

# First Episode Genital Herpes

## Introduction

### Aetiology and Epidemiology

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

### Symptoms

- Painful genital ulcers, itching, external dysuria
- Groin, leg/buttock pain
- Vaginal and /or urethral discharge (with cervical or urethral lesions)
- Systemic – fever, malaise, myalgia, headache

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

### Signs

- Genital blisters or ulcers
- Inguinal lymphadenopathy
- Cervicitis

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

### Complications – Primary Disease

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

## Diagnosis

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

- **Virological confirmation** and typing should be attempted **in all patients**
- **A negative test does not rule out diagnosis**
- **Serology** (see separate section)

## Tests

### Methods include:

- Culture and serotyping
- DNA detection by PCR
- Direct immunofluorescence
- Antigen detection test (enzyme immunoassay, EIA)
- Serology is not useful for primary episodes

Testing methods vary between laboratories, and these methods have different sampling requirements and accuracy. DNA testing with typing for HSV-1 or HSV-2 is preferred due to greater sensitivity. Highest yield of positive results is with blisters or early ulceration.

- **A negative test does not rule out diagnosis.**
- **Serology** (see separate section)

## Specimen Collection

- Use **appropriate swab depending on test used – vesicular fluid optimal**. Otherwise rub firmly on base of lesion to maximise isolation.
- Storage and transport conditions depend on test used eg with culture store at 4°C and transport chilled (not frozen)

## Management

### General Points

- Patients should be **offered antiviral therapy** immediately
- Antiviral therapy may still be appropriate if patient presents >72 hrs after development of symptoms, depending on clinical situation e.g. severe disease, new lesions developing.
- Patients with a diagnosis of genital herpes should be offered counselling, support, and written information
- Suppressive therapy should be offered to all **patients with frequent recurrences** (see Recurrent Genital Herpes)

### Male & Female

- **Aciclovir 400 mg po 3 x daily 5 days**

## Pregnancy

- Aciclovir 400 mg po 3 x daily 5 days

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

- **All pregnant women** with first episode genital herpes in the **third trimester of pregnancy require urgent review** by an obstetrician as this situation is high risk for neonatal transmission and requires specialist management
- All pregnant women with **first episode genital herpes in the first or second trimester require non-urgent review** by an obstetrician (+/- sexual health physician).

This is a low risk. See NZ Genital Herpes Guidelines for discussion on suppressive treatment from 36 weeks ([www.herples.org.nz](http://www.herples.org.nz))

## Partner Notification and Management of Sexual Partners

- Not necessary
- Partners with symptoms should be seen and evaluated
- Asymptomatic partners may be seen for routine sexual health screening and/or counselling as deemed appropriate by clinician, for example, in pregnancy, where there is a risk of neonatal transmission, specific counselling and management is required

## Follow-up

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

## Referral Guidelines

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

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

## Further information

**Note:** An in-depth guideline for the management of Genital Herpes has been produced by the Professional Advisory Board of the Viral Sexually Transmitted Infection Education Foundation.

[www.herples.org.nz](http://www.herples.org.nz)