Reference Number: UHBOBS218 Version Number: 1	Date of Next Review: 25 March 2028 Previous Trust/LHB Reference Number: N/A

HERPES SIMPLEX VIRUS (HSV) IN PREGNANCY

Introduction and Aim

The new Joint UK guideline from The British Association of Sexual Health and HIV and The Royal College of Obstetrics and Gynaecology for the management and treatment of the Herpes Simplex Virus in pregnancy to guide practitioners.

Included in the Appendix is the recommended Birth Plan proforma and the Management and Treatment Flow Chart

Equality Health Impact Assessment	An Equality Health Impact Assessment has not been completed.
Documents to read alongside this Procedure	
Approved by	Maternity Professional Forum

Accountable Executive or Clinical Board Director	Abi Holmes, Director of Midwifery
Author(s)	Sarah James (Consultant Midwife)

Disclaimer

If the review date of this document has passed please ensure that the version you are using is the most up to date either by contacting the document author or the Governance Directorate.

Summary of reviews/amendments

Version Number	Date of Review Approved	Date Published	Summary of Amendments
1	25 March 2025	25 March 2025	New Document

Contents

1. Link to UK -wide guidance (BASHH and RCOG) ……3

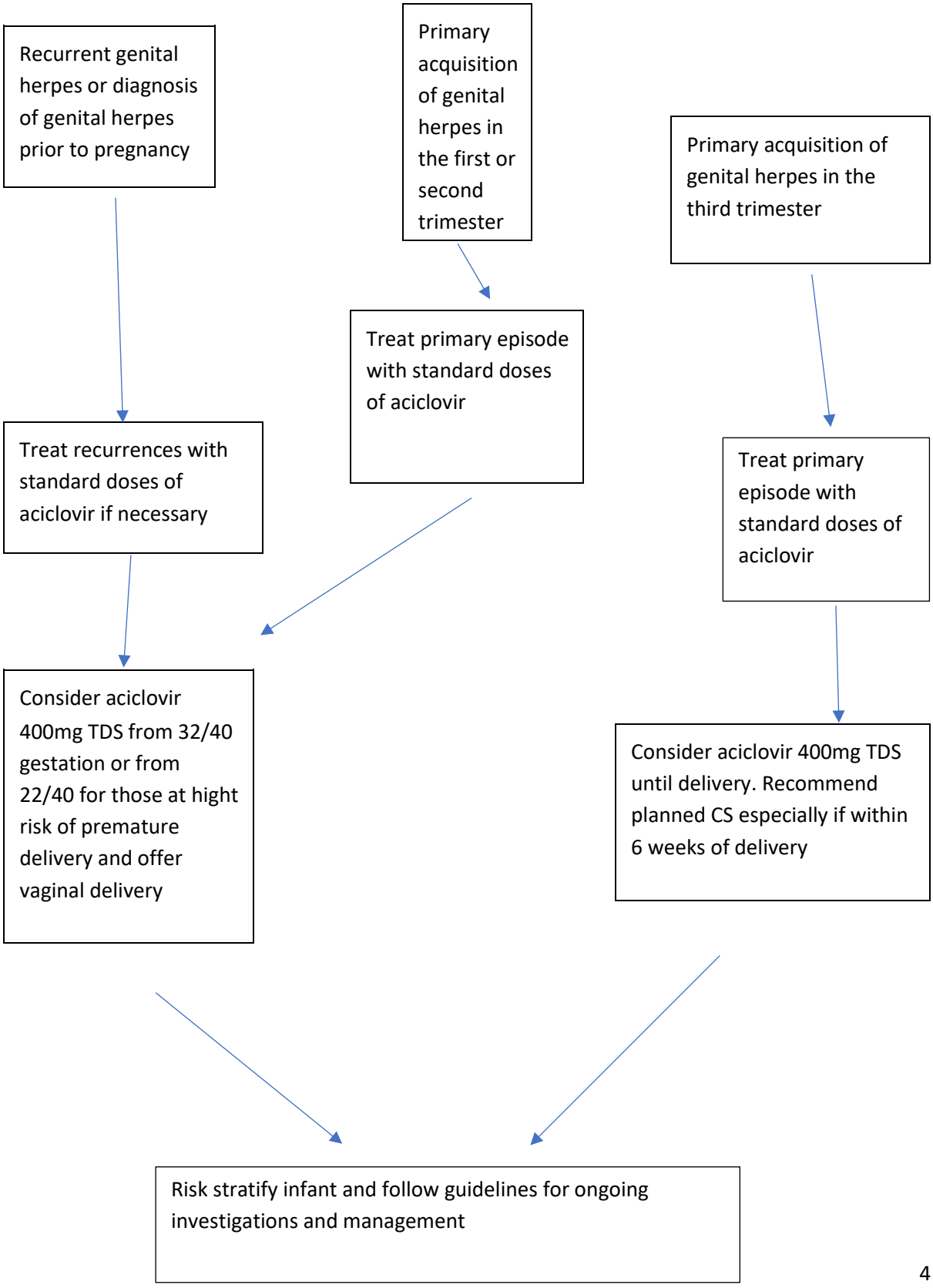
Appendix 1……..4

Appendix 2……..5

For National Guidance refer to **British Association of Sexual Health and HIV and The Royal College of Obstetrics and Gynaecology joint guidance**

Updated Guideline: Herpes in Pregnancy 2024 | BASHH

Appendix 2: algorithm for the management of herpes in pregnancy and care of the neonate



Appendix 3: Suggested birth plan

Local birth plans may also be used provided they are informed by these guidelines.

GENITAL HERPES BIRTH PLAN

Copies to Genitourinary medicine (GUM), Midwife, Obstetrics, Neonatology, and GP (with patient permission)

MOTHER'S / BIRTHING PARENT'S DETAILS

Name _____ DOB __ __/ __ __ / __ __

Address _____

Mobile _____

Hospital number_____ GUM number _____

Consent given to record GUM number in hospital records ☐

Estimated date of delivery __ __ / __ __ / __ __

MOTHER'S / BIRTHING PARENT'S HERPES DIAGNOSIS

Diagnosis (based on PCR)

Genital HSV-1 ☐ Genital HSV-2 ☐ Presumed genital HSV (type unknown) ☐

Oro-labial cold sores (HSV-1), (PCR confirmation not required) ☐

Serology results

HSV-1 IgG positive ☐ HSV-2 IgG positive ☐ serology awaited ☐ serology not done ☐

Date of acquisition

Prior to pregnancy ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐

If acquired in pregnancy: date of first lesions: __ __/ __ __ / __ __ at gestation __ __/40

MOTHER'S / BIRTHING PARENT'S HERPES MANAGEMENT

Antiviral suppression in pregnancy

Standard:

Aciclovir 400mg 3 times a day orally from 32 weeks □

Valaciclovir 500mg 2 times a day orally from 32 weeks □

High risk of preterm delivery:

Acyclovir 400mg 2 times a day orally from 22 weeks, then 3 times a day orally from 32 weeks □

Valaciclovir 500mg once a day orally from 22 weeks, then 2 times a day orally from 32 weeks □

Preterm prelabour rupture of membranes:

Aciclovir 5mg/kg IV every 8 hours □

Aciclovir 400mg 3 times a day orally from 32 weeks □

Valaciclovir 500mg 2 times a day orally from 32 weeks □

None: No antiviral suppression has been taken □

Other: _____

Planned delivery method

Vaginal delivery □ Planned Caesarean section on __ __ / __ __ / __ __ □

POST DELIVERY URGENT MANAGEMENT

Infants risk highest □ high □ low □ lowest □

See management for baby for assessing risk, immediate investigations and management at end of document in the neonatal management section

Post natal advice has been given to the parents on seeking urgent medical review if their baby is unwell up to 6 weeks post birth and informing the clinician that their baby has potentially been in contact with HSV □

Contact details for clinical teams

Specialty	**Name**	**Email**	**Telephone**
Genitourinary medicine consultant			
On call genitourinary medicine			
Obstetrics consultant			
On call obstetrics			
Midwife			
Delivery suite			
Neonatal consultant			
On call neonatology			
Paediatrics infectious diseases consultant (may be regional)			
On call paediatric infectious diseases (may be regional)			

NEONATAL MANAGEMENT

Immediate investigations and management

- All cases of possible neonatal HSV should be discussed urgently with the regional Paediatric Infectious Diseases Team [IV, C].
- Any positive HSV test from an infant must be managed as highest risk [IV, C].

Risk	Highest	High	Low	Lowest
Delivery Method	All infants with symptoms consistent with HSV infection regardless of delivery method Babies with <u>any</u> positive HSV test even if this is suspected to be	Pregnant parent had an initial HSV infection within the previous 6 weeks and baby is asymptomatic and born by: • Vaginal delivery **OR**	Asymptomatic babies born by any delivery method in the presence of active **recurrent** herpes lesions Asymptomatic babies born at <37 weeks by	Asymptomatic babies born at >37 weeks by any delivery method with (99) with no active lesions in birthing woman or person at

	detection of maternal HSV Babies born by vaginal delivery in the presence of active **initial** herpes lesions Birthing mother or parent systemically unwell with possible HSV Birthing mother or parent presents post-partum with active primary herpes lesions within 4 weeks of delivery	• Caesarean section regardless of duration of rupture of membranes	any delivery method with no active lesions at delivery and a history of HSV infection more than 6 weeks previously	delivery **AND a h**istory of HSV infection more than 6 weeks previously
Clinical Assessment	Urgently inform the neonatal team Urgent assessment soon after birth, bearing in mind that the presentation of neonatal HSV may be nonspecific and that skin lesions may not be present Isolate infant from other babies and nurse using barrier methods to reduce the risk of postnatal transmission to other babies. Isolation should continue until neonatal herpes has been excluded or treatment completed in the event of neonatal	Urgently inform the neonatal team Urgent assessment soon after birth bearing in mind that the presentation of neonatal HSV may be non-specific and that skin lesions may not be present. If evidence of neonatal HSV is found, investigate as per symptomatic infants. Isolate infant from other babies and nurse using barrier methods to reduce the risk of postnatal transmission to other babies. Isolation should continue until	Urgently inform the neonatal team Urgent assessment soon after birth bearing in mind that the presentation of neonatal HSV may be non-specific and that skin lesions may not be present. If evidence of neonatal HSV is found, investigate as per symptomatic infants.	Inform the neonatal team No investigations required Normal postnatal with a neonatal examination at 24 hours of age, after which the baby can be discharged from the hospital if well and feeding is established

	HSV being confirmed. Ophthalmology review.	neonatal herpes has been excluded or treatment completed in the event of neonatal HSV being confirmed.		
Timing of investigations	Urgent (note maternal or birth parent HSV may still be detected on surface swabs, and therefore should be repeated if taken <24 hours of life)	24 hours post-delivery (note maternal or birth parent HSV may still be detected on surface swabs, and therefore should be repeated if taken <24 hours of life)	24 hours post-delivery (note maternal or birth parent HSV may still be detected on surface swabs	
HSV PCR swab	Any visible lesions Throat swab Nose swab Conjunctival swabs Rectal swab	Throat swab Nose swab Conjunctival swabs Rectal swab	Throat swab Nose swab Conjunctival swabs Rectal swab	
Bloods	HSV PCR (1mL EDTA required) (note may take >24 hours for sufficient HSV replication to occur for a positive result to occur, and so a negative test does not exclude infection, may need to be repeated) (106) Full blood count Liver function tests Coagulation screen	HSV PCR (1mL EDTA required) (note may take >24 hours for sufficient HSV replication to occur for a positive result to occur, and so a negative test does not exclude infection, may need to be repeated) (106) Full blood count Liver function tests Coagulation screen	HSV PCR (1mL EDTA required) (note may take >24 hours for sufficient HSV replication to occur for a positive result to occur, and so a negative test does not exclude infection, may need to be repeated) (106) HSV PCR (1mL EDTA required) (note may take >24 hours for sufficient HSV replication to occur for a positive result to occur, and so a negative test	

			does not exclude infection, may need to be repeated) (106)	
Lumbar Puncture for CSF	If clinically safe, undertake lumbar puncture for CSF and send for: • HSV PCR • Protein • Glucose Cell count, microscopy and culture	If clinically safe, undertake lumbar puncture for CSF and send for: • HSV PCR • Protein • Glucose Cell count, microscopy and culture		
Other tests	As guided by the infant's clinical condition (for example chest X-ray)			
	In cases where drug resistance is a concern, discuss with a virologist and consider sending samples for drug resistance testing (available at the UK HAS laboratory at Collingdale)			
Management	Urgently start aciclovir 20mg/kg IV without waiting for results. In cases where there is concern around possible aciclovir resistance or there is a shortage of IV aciclovir, IV foscarnet or cidofovir may be considered.	Urgently start aciclovir 20mg/kg IV without waiting for results. In cases where there is concern around possible aciclovir resistance or there is a shortage of IV aciclovir, IV foscarnet or cidofovir may be considered. Duration of treatment:		

	Duration of treatment: • All results are negative, and no other cause identified: 10 days • Skin, eye and mouth disease only: 14 days CNS or disseminated disease, or no CNS obtainable but other positive HSV tests: 21 days. Send blood and CSF (if previously positive) on day 17-20 (near as possible to day 21 depending on duration of laboratory result return times) for HSV PCR to ensure negative prior to stopping treatment on day 21. If CSF remains positive, continue IV aciclovir for a further week and repeat blood and CSF prior to stopping IV aciclovir.	• All results are negative, and baby remains asymptomatic: 10 days • Positive skin swab from completely intact skin: 10 days. • Positive skin swabs from areas of trauma without vesicles should be treated as per highest risk. • If baby becomes symptomatic or if any test is positive manage as per highest risk A long line may be considered to avoid extravasation of IV aciclovir		

	IF a further positive test is obtained, provide a further week of IV aciclovir. A long line may be considered to avoid extravasation of IV aciclovir. Oral aciclovir prophylaxis at 300mg/m^3 TDS for 6 months to start post IV therapy for all infants with CNS or disseminated disease and considered in infants with skin, eye and mouth disease to reduce risk of CNS recurrences.			
Advice to Parent and Carers	Practice good hand hygiene and take care to reduce risk of postnatal infection from maternal genital secretions or other sources including anyone with oral HSV-1. Seek urgent medical help if they have concerns regarding their baby in the next 6 weeks, in particular:			

	• Skin, eye and mucous membrane lesions • Lethargy/irritability • Poor feeding • Fever			