MSHC
MELBOURNE SEXUAL HEALTH CENTRE

Herpes treatment guidelines

Also known as genital herpes, cold sore, herpes simplex virus, HSV

Herpes is a common STI, caused by the herpes simplex virus (HSV) and can be passed on by skin-to-skin contact during sexual contact.

Types

- **HSV type 1** is mainly transmitted by oral-to-oral contact to cause oral herpes (which can include symptoms known as 'cold sore'), but can also cause genital herpes.
- **HSV type 2** is a sexually transmissible infection that causes genital herpes.

Causes

- Genital HSV infection may be acquired from either symptomatic or asymptomatic partners, and from either genital or oral sexual contact.
- Most infections are caused by HSV type 2 but an increasing number of genital infections are due to HSV type 1.

Clinical presentation

- Most HSV infections are asymptomatic.
- Clinical manifestations depend on site of viral entry and immunity from previous exposure.
- Manifestations of newly acquired infection may be severe in non-immune persons who have had no previous exposure.
- Sexually acquired manifestations include genital ulceration, gingivostomatitis, urethritis, cervicitis and proctitis.

Diagnosis

Test	Site/ Specimen	Comments
PCR	Swab of lesion	HSV is usually a clinical diagnosis accompanied by a swab for HSV PCR.
HSV serology	Blood	Serology should not be used in screening and only ordered when there are clear individual clinical indications. The practitioner who orders HSV serology should have a clear understanding of the positive and negative predictive values of the test result.

Management

Condition	Recommended	Extra comments
Primary HSV or initial presentation	**Aciclovir 400 mg PO, 3-times a day for 7-10 days** OR **Valaciclovir 500 mg PO, twice daily for 7-10 days**	Treatment with antiviral medications is most effective when started early, but there are benefits with initiating treatment well after the onset of symptoms. Offer lignocaine 2% jelly or LMX4 cream topically. Exercise caution with topical anaesthetic agents as they may cause sensitisation with prolonged use. Offer paracetamol/codeine for pain relief. Consider antifungal medication (preferably oral) for thrush if present. Consider oral antibiotics if secondary bacterial infection is suspected. Topical antivirals and antibiotics are ineffective. Education and counselling for psychosocial effects of reactivation and reoccurrences.
Recurrent HSV (episodic therapy)	**Famciclovir 1g PO stat and repeated in 12 hours** OR **Valaciclovir 500 mg PO, twice daily for 5 days** OR **Famciclovir 500 mg PO, stat and three further doses of 250 mg at 12-hourly intervals** OR **Aciclovir 800 mg PO, three times a day for 2 days**	Viral replication during recurrent episodes lasts for only 1-2 days, so episodic therapy should be commenced within 24 hours of symptom onset and the earlier the better. 1 day antiviral courses are as effective as longer courses. **Valaciclovir 2g PO stat and repeated in 12 hours** has been shown to be effective but is not PBS approved in Australia.

Condition	Recommended	Extra comments
Recurrent HSV (suppressive therapy)	**Aciclovir 400 mg PO, twice a day** OR **Famciclovir 250 mg PO, twice a day** OR **Valaciclovir 500 mg PO, daily**	Patients who have frequent recurrences (10 or more peryear) may require **valaciclovir 500 mg tablets bd or 1g daily**. Patients with proven genital herpes who have > 6 episodes annually are likely to experience substantial reduction in frequency of outbreaks on suppressive therapy. All patients should be given information on advantages and disadvantages of suppressive therapy in the context of their overall clinical care. Treatment may be interrupted at 6 months to evaluate natural history. A single episode after stopping suppressive therapy is not necessarily an indication for recommencement of suppression.
People living with HIV with normal CD4 counts	-	Antiviral doses and duration is the same as for those without HIV.
People living with HIV who have moderate to severe immunosuppression	-	Initial or primary infections should be treated with twice the usual dose. If new lesions continue to develop 3-5 days after treatment has started, a further increase in dose may be necessary. Treatment should be continued until re-epithelialisation has occurred, which may exceed 10 days. For episodic treatment of recurrences not responding to standard doses, use twice the usual dose and continue treatment for 5 days or longer, depending on clinical response. Suppressive therapy should be given at least twice daily. The usual doses are usually effective, but may be doubled if recurrences are not satisfactorily controlled. Non-healing lesions may be seen in both severe immunodeficiency and as part of an immune reconstitution inflammatory syndrome following commencement of antiretroviral therapy. Such lesions require referral for further virological assessment and topical and/or intravenous therapy.
Herpes in Pregnancy	-New Zealand Herpes Foundation STIEF-	

Disclaimer

We recognise that gender identity is fluid. In our treatment guidelines, the words and language we use to describe genitals and gender are based on the sex assigned at birth.

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