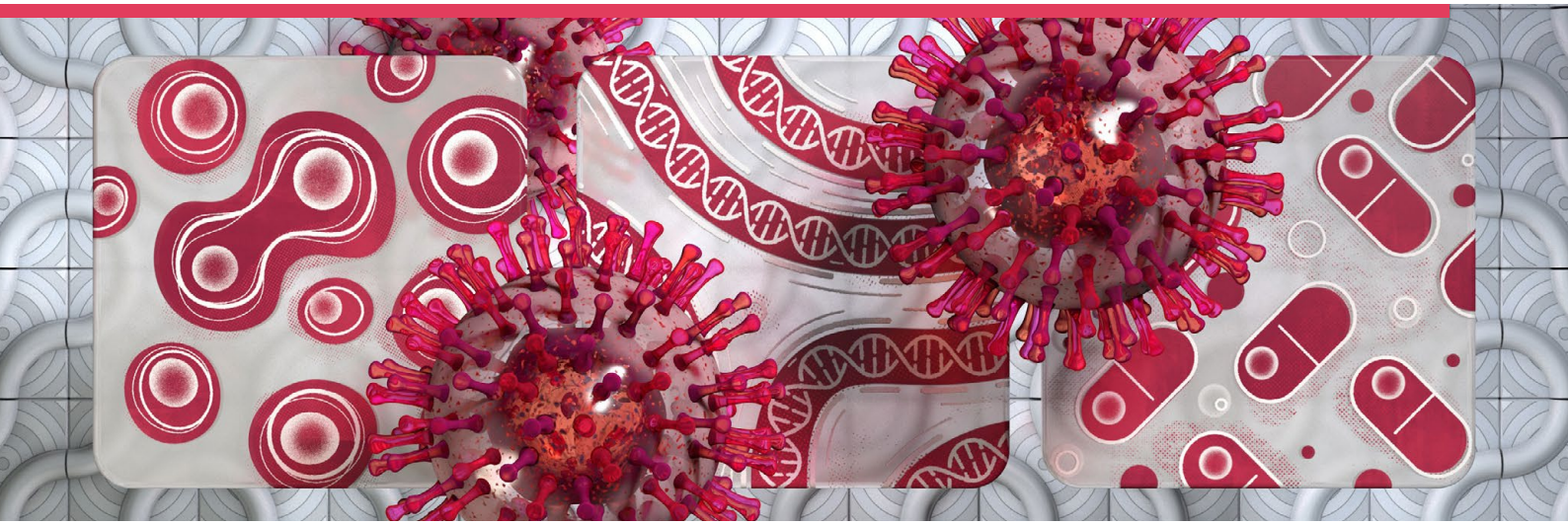


Management of genital herpes: reducing stigma

From a medical perspective, genital herpes is a straight-forward, easily treated condition for most patients. However, significant social stigma is often associated with a diagnosis. Effective management of genital herpes requires consideration of both medical and psychosocial implications. The 2024 Guidelines for the Management of Genital Herpes in Aotearoa New Zealand provide a comprehensive reference for all aspects of management.

KEY PRACTICE POINTS

- There are two subtypes of herpes simplex virus (HSV) that can cause genital herpes: HSV-1 and HSV-2. HSV-2 has historically been the predominant cause of genital herpes, but the incidence of HSV-1 genital herpes is now high and increasing in young adults.
- HSV can be transmitted via oral-to-anogenital or anogenital-to-anogenital contact with a person who is shedding either HSV subtype from the face or the genitalia. Transmission can occur even in the absence of symptoms, due to periodic asymptomatic shedding.
- Most people who acquire HSV are unaware. In those who do develop symptoms, painful anogenital lesions typically appear 2 – 14 days after HSV acquisition, often associated with dysuria. Less commonly, patients may also report pruritus, vaginal, urethral or anal discharge, or systemic symptoms, e.g. lymphadenitis, fever, headache, sacral/lumbar nerve pain radiating to the thighs or back.
  - HSV infection can also lie dormant for some time following acquisition, meaning that symptoms do not appear until months or years after initial infection
- Genital HSV infection can also cause proctitis, an inflammatory condition of the distal rectum. Symptoms may include anal pain or bleeding, constipation, tenesmus, difficulty urinating and sacral paraesthesia.
- Treatment for genital herpes can be commenced based on clinical presentation, however, polymerase chain reaction (PCR) confirmation of HSV infection is required to confirm the diagnosis and identify the HSV subtype. A swab collected from open ulcers or deroofed vesicles is most likely to be diagnostically useful. If herpes proctitis is suspected, collect an anal/rectal swab.
  - Also request syphilis serology and offer a full sexual health check with routine STI testing (including HIV serology), as appropriate
- Initiate oral antiviral treatment with valaciclovir (or alternatively, aciclovir) while awaiting PCR results. Treat for seven days or longer if lesions have not re-epithelialised or new lesions continue to develop; extended treatment may be required for severe episodes. Consider also prescribing a "back pocket" supply of episodic treatment.
  - Seek specialist advice or referral for patients who are immunocompromised or pregnant and those with suspected herpes proctitis
- Some patients with genital herpes experience recurrent episodes due to periodic HSV reactivation; recurrences are more frequent with HSV-2 than HSV-1. Management depends on individual circumstances and may involve supportive care only, episodic antiviral treatment or continuous suppressive antiviral treatment.
  - Suppressive antiviral treatment may be appropriate for patients who experience frequent or severe recurrent episodes or are concerned about transmitting HSV
  - Suppressive treatment is also generally recommended following a first episode of genital herpes that occurs during pregnancy and in pregnant people with a history of genital herpes
- A genital herpes diagnosis is distressing for many patients. Provide education in a supportive and non-judgemental way, and refer patients for psychosocial support, as appropriate, e.g. the Herpes Helpline, sexual health counselling.
  - A common misconception is that the absence of symptoms in a sexual partner implies that they have not acquired HSV. However, this is not necessarily the case, as many people do not develop or recognise symptoms.
- Information about genital herpes for patients and health professionals is available from the New Zealand Herpes Foundation website. Patients can also be referred to the Herpes Helpline for advice.

Genital herpes is caused by infection with the herpes simplex virus

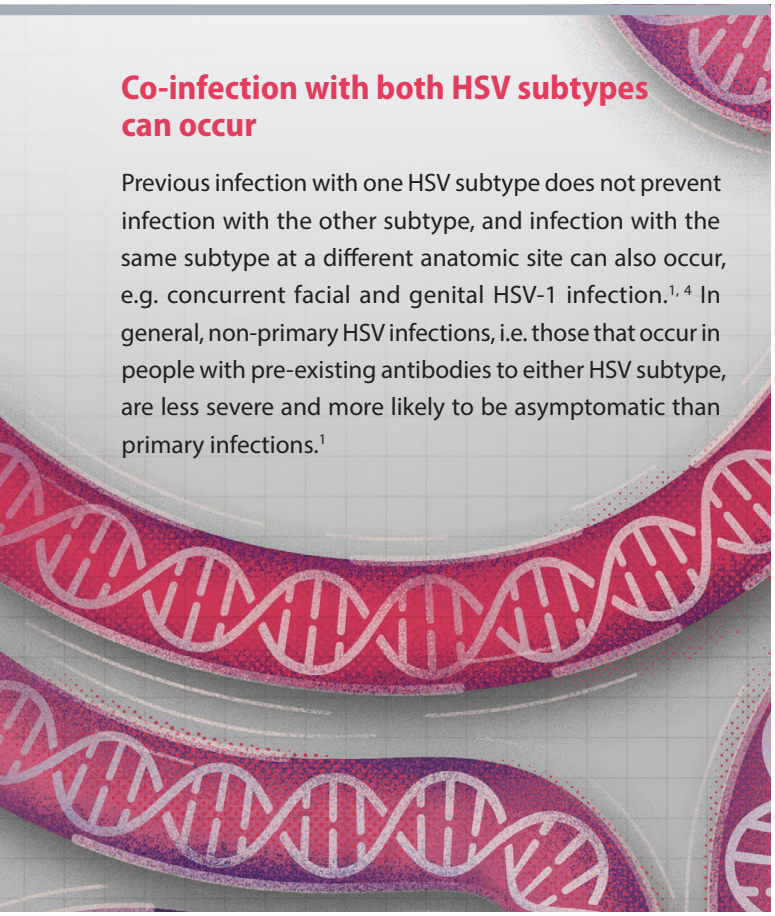
Genital herpes is a sexually transmitted infection (STI) caused by the herpes simplex virus (HSV).[1] There are two subtypes of HSV: HSV type-1 (HSV-1) and HSV type-2 (HSV-2).[1] HSV-2 predominantly causes genital infections and accounts for approximately 70% of laboratory-confirmed cases of genital herpes in Australia and New Zealand.[1, 2] HSV-1 is often associated with facial herpes, i.e. cold sores, but can cause infection at any site.[1] In fact, the epidemiology of HSV-1 is moving away from oral acquisition during childhood as genital acquisition in early adulthood is increasing.[3] In Australia and New Zealand, HSV-1 is the cause of approximately 45% of cases of laboratory-confirmed genital herpes in people aged under 35 years.[3]

HSV infection is highly prevalent

In Australia and New Zealand, approximately 15% of the general population are seropositive for HSV-2.[2] New Zealand data are not available for HSV-1, but approximately 76% of the general Australian population are seropositive for this subtype.[3] As seropositivity does not distinguish the anatomical site of infection, it is not possible to determine the proportion of people who are HSV-1 seropositive that have genital infections (see: "HSV serology: the positives and negatives").[1]

Co-infection with both HSV subtypes can occur

Previous infection with one HSV subtype does not prevent infection with the other subtype, and infection with the same subtype at a different anatomic site can also occur, e.g. concurrent facial and genital HSV-1 infection.[1, 4] In general, non-primary HSV infections, i.e. those that occur in people with pre-existing antibodies to either HSV subtype, are less severe and more likely to be asymptomatic than primary infections.[1]



Most people who acquire HSV are unaware of their status, as they are asymptomatic or experience mild symptoms that are never recognised as genital herpes.[1] Only approximately 20% of people who are seropositive for HSV-2 have been diagnosed with genital herpes.[1]

Both HSV-1 and HSV-2 are transmitted via skin-to-skin contact

Genital HSV-2 infection is most often transmitted via anogenital-to-anogenital contact; HSV-1 can also be transmitted to the genitalia via this route, but is frequently acquired through oral-to-anogenital contact, especially in young adults.[1] HSV enters through a break in the skin or mucous membranes and infects epithelial cells and nerve endings at the site of exposure before travelling via retrograde axonal transport to the sacral ganglia, where it establishes a dormant infection that is life-long.[1] This dormant HSV infection can periodically reactivate, in some cases causing symptomatic episodes of genital herpes.[1]

Risk factors for genital HSV infection

The overall seroprevalence of both HSV-1 and HSV-2 increases with age, as HSV infection persists for life.[1] However, the incidence of HSV-2 infection is highest among young adults.[1] Risk factors for the acquisition of genital HSV infection include:[5]

- Female sex
- Multiple sexual partners
- Infection with other STIs
- Oral-to-anogenital contact with a partner with facial herpes (HSV-1)

Most cases of genital herpes are acquired sub-clinically

Most people acquire genital herpes from a sexual partner who is unaware that they are infected with HSV or do not realise that they can transmit HSV after a symptomatic episode has resolved.[1] HSV can periodically reactivate without symptoms developing; this is termed asymptomatic shedding, and is a significant contributor to the transmission of HSV.[1, 6]

The incubation period of HSV is highly variable

If genital herpes lesions develop, onset usually occurs within 2 – 14 days of HSV acquisition (see: "Diagnosing a first episode of genital herpes").[1] However, some people may not experience a first episode for months or years after acquiring HSV and many never develop or recognise lesions at all.[1]

Painful anogenital lesions are a characteristic feature of genital herpes

Genital herpes lesions typically start as clusters of multiple, fluid-filled vesicles (2 – 4 mm in diameter) in the anogenital region that progress to painful ulcers; individual ulcers may

coalesce, resulting in larger regions of ulceration.[7, 8] Over time, the ulcers form a crust and heal, usually without signs of scarring.[1] Genital herpes lesions can also have an atypical appearance, e.g. resembling linear skin splits or fissuring.[1] The onset of lesions may be preceded by localised prodromal symptoms, e.g. tingling, pain.[9] Patients also often have dysuria and bilateral inguinal lymphadenitis; in some cases, dysuria may be the only symptom, e.g. in females without visible lesions.[1] Less commonly, symptoms may include pruritus, vaginal, urethral and/or anal discharge or sacral/lumbar nerve pain radiating to the thighs or back.[1] Genital HSV infection is also a significant cause of proctitis, see: "Herpes proctitis: a potential presentation of genital HSV infection".[1, 10]

For images of genital herpes lesions, see: https://dermnetnz.org/topics/genital-herpes-images

Local symptoms may be accompanied by systemic or psychological symptoms

Patients with genital herpes may also present with flu-like systemic symptoms, e.g. fever, headache, myalgia.[1] Systemic symptoms are more likely during a first episode of genital herpes (fever is present in approximately 60% of patients with a primary infection),[13] and in females relative to males.[1, 4]

Psychological symptoms, e.g. tearfulness, low mood, are relatively common and may reflect a response to physical symptoms or concerns about their implications (see: "Managing the psychosocial impact of a genital herpes diagnosis"). It is important to be aware that distress associated with a symptomatic episode of genital herpes can trigger a depressive, or rarely, a psychotic episode, particularly in people with pre-existing mental health conditions.

Diagnosing a first episode of genital herpes

The severity of symptoms associated with a first episode of genital herpes can differ significantly between patients.[1] However, a person's first episode will usually be the most severe.[1]

Refer to the genital ulcer disease pathway

The genital ulcer disease pathway in the Aotearoa New Zealand STI Management Guidelines for use in primary care provides a concise management summary for a patient presenting with a genital sore or ulcer.[14] It is recommended that syphilis serology is requested for all patients and that a full sexual health check with routine STI testing (including HIV serology) is offered, as appropriate.[14]

For further information on sexual health checks and STI testing recommendations, see: https://sti.guidelines.org.nz/sexual-health-check/

Perform a physical examination if genital herpes is suspected

Examine the genital area to assess the presence and extent of lesions.[1] During a first episode of genital herpes, lesions are usually distributed bilaterally and affect the external genitalia and/or the peri-anal region.[10] Lesions may also be present on the cervix, in the rectum (see: "Herpes proctitis: a potential presentation of genital HSV infection") or at extragenital sites, e.g. the thighs or buttocks.[1] Also palpate for enlarged or tender inguinal lymph nodes and check body temperature.[1, 13]

Herpes proctitis: a potential presentation of genital HSV infection

Both subtypes of HSV have been associated with proctitis, an inflammatory condition that affects the distal rectum.[11] Herpes proctitis often affects men who have sex with men (MSM), with a higher prevalence in those with human immunodeficiency virus (HIV).[1] However, any person with a history of receptive anal sex, e.g. oral, genital, digital, may be at risk.[1]

Herpes proctitis is characterised by the presence of herpetic vesicles, mucosal ulceration and oedema in the distal rectum.[1] Visible external ulceration is not always present (reported in approximately 30% of cases of herpes proctitis in MSM), but intra-anal lesions may be extensive.[1, 11] Similarly, palpable external lymph nodes may be absent.[12] Consider herpes proctitis in any patient with a history of receptive anal sex with severe anal pain or bleeding, constipation, tenesmus, difficulty urinating and/or sacral paraesthesia.[1]

For further information on herpes proctitis, see: guidelines.stief.org.nz/herpes-first-clinical-episode-genital-herpes

Table 1. Key differential diagnoses for genital herpes.

Differential diagnosis		Key dermatological features	Recommended investigations
Syphilis N.B. Syphilis serology should be routinely requested for all patients who present with genital ulcers.[14]	**Primary**	Single, often painless, ulcer 1 – 2 cm in diameter with a well-defined margin and indurated base (chancre).[14, 16] Approximately 30% of patients have multiple chancres.[14]	Syphilis serology If clinical presentation is compatible with syphilis or patient is high-risk, e.g. MSM, pregnant, also seek sexual health advice; syphilis PCR may be indicated (specialist access only)[14]
	Secondary	Rough, red-brown rash; usually generalised, though may only affect the palms and soles of feet.[14, 16] May also have painless, flat, warty growths in the anogenital region (condylomata lata) and/or alopecia.[16]	
	Tertiary	Skin lesions (gummas) are a potential complication of late-stage disease[14]	
Mpox (formerly Monkeypox)		Initial lesions are often macules, generally 2 – 5 mm in diameter; may be pruritic or painful.[8] The macules follow a characteristic progression to papules, clear-fluid filled vesicles, yellow fluid-filled pustules and finally scabs that fall off approximately three weeks after lesion onset.[8]	Mpox viral PCR. Ideally, collect a sample of fluid from vesicles or pustules using a swab; if not possible, dry crusts or biopsy material can be tested.[17]
Also consider:[1, 14] ■ Other STIs, e.g. HIV, LGV, tropical genital ulcer diseases ■ Non-sexually transmitted infections, e.g. candidiasis, folliculitis, herpes zoster ■ Non-infectious causes, e.g. aphthous ulcers, pemphigus vulgaris, mucous membrane pemphigoid			

For further information on the management of genital ulcers, see: https://sti.guidelines.org.nz/

Consider differential diagnoses

Key differential diagnoses for genital herpes are presented in Table 1. In New Zealand, most genital ulcers are caused by either HSV or syphilis.[14] However, genital ulceration may also be associated with other STIs, e.g. Mpox, HIV or lymphogranuloma venereum (LGV; not a common presentation but incidence is increasing in New Zealand).[15] Human papillomavirus (HPV) is unlikely to be mistaken for HSV – genital warts are painless, usually raised and may have a cauliflower-like appearance.[16]

Tropical genital ulcer diseases, e.g. chancroid, donovanosis, are rare but should be considered in patients with a history of sexual contact overseas and those in higher risk population groups, e.g. MSM.[14] Genital herpes can also co-exist with other STIs, complicating diagnosis.

Also consider non-sexually transmitted infections, e.g. candidiasis, folliculitis.[1] Patients with herpes zoster infection, i.e. shingles, may present with vesicular lesions in the anogenital region, however, this is rare and the lesions are almost always unilateral.*[1] Genital ulceration may also be associated with other viral infections, e.g. Epstein-Barr, SARS-CoV-2.[14]

* Unilateral vesicular lesions may also be associated with a recurrent episode of genital herpes, see: "Recurrent episodes of genital herpes"

Non-infectious causes of anogenital lesions include aphthous ulcers and autoimmune blistering disorders, e.g. pemphigus vulgaris, mucous membrane pemphigoid.[1, 18]

PCR testing is necessary to confirm a genital herpes diagnosis

If genital herpes is suspected based on clinical presentation, collection of a swab from the lesion(s) for polymerase chain reaction (PCR) testing is required to confirm the diagnosis and identify the HSV subtype.[1] Also request syphilis serology and other STI tests, as appropriate (see: "Refer to the genital ulcer disease pathway"). HSV serology is not routinely recommended (see: "HSV serology: the positives and negatives").[1]

The accuracy of a viral PCR result is highly dependent on sample quality

Collect a swab from the base of the lesion(s); if tolerated, deroof vesicles to increase the viral load collected.[9] Swabs that are collected soon after lesions develop are most likely to be diagnostically useful, as lesions that have formed a scab or dried out generally yield lower viral loads.[13] If herpes proctitis is suspected (see: "Herpes proctitis: a potential presentation of genital HSV infection"), collect an anal/rectal swab for PCR testing (also see: "Additional considerations for managing herpes proctitis").[1]

HSV serology: the positives and negatives

In New Zealand, routine HSV serology is not recommended for patients with suspected genital herpes as the clinical interpretation of results is complex and unnecessary testing can result in harm, e.g. health anxiety.[1]

Consider requesting HSV serology in the following situations:[1]

- Patients with a suspected first episode of genital herpes during pregnancy, to inform maternal-fetal transmission risk and, therefore, management
- Asymptomatic patients who are pregnant, or intending to become pregnant, with a partner with known genital herpes, to determine their HSV status and guide management during their pregnancy
- Patients with recurrent genital disease of unknown cause, i.e. if clinical suspicion of genital herpes persists despite multiple negative HSV PCR results

HSV serology testing detects the presence of HSV IgG antibodies in the blood; seropositivity for either HSV-1 or HSV-2 implies past infection (Table 2).[1] However, the absence of antibodies does not definitively exclude prior HSV infection, as the process of antibody production, i.e. seroconversion, is highly variable; it can take from weeks to months, and in some people may not occur at all.[1] In the absence of antigenic stimulation some people may also revert from seropositive to seronegative.[1]

Seropositivity does not identify the anatomical site of HSV infection.[1] Seropositivity for HSV-2 most likely reflects previous genital infection as facial HSV-2 infection in isolation is rare.[1] However, seropositivity for HSV-1 may imply previous facial or genital infection.[1] HSV-1 antibody testing also has variable performance depending on the population tested and can produce false negative and false positive results.[1]

Table 2. Interpretation of HSV serology results. *Adapted from the Sexually Transmitted Infections Education Foundation (2024).*[1]

	HSV-2 negative	HSV-2 positive
HSV-1 negative	■ Implies no prior infection with either HSV subtype* ■ Consider patient at risk of infection with both HSV-1 and HSV-2	■ Implies prior infection with HSV-2; most likely genital ■ Consider patient at risk of infection with HSV-1
HSV-1 positive	■ Implies prior infection with HSV-1; either facial or genital ■ Consider patient at risk of infection with HSV-2	■ Implies prior infection with both HSV subtypes; most likely genital HSV-2 and facial HSV-1

* May also indicate that seroconversion has not yet occurred (for either, or both, subtypes), i.e. the sample was collected outside the test window period, or that the patient has sero-reverted[1]

HSV infection may be associated with HIV infection

There is epidemiological evidence that HSV infection increases the replication and transmission of HIV, and that infection with HSV-2 increases the risk of acquiring HIV.[6] The seroprevalence of HSV-2 is also higher in people who are HIV-positive.[2]

People with HSV/HIV co-infection experience more frequent episodes of asymptomatic HSV shedding.[1] Those with HIV-mediated immunosuppression, e.g. late-stage HIV, are also more susceptible to complications with genital herpes, e.g. herpes proctitis, clinically refractory genital herpes.[1]

For further information on the management of genital herpes in people with HIV, see: https://www.bashh.org/resources/23/updated_guideline_anogenital_herpes_2024/

Management of a first episode of genital herpes

Empiric oral antiviral treatment is indicated for all patients with a suspected first episode of genital herpes.[1] The primary aims of treatment are to reduce the severity and duration of symptoms and the risk of complications (see: "Potential complications of a first episode of genital herpes").[1, 6] Genital herpes is often associated with social stigma and a diagnosis can have a significant psychological impact; see: "Managing the psychosocial impact of a genital herpes diagnosis".[1]

Oral antiviral treatment is recommended for all patients with suspected genital herpes

Initiate oral antiviral treatment for all patients with suspected genital herpes while awaiting laboratory results, independent of time since lesion onset; seek specialist advice for immunocompromised patients.[1, 22] Also see: "Managing genital herpes in pregnancy".

Oral valaciclovir, twice daily, for seven days is the first-line treatment option; aciclovir is an alternative (Table

Managing the psychosocial impact of a genital herpes diagnosis

Patients may experience a range of emotions when informed that they have genital herpes, e.g. guilt, shame, anger, shock.[1] For some patients, a diagnosis can worsen or trigger the onset of a mental health condition, e.g. depression, anxiety, psychosis.[21] Many factors influence how a patient responds, e.g. their coping strategies, level of support, social and cultural beliefs about sexuality; conduct a psychological harm risk assessment, and seek mental health advice as appropriate.[1]

Patients are often concerned about the impact of their diagnosis on their relationships, e.g. fear of rejection from sexual partners, suspicions of infidelity.[1] Addressing these concerns is essential for helping them understand and process their diagnosis.[1] It is important not to apportion "blame" to either the patient or a partner for causing the infection. Provide information about genital herpes in a non-judgemental way and refer patients to accurate, up-to-date resources, e.g. the New Zealand Herpes Foundation website, the Herpes Helpline.[1]

When delivering a genital herpes diagnosis, explain that:[1, 6]

- Many people have genital herpes and there are effective medicines available to treat it
- Genital herpes does not negatively impact a person's overall health, life-expectancy or fertility; it is equivalent to having a cold sore on the genitalia
- The absence of symptoms in a sexual partner does not mean that they have not acquired HSV, as many people do not develop or recognise symptoms
- A diagnosis of genital herpes while in a monogamous relationship does not imply that either sexual partner has been unfaithful. As many people are infected with HSV, either or both partner(s) may have entered the relationship with a pre-existing infection. A subsequent symptomatic episode of genital herpes may reflect HSV transmission from an asymptomatic partner or the first outbreak of a pre-existing HSV infection (can occur after months or years).
  - Genital herpes can also be acquired following oral sex with a partner with facial herpes, i.e. cold sores, even when active cold sores are absent
- People with genital herpes can resume sexual contact once their lesions have resolved and there are measures that they can take to reduce the risk of transmitting HSV (see: "Educate patients about reducing the risk of HSV transmission")

If a single appointment is insufficient to address all of the patient's concerns, schedule a follow-up appointment or consider referral for additional support, e.g. counselling at a local sexual health clinic, the Herpes Helpline.

For further information on counselling patients when delivering a genital herpes diagnosis, see: guidelines.stief.org.nz/counselling-diagnosis

3).[1, 22] All patients should be encouraged to maintain adequate hydration for the duration of antiviral treatment as renal toxicity can occur.[22] Dose adjustment is required in patients with renal impairment.[22]

Topical antiviral treatments, e.g. aciclovir cream, are not recommended, as they provide limited benefit for genital lesions.[1]

For further information about the toxicity of valaciclovir and aciclovir in renal impairment, see: medsafe.govt.nz/profs/PUArticles/December2024/Aciclovir-and-valaciclovir-toxic-in-renal-impairment.html

Managing co-infection with another STI

If co-infection with genital herpes and another STI is identified, they can usually be treated concurrently but consider potential medicine interactions, e.g. increased risk of renal toxicity with ceftriaxone (gonorrhoea) or tenofovir disoproxil (HIV).

Medicine interactions can be checked on the NZF: nzf.org.nz

Additional considerations for managing herpes proctitis

Ideally, patients with suspected herpes proctitis should be referred to specialist sexual health services for management; if this is not possible, seek sexual health advice.[14] As proctitis can also be caused by other STIs and non-infectious causes, collect rectal swabs for chlamydia, gonorrhoea and HSV, ideally via a proctoscope, in addition to conducting a full STI screen.[14] LGV testing is indicated for patients with a positive rectal chlamydia test result (not routinely offered in the community; seek specialist advice).[14] Also request faecal culture in patients with diarrhoea.[14]

Initiate treatment for non-specific proctitis while awaiting laboratory results (Table 4).[14]

Table 4. Treatment of non-specific proctitis.[1, 14]

Medicine	Dose	Duration
Doxycycline (oral)	100 mg, twice daily	21 days*
Valaciclovir (oral)†	500 mg, twice daily	Seven days**
Ceftriaxone (intramuscular injection)	500 mg in 2 mL of 1% lidocaine	Single dose

* Treatment for 21 days is indicated to cover the possibility of LGV

† Aciclovir, 400 mg, three times daily, is an alternative if valaciclovir is not tolerated

** Continue treatment until pain from all causes has resolved

Once laboratory results are available, discontinue medicines that are not required;[14] expert opinion is that antiviral treatment should be continued until pain from any cause has fully resolved.

Table 3. Oral antiviral regimens for a first episode of genital herpes.[1, 22] For information on contraindications, monitoring, adverse effects and interactions, refer to the New Zealand Formulary (NZF): nzf.org.nz.

Treatment of a first episode of genital herpes		
Oral antiviral	**Dose**	**Duration**
First-line: Valaciclovir	500 mg, twice daily N.B. If creatinine clearance < 30 mL/minute, reduce dose to 500 mg, once daily.	Seven days*
Alternative: Aciclovir	400 mg, three times daily N.B. If creatinine clearance < 10 mL/minute, reduce dose to 200 mg, twice daily.	

* Extended treatment is indicated if lesions have not re-epithelialised, i.e. are still open, or new lesions continue to develop after seven days.

N.B. A longer course of antiviral treatment may be required for patients who are immunocompromised; seek specialist advice.

Best Practice Tip: In addition to a seven-day course of oral antiviral treatment, consider also prescribing a "back pocket" three-day episodic course. The lesions associated with a primary episode of HSV-1 genital herpes may persist for longer than seven days; if this occurs, treatment can be extended with the three-day course. In patients with HSV-2 genital herpes, episodic treatment may be useful in the event of an early recurrent episode. Also see: "Consider anticipatory episodic antiviral treatment".

For further information on the management of patients with anorectal symptoms, see: https://sti.guidelines.org.nz/syndromes/anorectal-syndromes/

Recommend supportive care measures

Most people with genital herpes will achieve sufficient pain relief with paracetamol and ibuprofen.[1] Topical 2% lidocaine gel (available over-the-counter), ice packs and saline soaks may provide additional symptomatic relief.[1] In patients with significant pain, a mild opioid, e.g. codeine, may be considered for short-term use only.[1]

Urination can be very painful, particularly in people with extensive lesions.[9] To prevent urinary retention, advise patients not to "hold on" and to maintain sufficient fluid intake as this may reduce pain by diluting the urine.[1] Urinating under water, e.g. while showering, may further decrease discomfort.[1] Also advise patients to avoid using cleansers, e.g. soap, body wash, antiseptic solutions, on the genital area as they may cause additional skin irritation.[1]

Follow up after a genital herpes diagnosis

Genital herpes lesions may not heal completely by the end of the antiviral course and mild pain or tingling may persist.[1] However, extended treatment is generally only indicated if the patient's lesions have not re-epithelialised (i.e. they are still open) or new lesions continue to develop after seven days; prescribe an additional three days of antiviral treatment (Table 3).[1] Advise patients to return if they experience ongoing symptoms or require additional psychosocial support (see: "Managing the psychosocial impact of a genital herpes diagnosis").[1]

Contact patients with their laboratory results once they are available and make a plan for ongoing management. In patients with PCR-confirmed genital herpes, consider prescribing a "back pocket" supply of episodic antiviral treatment so that they can self-manage recurrent episodes (see: "Consider anticipatory episodic antiviral treatment").[1] Also offer patients with HSV-2 genital herpes suppressive antiviral treatment to reduce the frequency of recurrent episodes (see: "The role of suppressive antiviral treatment"). If the patient's viral PCR result was negative for HSV but it is a suspected false negative, e.g. due to insufficient viral load on the sample, advise them to return if they experience symptoms or signs of a recurrent episode so that another viral swab can be collected to confirm the diagnosis (see: "Viral swab PCR is not generally required for recurrent lesions"). Patients with HSV-negative genital ulcers that have not resolved should be discussed with, or referred to, a sexual health specialist.[14]

Educate patients about reducing the risk of HSV transmission

Advise patients to avoid sexual activity while they have active lesions.[1] Also explain that they will need to take ongoing precautions to prevent HSV transmission to sexual partners even after their lesions have healed, due to asymptomatic shedding.[1] Asymptomatic shedding increases in the week preceding and following a symptomatic episode, and intermittent episodes of asymptomatic shedding occur most often in the first year following HSV acquisition; frequency is higher with HSV-2 relative to HSV-1, and with concurrent HIV infection.[1]

Consistent condom use is advisable, as it has been demonstrated to reduce the risk of HSV transmission.[1, 6] However, condoms do not provide complete protection, e.g. they may not prevent contact with all affected areas or genital secretions, and can slip or break.[1] Patients who are concerned about transmitting HSV may wish to consider continuous suppressive antiviral treatment as an adjunct to condom use (see: "The role of suppressive antiviral treatment").[1] Reassure patients that HSV is not transmitted through contact with inanimate objects, e.g. sheets, towels, toilet seats.[10]

Implications of a genital herpes diagnosis for sexual partners

In New Zealand, HSV is not a notifiable disease and contact tracing is not required.[14] Patients can be counselled that although there is no need to inform casual sexual contacts, disclosing their diagnosis to regular sexual partner(s) promotes transparency in the relationship and it is likely that they have already acquired HSV, even if asymptomatic. Patients are often worried about sharing their diagnosis; approach the topic of disclosure sensitively and provide practical advice tailored to the patient's circumstances.[6]

HSV serology (i.e. to find out if they have HSV antibodies) is not recommended for sexual partners of people with genital herpes, due to the significant risk of false negative and false positive results (see: "HSV serology: the positives and negatives").[1] PCR testing for HSV is indicated if the partner is symptomatic, i.e. has anogenital lesions that can be swabbed.

Potential complications of a first episode of genital herpes

The risk of local and systemic complications with a first episode of genital herpes is increased if treatment is delayed.[6] Superinfection of lesions, e.g. with *Candida* or *Streptococcus* species, can occur in the second week of progression, particularly in patients with extensive lesions.[10] Neurological complications, e.g. meningitis, encephalitis, acute radiculitis (potentially associated with acute urinary retention or sacral neuralgia), occur infrequently.[7] Infection with HSV is a primary trigger for erythema multiforme (particularly HSV-1) and a significant risk factor for Bell's Palsy, however both conditions have a population prevalence of < 1%.[19, 20] Disseminated HSV infection, i.e. spread into the bloodstream (viraemia) and to other organs, is very rare but associated with a significant risk of mortality.[1]

For further information on the identification and management of complications associated with a first episode of genital herpes, see: guidelines.stief.org.nz/herpes-first-clinical-episode-genital-herpes

Recurrent episodes of genital herpes

Following resolution of a first episode of genital herpes, the dormant HSV infection in the sacral ganglia can periodically reactivate, resulting in a return of symptoms, i.e. a recurrent episode.[1, 9] Reactivation can occur due to a range of triggers, such as:[1, 9]

- Psychological distress
- Illness
- Hormonal contraceptive use
- Bacterial vaginosis
- Colonisation with Group B *Streptococcus* (GBS)
- HIV co-infection

Recurrent episodes are approximately four times more frequent with HSV-2 genital herpes than HSV-1.[10] People with HSV-2 genital herpes experience an average of four recurrent episodes per year.[1] Most people with HSV-1 genital herpes (70%) will experience a recurrent episode in the first year following their diagnosis.[1] However, over 50% will not experience a recurrent episode after this time, with the recurrence rate further declining over time.[1] Recurrent episodes occur more frequently in immunocompromised people.[4]

Recurrent lesions are usually less severe, e.g. smaller, less numerous, unilateral and restricted to the infected dermatome, and may present atypically, e.g. small fissures.[1] The onset of recurrent lesions is often preceded by prodromal symptoms, e.g. localised tingling, burning or shooting pain, by 12 – 24 hours.[4]

Viral swab PCR is not generally required for recurrent lesions

PCR testing is usually only required if the patient's diagnosis has not yet been virologically confirmed, e.g. an adequate viral swab sample could not be collected during their first episode, or if lesions affect a new area.[1] Swabs collected within 24 hours of lesion onset are generally the most valuable for virological confirmation, as the viral load in recurrent lesions is generally lower.[1]

If clinical suspicion of genital herpes remains following a negative HSV PCR result, discuss with, or refer to, a sexual health specialist; type-specific HSV serology testing may be appropriate (see: "HSV serology: the positives and negatives").[1]

Managing recurrent episodes of genital herpes

There are three strategies for the management of patients with virologically-confirmed genital herpes who experience recurrent episodes:[1]

1. **Supportive care only** – the use of non-pharmacological self-care measures to manage symptoms, e.g. if mild or infrequent symptoms only
2. **Episodic antiviral treatment** – the short-term use of oral antiviral treatment during a recurrent episode to reduce symptoms and the duration of viral shedding
   - Patients can be prescribed a "back pocket" supply so that they can self-manage recurrences (see: "Consider anticipatory episodic antiviral treatment")
3. **Suppressive antiviral treatment** – the continuous use of oral antiviral treatment, either short- or long-term, to reduce the frequency of recurrent episodes and risk of HSV transmission

The best management strategy will differ between patients and may change over time; develop an individualised management plan in collaboration with the patient.[1] Also see: "Managing genital herpes in pregnancy".

Episodic antiviral treatment reduces the severity and duration of recurrent episodes

Antiviral treatment (Table 5) reduces the duration of symptoms and viral shedding associated with recurrent episodes of genital herpes.[1] Early initiation significantly improves efficacy, e.g. if started during the prodromal period, patients may be able to prevent the onset of lesions.[1]

Table 5. Episodic antiviral regimens for recurrent episodes of genital herpes.[1, 22] For information on contraindications, monitoring, adverse effects and interactions, refer to the NZF: https://nzf.org.nz/.

Episodic treatment of a recurrent episode of genital herpes		
Oral antiviral	**Dose**	**Duration**
First-line: Valaciclovir	500 mg, twice daily N.B. If creatinine clearance < 30 mL/minute, reduce dose to 500 mg, once daily.	Three days
Alternative: Aciclovir	800 mg, three times daily N.B. If creatinine clearance < 10 mL/minute, reduce dose to 200 mg, twice daily.	Two days

N.B. A longer course of episodic antiviral treatment may be required for patients who are immunocompromised; seek specialist advice.

Some pharmacists who have undergone additional training can prescribe episodic antiviral treatment with valaciclovir for patients with known genital herpes under a standing order (charges apply).[1] For further information, see: https://www.herpes.org.nz/help-and-resources/find-sexual-health-clinic-or-pharmacy.

Consider anticipatory episodic antiviral treatment

New Zealand guidelines recommend the prescription of anticipatory episodic antiviral treatment following virological confirmation of genital HSV infection.[1] In practice, the quantity of tablets prescribed as a "back pocket" supply will depend on the known, or anticipated, frequency of a patient's recurrent episodes, e.g. patients with HSV-2 genital herpes may require a larger supply, as they are likely to experience more frequent recurrences (see: "Recurrent episodes of genital herpes"). Six tablets of either valaciclovir or aciclovir is sufficient for the treatment of one recurrent episode (Table 5); advise the patient to initiate treatment at the first sign of a recurrent episode, ideally during the prodromal stage or within one day of lesion onset.[1, 22]

The role of suppressive antiviral treatment

The primary aim of continuous suppressive antiviral treatment is to improve quality of life, by reducing the frequency of recurrent episodes of genital herpes and the risk of transmitting HSV.[1]

Suppressive antiviral treatment may be particularly useful for patients with:[1]

1. Frequent or severe recurrent episodes, including those with herpes proctitis
2. Concerns about transmitting HSV, e.g. multiple sexual partners, an asymptomatic sexual partner who is pregnant
3. Immunosuppression, e.g. late-stage HIV
4. Complications associated with recurrent genital herpes, e.g. lumbosacral radiculopathy, erythema multiforme, recurrent proctitis

For further information on complications, see: https://guidelines.stief.org.nz/recurrent-episodes-of-genital-herpes

Suppressive antiviral treatment can be taken short-term or continuously, depending on the patient's circumstances.[1] Short courses may be considered to prevent recurrent episodes when they may be particularly undesirable, e.g. while on holiday, or when more frequent recurrences are anticipated due to high stress, e.g. examinations, work deadlines.[1, 6] Also see: "Suppressive antiviral treatment is recommended prior to delivery".

Prescribing continuous suppressive antiviral treatment

Options for suppressive antiviral regimens are given in Table 6.[22] The full suppressive effect is usually achieved after five days of treatment.[1] Some patients may experience a breakthrough recurrent episode while taking suppressive antiviral treatment; if this occurs, the dose can be increased (Table 6).[1]

Table 6. Suppressive antiviral regimens for patients with genital herpes.[1, 22] For information on contraindications, monitoring, adverse effects and interactions, refer to the NZF: https://nzf.org.nz/.

Suppressive antiviral treatment for genital herpes		
Oral antiviral	**Dose**	
	Initially	**If breakthrough episodes occur**
Valaciclovir	500 mg, once daily	500 mg, twice daily
Aciclovir	400 mg, twice daily	400 mg, three times daily

N.B. Dose adjustment may be required in patients who are immunocompromised and in those with severe renal impairment; seek specialist advice.

Review patients every 12 months to determine whether suppressive treatment is still indicated.[1] If treatment is withdrawn, consider prescribing a "back pocket" supply of episodic treatment (Table 5), as many patients experience a recurrent episode soon after discontinuation.[1] The treatment-free period needs to be long enough to assess whether the frequency of recurrent episodes has changed, e.g. three months or at least two recurrences, in order to determine whether ongoing suppressive treatment is required.[1, 22] Patients who continue to experience frequent and/or severe recurrent episodes may need to continue suppressive antiviral treatment long-term.[1]

Managing genital herpes in pregnancy

The main risk associated with genital herpes during pregnancy is maternal-fetal HSV transmission resulting in neonatal HSV infection, which is rare but potentially serious.[1] Maternal-fetal transmission of HSV mainly occurs during labour; risk is highest if primary genital herpes is acquired in the third trimester, particularly if active lesions are present at delivery.[1] The risk of transmission is low with a history of genital herpes prior to pregnancy.[1] Only approximately 20% of HSV infections in infants are associated with a known history of herpes in the pregnant person or their partner.[1]

For further information on neonatal HSV infection, see: https://guidelines.stief.org.nz/herpes-neonatal-hsv-infection

There are three components to reducing the risk of maternal-fetal HSV transmission:[1]

- Preventing HSV acquisition during pregnancy in people who have not previously been diagnosed with genital herpes, e.g. from partners with known genital herpes
- Identifying and treating a first episode of genital herpes that occurs during pregnancy, and reducing the risk of subsequent recurrent episodes
- Reducing the risk of recurrent episodes during pregnancy in people who have previously been diagnosed with genital herpes

Interventions to reduce the risk of maternal-fetal HSV transmission may be managed by a patient's primary care clinician, lead maternity carer (LMC), obstetrician, or a combination of providers.

No intervention is completely protective against maternal-fetal HSV transmission. All pregnant people with genital herpes should be educated about the risk of HSV transmission and informed that their baby will require monitoring for neonatal HSV infection after birth, regardless of the timing of their first episode or delivery method.[1]

Prevention of genital herpes in pregnancy

Initiate a conversation with patients early in their pregnancy about maternal infections that may affect their baby, including HSV, regardless of their history of genital herpes.[1] Also enquire about their partner's history of facial or genital herpes.[1] This discussion may need to be repeated, e.g. if they have new sexual contacts during the pregnancy.

Considerations for those with a partner with known genital herpes

Request HSV serology for asymptomatic people who are pregnant and have a partner with known genital herpes, to determine their HSV status (see: "HSV serology: the positives and negatives").[1] If serology results indicate that they have HSV antibodies, management is consistent with patients with recurrent genital herpes (see: "Management of recurrent episodes of genital herpes during pregnancy").

People who are pregnant should be advised to avoid sexual activity when their partner has prodromal symptoms or active lesions; this includes oral sex if their partner has facial herpes, due to the risk of oral-to-genital HSV transmission.[1] Also recommend consistent condom use to reduce the risk of HSV transmission due to asymptomatic shedding and consideration of suppressive antiviral treatment for the HSV-positive partner (see: "The role of suppressive antiviral treatment").[1]

Management of a first episode of genital herpes during pregnancy

Seek gynaecology/obstetrics advice for any patient who presents with a suspected first episode of genital herpes during pregnancy.[1] Collect a viral swab from the lesion(s) for PCR testing and request HSV serology to determine whether the first episode is the result of a primary or non-primary infection (see: "HSV serology: the positives and negatives").[1]

Primary HSV infection during pregnancy increases the risk of severe disease

Pregnancy increases the risk of complications with primary HSV infection, e.g. viraemia (HSV enters the bloodstream), disseminated HSV infection.[1, 23] Disseminated HSV infection is rare but has a mortality rate of approximately 50% in people who are pregnant.[1, 23] Symptoms may include sepsis-like illness or impaired/deteriorating liver function; urgent secondary referral is required if disseminated HSV infection is suspected.[1]

Oral antiviral treatment is indicated

Treatment of a first episode of genital herpes during pregnancy is consistent with non-pregnant patients; valaciclovir is first-

Table 7. Prophylactic suppressive antiviral regimens for genital herpes during pregnancy.[1, 22] For information on contraindications, monitoring, adverse effects and interactions, refer to the NZF: https://nzf.org.nz/

Initiate suppressive treatment (under specialist guidance) four weeks before anticipated delivery, e.g. at 36 weeks gestation, or earlier if the patient experiences frequent recurrent episodes			
		Initially	**If breakthrough episodes occur**
Valaciclovir	First trimester	500 mg, once daily	500 mg, twice daily
	Second and early third trimester	500 mg, twice daily*	
Aciclovir	First trimester	400 mg, twice daily	400 mg, three times daily
	Second and early third trimester	400 mg, three times daily*	
From 36 weeks gestation			
		Initially	**If breakthrough episodes occur**
Valaciclovir		500 mg, twice daily until delivery	Seek specialist advice
Aciclovir		400 mg, three times daily, until delivery	Seek specialist advice

* A higher frequency dosing regimen is recommended in the second and early third trimester of pregnancy, due to increased plasma volume[1]

line, aciclovir is an alternative (Table 3).[1] Both valaciclovir and aciclovir are considered safe during pregnancy and maternal oral antiviral treatment has not been associated with an increased risk of adverse neonatal outcomes, e.g. birth defects.[1, 22]

For further information on the evidence regarding the safety of aciclovir and valaciclovir in pregnancy, see: https://guidelines.stief.org.nz/herpes-genital-herpes-in-pregnancy

Suppressive antiviral treatment is recommended prior to delivery

Suppressive antiviral treatment in the final four weeks of gestation is recommended for all patients who present with a first episode of genital herpes during pregnancy, particularly in the third trimester, to reduce the risk of recurrent episodes and viral shedding at the time of delivery.[1, 14]

Suppressive antiviral treatment is generally initiated at 36 weeks gestation, or earlier if pre-term delivery is anticipated, with the aim of ensuring treatment for a minimum of four weeks preceding delivery (Table 7).[1]

Most people who experience a first episode of genital herpes in the first or second trimester can deliver vaginally if they do not have active lesions at term.[1] If the first episode occurs in the third trimester, delivery via Caesarean section is usually required due to high viral shedding and insufficient time for the development of a maternal antibody response.[1]

Management of recurrent episodes of genital herpes during pregnancy

The risk of maternal-fetal HSV transmission is lowest in pregnant people with a history of genital herpes prior to pregnancy, as maternal antibodies are shared with the neonate.[1] The risk of maternal-fetal transmission is < 0.04%* in people who do not experience a recurrent episode during pregnancy and 1 – 3% if active recurrent lesions are present at the time of delivery (greater with HSV-1 than HSV-2).[1] Record a previous diagnosis of genital herpes in the patient's clinical notes and ensure that their LMC is aware of this diagnosis.[1] A maternal history of genital herpes should also be recorded in the infant's clinical notes, following delivery.[1]

* Transmission risk is not zero due to asymptomatic shedding[1]

Recurrent episodes that occur during pregnancy are usually brief and can be treated with episodic antiviral treatment (Table 5) in the first or second trimester (seeking specialist advice first is advisable).[1] Suppressive antiviral treatment for a minimum of four weeks prior to delivery is also recommended (Table 7) and may be initiated earlier in patients who experience frequent recurrent episodes during pregnancy or if there is a risk of pre-term delivery.[1]

As the risk of maternal-fetal transmission at delivery is low, even with active recurrent lesions, most people who experience a recurrent episode of genital herpes during pregnancy are able to deliver vaginally.[1]

Resources

- The 2024 Guidelines for the Management of Genital Herpes in Aotearoa New Zealand are available from: guidelines.stief.org.nz/herpes
- Educational resources for health professionals supporting patients with genital herpes are available from: www.herpes.org.nz/Herpes-health-professionals
- The New Zealand Herpes Foundation website provides comprehensive information about genital herpes for patients, including resources to support people who have recently been diagnosed, see: www.herpes.org.nz
  - The New Zealand Herpes Foundation's The best place in the world to have herpes destigmatisation campaign may be helpful for patients when first diagnosed
- The Herpes Helpline provides free, confidential and non-judgemental advice to New Zealand residents from 9 am – 5 pm, Monday to Friday. Outside of these hours, people can leave a message requesting a return call.
  - From a landline: 0508 11 12 13
  - From a mobile: 09 433 6526
  - Email queries can also be sent to info@stief.org.nz

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References

1. Sexually Transmitted Infections Education Foundation. Guidelines for the management of genital herpes in Aotearoa New Zealand: 13th edition. 2024. Available from: https://guidelines.stief.org.nz/herpes (Accessed Apr, 2026).
2. AlMukdad S, Farooqui US, Harfouche M, et al. Epidemiology of herpes simplex virus type 2 in Canada, Australia, and New Zealand: systematic review, meta-analyses, and meta-regressions. Sex Transm Dis 2022;49:403–13. doi:10.1097/OLQ.0000000000001612.
3. AlMukdad S, Harfouche M, Farooqui US, et al. Epidemiology of herpes simplex virus type 1 and genital herpes in Australia and New Zealand: systematic review, meta-analyses and meta-regressions. Epidemiol Infect 2023;151:e33. doi:10.1017/S0950268823000183.
4. Van Wagoner N, Qushair F, Johnston C. Genital herpes infection: progress and problems. Infect Dis Clin North Am 2023;37:351–67. doi:10.1016/j.idc.2023.02.011.
5. Groves MJ. Genital herpes: a review. Am Fam Physician 2016;93:928–34.
6. Patel R, Moran B, Clarke E, et al. 2024 European guidelines for the management of genital herpes. J Eur Acad Dermatol Venereol 2025;39:742–58. doi:10.1111/jdv.20450.
7. Batteiger TA, Rietmeijer CA. Herpes simplex virus: a practical guide to diagnosis, management, and patient counseling for the primary care clinician. Med Clin North Am 2024;108:311–23. doi:10.1016/j.mcna.2023.08.016.
8. Long B, Liang SY, Carius BM, et al. Mimics of monkeypox: considerations for the emergency medicine clinician. Am J Emerg Med 2023;65:172–8. doi:10.1016/j.ajem.2023.01.007.
9. Meller N. Genital herpes simplex virus infections in women - a clinical update. Clin Obstet Gynecol 2025;68:170–9. doi:10.1097/GRF.0000000000000933.
10. Patel R, Green J, Moran B, et al. British Association of Sexual Health and HIV UK national guideline for the management of anogenital herpes, 2024. Int J STD AIDS 2025;36:90–105. doi:10.1177/09564624241282396.
11. McNeil CJ, Barroso LF, Workowski K. Proctitis: an approach to the symptomatic patient. Med Clin North Am 2024;108:339–54. doi:10.1016/j.mcna.2023.09.002.
12. Hughes Y, Lewis DA. HSV-associated proctitis presenting without perianal lesions: why testing and empirical treatment may be important. BMJ Case Rep 2021;14:e237247. doi:10.1136/bcr-2020-237247.
13. Johnston C, Wald A. Genital herpes. JAMA 2024;332:835–6. doi:10.1001/jama.2024.12743.
14. New Zealand Sexual Health Society. Aotearoa New Zealand STI management guidelines for use in primary care. 2021. Available from: https://sti.guidelines.org.nz/ (Accessed Apr, 2026).
15. Stamm AW, Kobashi KC, Stefanovic KB. Urologic dermatology: a review. Curr Urol Rep 2017;18:62. doi:10.1007/s11934-017-0712-9.
16. Gabrielson AT, Le TV, Fontenot C, et al. Male genital dermatology: a primer for the sexual medicine physician. Sex Med Rev 2019;7:71–83. doi:10.1016/j.sxmr.2018.09.004.
17. Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine. Australian STI management guidelines for use in primary care. 2024. Available from: https://sti.guidelines.org.au/ (Accessed Apr, 2026).
18. Stewart KMA. Challenging ulcerative vulvar conditions: hidradenitis suppurativa, Crohn disease, and aphthous ulcers. Obstet Gynecol Clin North Am 2017;44:453–73. doi:10.1016/j.ogc.2017.05.009.
19. Trayes KP, Love G, Studdiford JS. Erythema multiforme: recognition and management. Am Fam Physician 2019;100:82–8.
20. Neckel N, Nahles S, Heiland M, et al. Risk factors associated with Bell's Palsy: a real-world analysis of 281,600 patients. Eur J Neurol 2025;32:e70336. doi:10.1111/ene.70336.
21. Bennett C, Rebafka A, Carrier J, et al. Impact of primary and recurrent genital herpes on the quality of life of young people and adults: a mixed methods systematic review. JBI Evid Synth 2022;20:1406–73. doi:10.11124/JBIES-21-00057.
22. New Zealand Formulary (NZF). NZF v166. Available from: https://nzf.org.nz/ (Accessed Apr, 2026).
23. Hammad WAB, Konje JC. Herpes simplex virus infection in pregnancy - an update. Eur J Obstet Gynecol Reprod Biol 2021;259:38–45. doi:10.1016/j.ejogrb.2021.01.055.

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