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Clinical Management Guidelines for Obstetrician–Gynecologists

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For a comprehensive overview of these recommendations, the full-text version of this Practice Bulletin is available at http://dx.doi.org/10.1097/AOG.0000000000003840.

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Committee on Practice Bulletins—Obstetrics. This Practice Bulletin was developed by the ACOG Committee on Practice Bulletins—Obstetrics with the assistance of Lisa Hollier, MD, MPH and Denise Jamieson, MD, MPH.

Management of Genital Herpes in Pregnancy

Genital herpes simplex virus (HSV) infection during pregnancy poses a risk to the developing fetus and newborn. Genital herpes is common in the United States. Among 14- to 49-year-old females, the prevalence of HSV-2 infection is 15.9%. However, the prevalence of genital herpes infection is higher than that because genital herpes is also caused by HSV-1 (1). Because many women of childbearing age are infected or will be infected with HSV, the risk of maternal transmission of this virus to the fetus or newborn is a major health concern. This document has been revised to include that for women with a primary or nonprimary first-episode genital HSV infection during the third trimester of pregnancy, cesarean delivery may be offered due to the possibility of prolonged viral shedding.

Clinical Management Questions

- ▶ *How can the diagnosis of herpes simplex virus be established?*
- ▶ *How can primary herpes simplex virus infection be distinguished from a nonprimary first episode during pregnancy?*
- ▶ *Is there a role for routine screening for genital herpes during pregnancy?*
- ▶ *What antiviral medications are available for treatment of herpes simplex virus infection during pregnancy?*
- ▶ *What antiviral therapy is recommended for a primary or a nonprimary first-episode herpes simplex virus outbreak in pregnancy?*
- ▶ *What antiviral therapy is recommended for a recurrent herpes simplex virus infection in pregnancy?*
- ▶ *When should cesarean delivery be performed to prevent perinatal herpes simplex virus transmission?*
- ▶ *Is cesarean delivery recommended for women with recurrent herpes simplex virus lesions on the back, thigh, or buttock?*

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- *In a patient with active genital herpes simplex virus lesions and ruptured membranes at term, should cesarean delivery be performed to prevent perinatal transmission?*
- *How should a woman with active genital herpes simplex virus lesions and preterm prelabor rupture of membranes be managed?*
- *Are invasive procedures contraindicated in pregnant women with herpes simplex virus?*
- *Should women with active herpes simplex virus breastfeed or handle their infants?*

Summary of Recommendations

The following recommendations are based on limited or inconsistent scientific evidence (Level B):

- In pregnancy, suspected genital herpes virus infections should be confirmed with type-specific laboratory testing. However, retesting is not warranted in pregnant women with a history of laboratory-confirmed genital HSV.
- Women with a clinical history of genital herpes should be offered suppressive viral therapy at or beyond 36 weeks of gestation. For primary outbreaks that occur in the third trimester, continuing antiviral therapy until delivery may be considered.
- Because of enhanced renal clearance, the doses of antiviral medication used for suppressive therapy for recurrent HSV infection in pregnancy are higher than the corresponding doses in nonpregnant women.
- Cesarean delivery is indicated in women with active genital lesions or prodromal symptoms, such as vulvar pain or burning at delivery, because these symptoms may indicate viral shedding.

The following recommendations are based primarily on consensus and expert opinion (Level C):

- Routine HSV screening of pregnant women is not recommended. In addition, routine antepartum genital HSV cultures in asymptomatic patients with recurrent disease are not recommended.
- In general, cesarean delivery is not recommended for women with a history of HSV infection but no active genital lesions or prodromal symptoms during labor. However, for women with a primary or nonprimary first-episode genital HSV infection during the third trimester of pregnancy, cesarean delivery may be offered due to the possibility of prolonged viral shedding.
- Cesarean delivery is not recommended for women with nongenital lesions (eg, lesions on back, thigh, buttock). These lesions may be covered with an occlusive dressing and the patient can give birth vaginally.
- In women with preterm prelabor rupture of membranes, there is no consensus on the gestational age at which the risks of prematurity outweigh the risks of HSV. When expectant management is elected, treatment with an antiviral is recommended.

Reference

1. McQuillan G, Kruszon-Moran D, Flagg EW, Paulose-Ram R. Prevalence of herpes simplex virus type 1 and type 2 in persons aged 14-49: United States, 2015-2016. NCHS Data Brief 2018;(304):1–8. (Level III)

Studies were reviewed and evaluated for quality according to the method outlined by the U.S. Preventive Services Task Force. Based on the highest level of evidence found in the data, recommendations are provided and graded according to the following categories:

Level A—Recommendations are based on good and consistent scientific evidence.

Level B—Recommendations are based on limited or inconsistent scientific evidence.

Level C—Recommendations are based primarily on consensus and expert opinion.

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