



B-QuiCK: Genital herpes

First episode of genital herpes

- Only a small proportion of people who contract herpes simplex virus (HSV) have symptoms
 - Symptoms typically develop within 2 – 14 days, but in some cases do not appear until months or years later
- The characteristic presentation is clusters of painful fluid-filled vesicles that progress to ulcers, affecting the external genitalia, peri-anal area, cervix, rectum or extragenital sites, e.g. thighs, buttocks
 - Usually bilaterally distributed in a first episode
- Dysuria (may be the only symptom if lesions are not visible) and bilateral inguinal lymphadenitis are common. Flu-like systemic symptoms, e.g. fever, headache, malaise, and psychological symptoms, e.g. tearfulness, low mood, may also be present.
 - Less common symptoms include pruritus, vaginal, urethral or anal discharge and sacral/lumbar nerve pain radiating to the thighs or back
- HSV can cause herpes proctitis; receptive anal sex, e.g. oral, genital, digital, is the main risk factor. Symptoms include severe anal pain or bleeding, constipation, tenesmus, difficulty urinating and sacral paraesthesia. Visible external ulceration and palpable external lymph nodes may be absent.

PCR testing is required to confirm diagnosis

- Collect a swab from the lesion(s); derroof vesicles, if tolerated. Request polymerase chain reaction (PCR) testing to confirm the diagnosis and identify the HSV subtype.
- Request syphilis serology and offer a complete sexual health check with routine STI testing (including HIV serology), as appropriate

If patient is pregnant:

- Seek gynaecology/obstetrics advice
- In addition to PCR testing, request HSV serology to determine whether infection is primary (associated with a higher risk of complications and maternal-fetal transmission) or non-primary

If herpes proctitis is suspected:

- Ideally, refer to specialist sexual health services. If this is not possible, seek sexual health advice.
- Collect rectal swabs for chlamydia, gonorrhoea and HSV (ideally via a proctoscope) and conduct a full STI screen. Also request faecal culture if diarrhoea is reported.
 - Lymphogranuloma venereum (LGV) testing is indicated if rectal chlamydia result is positive (not routinely offered in the community; seek specialist advice)

Management of a first episode of genital herpes

- A first episode of genital herpes can have a significant psychological impact; assess for mental health co-morbidities and conduct a psychological harm risk assessment, as appropriate
- Initiate empiric oral antiviral treatment while awaiting laboratory results, independent of time since lesion onset (see Table 3 for dosing)
 - Consider also prescribing a “back pocket” three-day episodic antiviral course so that treatment can be extended, if required (see Table 5 for dosing)
- Encourage sufficient fluid intake for the duration of antiviral treatment to reduce risk of renal toxicity and alleviate dysuria (by diluting urine)
- Recommend supportive care measures to manage discomfort, e.g. paracetamol, ibuprofen, topical 2% lidocaine gel, ice packs, saline soaks, urinating while showering

Additional management considerations: first episode during pregnancy

- Initiate oral antiviral treatment as for non-pregnant patients (under specialist guidance); both valaciclovir and aciclovir are considered safe during pregnancy
- Record diagnosis in clinical notes and inform the lead maternity carer (LMC)
- Advise suppressive antiviral treatment for a minimum of four weeks prior to delivery, i.e. from 36 weeks gestation or earlier if pre-term delivery is anticipated (see Table 7 for dosing)
- Provide education about maternal-fetal HSV transmission; risk is highest with a primary infection in the third trimester, particularly with active lesions at delivery
 - Explain that the baby will require monitoring for neonatal HSV after birth

Additional management considerations: suspected herpes proctitis

- Initiate treatment for non-specific proctitis (under specialist guidance) while awaiting laboratory results (see Table 4 for dosing)
- Once laboratory results are available, discontinue medicines that are not required
 - Expert opinion is to continue antiviral treatment until pain from any cause has fully resolved

Follow-up after a first episode of genital herpes

- Contact the patient with their laboratory results and develop a management plan:
 - Positive PCR result - consider prescribing a “back pocket” supply of episodic antiviral treatment (see Table 5 for dosing) and offer suppressive antiviral treatment if positive for HSV-2 (see Table 6 for dosing)
 - Negative PCR result - advise patient to return if symptoms recur so that another swab can be collected to confirm the diagnosis. If lesions have not resolved, seek sexual health advice/referral.
- Provide education about asymptomatic shedding and measures to reduce HSV transmission, e.g. avoiding sexual activity with active lesions, consistent condom use, suppressive antiviral treatment
- Explain that contact tracing is not required, however, disclosure to regular sexual partner(s) promotes transparency
 - HSV serology is not recommended for partner(s). However, PCR testing is indicated if symptomatic.
- Consider scheduling a follow-up appointment or referral for additional support, e.g. sexual health counselling, the [Herpes Helpline](#), if required

Recurrent episodes of genital herpes

- Recurrent episodes are more frequent with HSV-2 genital herpes than HSV-1, and in immunocompromised people. Recurrence frequency decreases over time.
- 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
 - Onset is often preceded by prodromal symptoms by 12 – 24 hours

PCR testing not generally required for recurrent episodes

- Only collect a swab from recurrent lesions(s) for PCR testing if they affect a new site or the diagnosis has not been confirmed
- Seek specialist advice if clinical suspicion remains following a negative PCR result

Managing recurrent episodes of genital herpes

Supportive care only: if mild or infrequent recurrent episodes, use non-pharmacological self-care measures to manage symptoms

Episodic antiviral treatment: use oral antiviral treatment during the episode to reduce symptoms and the duration of viral shedding (see Table 5 for dosing)

- Consider prescribing a “back pocket” supply so that episodic treatment can be initiated at the first sign of a recurrence, e.g. during the prodromal period
 - Consider a larger supply of episodic treatment if recurrent episodes are known, or anticipated, to occur frequently, e.g. HSV-2 genital herpes

Suppressive antiviral treatment: use oral antiviral treatment continuously (short- or long-term) to reduce frequency of recurrences and risk of HSV transmission (see Table 6 for dosing)

- Consider suppressive treatment if recurrent episodes are severe, frequent and/or associated with complications or if HSV transmission is a concern, e.g. asymptomatic sexual partner who is pregnant
 - Usually offered for HSV-2 genital herpes, as recurrences are more frequent
 - Can also be used short-term to prevent recurrences during certain circumstances, e.g. high-stress periods
- The full suppressive effect is usually achieved after five days of treatment
- If used long-term, review annually to determine whether suppressive treatment is still indicated

Managing recurrent episodes during pregnancy

- Ensure diagnosis is recorded in clinical notes and inform the LMC
- Treat recurrent episodes in the first or second trimester with episodic antiviral treatment as for non-pregnant people (under specialist guidance)
- Advise suppressive antiviral treatment for a minimum of four weeks prior to delivery, i.e. from 36 weeks gestation or earlier if pre-term delivery is anticipated or recurrent episodes are frequent (see Table 7 for dosing)
- Provide education about maternal-fetal HSV transmission; risk is low with a history of genital herpes prior to pregnancy, as maternal antibodies are protective

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

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.

Table 4. Treatment of non-specific proctitis.

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

Table 5. Episodic antiviral regimens for recurrent episodes of genital herpes. For information on contraindications, monitoring, adverse effects and interactions, refer to the [New Zealand Formulary](#).

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.

Table 6. Suppressive antiviral regimens for patients with genital herpes. For information on contraindications, monitoring, adverse effects and interactions, refer to the [New Zealand Formulary](#).

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.

Table 7. Prophylactic suppressive antiviral regimens for genital herpes during pregnancy. For information on contraindications, monitoring, adverse effects and interactions, refer to the [New Zealand Formulary](#).

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



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