In the third trimester, treatment will usually continue with daily suppressive aciclovir 400 mg 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 6 weeks of expected delivery, as the risk of neonatal transmission of HSV is very high at 41%. The caesarean section should be performed within 4 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 (New 2019).

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 6 weeks of expected delivery, type-specific HSV antibody testing (immunoglobulin G [IgG] antibodies to HSV-1 and HSV-2) is advisable. 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 2–3 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.


2.2.1. 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 7–10 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 6 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 4 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 4 hours prior to caesarean section the neonate will get empirical treatment regardless of the mode of delivery see appendix A (in appendix 3) (New 2019).

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 6 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
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 (foetal blood sampling, application of foetal 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.
2.4. 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 6 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 400 mg 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 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 A and B (in appendix 3) *(New 2019)*

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**

<table>
<thead>
<tr>
<th>Element to be monitored</th>
<th>Numbers of pregnant women with diagnosed HSV infection who are known to both Obstetric and Sexual Health services. Management to be audited annually.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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%.</td>
</tr>
<tr>
<td></td>
<td>Documentation in the clinic notes regarding discussion with patient of mode of delivery - target 100%</td>
</tr>
<tr>
<td></td>
<td>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%.</td>
</tr>
<tr>
<td></td>
<td>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%.</td>
</tr>
<tr>
<td></td>
<td>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.</td>
</tr>
</tbody>
</table>
Investigation to be led by Obstetric lead with input from both neonatal and sexual health teams.

<table>
<thead>
<tr>
<th>Lead</th>
<th>Audit Midwife</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tool</td>
<td>Annual audit of case notes. Immediate audit of notes of any child with proven or suspected neonatal herpes.</td>
</tr>
<tr>
<td>Frequency</td>
<td>Annual audit of all cases with input from both Obstetric and Sexual Health teams. Annual report</td>
</tr>
<tr>
<td></td>
<td>Immediate DATIX and investigation of any cases of neonatal herpes with sharing of any learning between the three disciplines.</td>
</tr>
<tr>
<td>Reporting arrangements</td>
<td>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</td>
</tr>
<tr>
<td>Acting on recommendations and Lead(s)</td>
<td>Departmental audit and governance leads will undertake subsequent recommendations and action planning for any or all deficiencies and recommendations within reasonable timeframes. The Sexual Health governance lead will organise and oversee this. Required actions will be identified and completed in a specified timeframe</td>
</tr>
<tr>
<td>Change in practice and lessons to be shared</td>
<td>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</td>
</tr>
</tbody>
</table>

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 & Human Rights 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

<table>
<thead>
<tr>
<th>Document Title</th>
<th>Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V2.0</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Issued/Approved:</td>
<td>September 2019</td>
</tr>
<tr>
<td>Date Valid From:</td>
<td>September 2019</td>
</tr>
<tr>
<td>Date Valid To:</td>
<td>September 2022</td>
</tr>
<tr>
<td>Directorate / Department responsible (author/owner):</td>
<td>Dr Sophie Haynes (Obstetric consultant), Dr Chris Bell (Neonatal consultant), Dr. Lisa Haddon (Sexual Health consultant).</td>
</tr>
<tr>
<td>Contact details:</td>
<td>01872 258477</td>
</tr>
<tr>
<td>Brief summary of contents</td>
<td>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.</td>
</tr>
<tr>
<td>Suggested Keywords:</td>
<td>Genital Herpes, antenatal, neonatal</td>
</tr>
<tr>
<td>Target Audience</td>
<td>RCHT</td>
</tr>
<tr>
<td></td>
<td>✓</td>
</tr>
<tr>
<td>Executive Director responsible for Policy:</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Date revised:</td>
<td>5th September 2019</td>
</tr>
<tr>
<td>This document replaces (exact title of previous version):</td>
<td>Genital Herpes in Pregnancy V1.0</td>
</tr>
<tr>
<td>Approval route (names of committees)/consultation:</td>
<td>Sexual Health governance group and specialty board, Obstetrics guidelines group, neonatal guidelines group. WCSH divisional board.</td>
</tr>
<tr>
<td>Care Group Manager confirming approval processes</td>
<td>Debra Shields (Care Group manager)</td>
</tr>
<tr>
<td>Name and Post Title of additional signatories</td>
<td>Specialty leads for Obstetrics and Neonatal medicine.</td>
</tr>
<tr>
<td>Name and Signature of Divisional/Directorate Governance Lead confirming approval by specialty and divisional management meetings</td>
<td>{Original Copy Signed}</td>
</tr>
<tr>
<td>Name: Caroline Amukusana</td>
<td>Name: Caroline Amukusana</td>
</tr>
<tr>
<td>Signature of Executive Director giving approval</td>
<td>{Original Copy Signed}</td>
</tr>
</tbody>
</table>
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

Dr. Lisa Haddon. Consultant in Sexual Health

Sarah-Jane Pedler. Practice development midwife
# Appendix 2. Initial Equality Impact Assessment Form

<table>
<thead>
<tr>
<th>Name of the strategy / policy / proposal / service function to be assessed</th>
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</thead>
<tbody>
<tr>
<td>Genital Herpes in Pregnancy Clinical Guideline V2.0</td>
</tr>
</tbody>
</table>

## Directorate and service area:
Obs and Gynae

## New or existing document:
Existing

### Name of individual completing assessment:
Dr Sophie Haynes (Obstetric consultant), Dr Chris Bell (Neonatal consultant), Dr. Lisa Haddon (Sexual Health consultant).

### Directorate and service area:
Obs and Gynae

### Name of individual completing assessment:
Existing

### Telephone:
01872 250 000

## 1. Policy Aim*

**Who is the strategy / policy / proposal / service function aimed at?**

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 the 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.

## 6a Who did you consult with?

<table>
<thead>
<tr>
<th>Workforce</th>
<th>Patients</th>
<th>Local groups</th>
<th>External organisations</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>X</td>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

b). Please identify the groups who have been consulted about this procedure.

Sexual Health governance group and specialty board, Obstetrics guidelines group, neonatal guidelines group. WCSH divisional board.

## What was the outcome of the consultation?

Guideline agreed

## 7. The Impact

Please complete the following table. **If you are unsure/don’t know if there is a negative impact you need to repeat the consultation step.**

Are there concerns that the policy could have differential impact on:

Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V2.0
Page 14 of 17
### Equality Strands:

<table>
<thead>
<tr>
<th>Equality Strands</th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>Age</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sex (male, female, trans-gender / gender reassignment)</td>
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</tr>
<tr>
<td>Race / Ethnic communities /groups</td>
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<td>X</td>
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</tr>
<tr>
<td>Disability - Learning disability, physical impairment, sensory impairment, mental health conditions and some long term health conditions.</td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Religion / other beliefs</td>
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<td>X</td>
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</tr>
<tr>
<td>Marriage and Civil partnership</td>
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<td>X</td>
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<tr>
<td>Pregnancy and maternity</td>
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<tr>
<td>Sexual Orientation, Bisexual, Gay, heterosexual, Lesbian</td>
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<td>X</td>
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</tr>
</tbody>
</table>

**Rationale for Assessment / Existing Evidence**

You will need to continue to a full Equality Impact Assessment if the following have been highlighted:

- You have ticked “Yes” in any column above and
- No consultation or evidence of there being consultation- this excludes any policies which have been identified as not requiring consultation. or
- Major this relates to service redesign or development

8. Please indicate if a full equality analysis is recommended. [Yes] [No] [X]

9. If you are not recommending a Full Impact assessment please explain why.

Not indicated

Date of completion and submission: September 2019

Members approving screening assessment: Policy Review Group (PRG)

Policy Review Group (PRG) APPROVED

**This EIA will not be uploaded to the Trust website without the approval of the Policy Review Group.**

A summary of the results will be published on the Trust’s web site.

Genital Herpes in Pregnancy, Obstetrics and Neonates Clinical Guideline V2.0

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Appendix B: Primary Herpes more than 6 weeks prior to delivery OR Herpes recurrence in pregnancy

Delivery- with or without lesions: SVD & LSCS

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 & admission
- Repeat HSV PCR @ 72 hours (processing time 5 working days)

Unwell Baby
- Admit NNU (Continuous observation monitoring & CFM)
- Take blood culture FBC/LFT/Coag/UE/CRP
- Commence IV Aciclovir (20mg/kg 8h) & IV antibiotics
- Viral Swabs for HSV PCR and Blood HSV PCR (EDTA) @24h
- LP CSF PCR once Coag & Platelets normal
- Inform on call NNU consultant
- Discuss with micro consultant (in hours)
- Repeat Swab and Blood PCR @ 72 hours

Well Baby
- Recommend Remain as inpatient until 24 hours of age on NEWS obs
- Neonatal Team review once > 24 hours
- If clinical concerns or skin lesions treat as unwell baby
- If well @ 24 hours 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-education of treatment
Skin Lesions only (Blood and CSF Negative)
- 14 days Aciclovir

Positive skin swabs or skin lesions or clinical concern
- Admit Polkerris ward
- Start IV Aciclovir (20mg/kg 8h)
- Lumbar Puncture and Blood HSV PCR
- Consider other causes if unwell
- Discuss with Micro with result

Standard advice to parents
All parents must be told to look for the signs of Neonatal HSV. These signs include - Lethargy or Irritability, Poor feeding and Skin, eye or mucous membrane lesions or spontaneous bleeding

If parents have any concerns they MUST contact a healthcare professional immediately.

Swab Sites for HSV PCR
Skin, Conjunctiva, Oropharynx, Rectum
Use red-top viral swab - 4 swabs