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Royal College of Obstetricians & Gynaecologists

Information for you

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Genital herpes and pregnancy

About this information

This information is for you if you are pregnant and want to know about genital herpes and pregnancy. If you are a partner, relative or friend of someone who is in this situation, you may also find it helpful.

What is genital herpes?

Genital herpes is a common sexually transmitted infection caused by the herpes simplex virus (HSV). There are two types, HSV-1 and HSV-2, both of which can cause infection in the genital and anal area (genital herpes). Herpes simplex can also occur around the mouth and nose (cold sores) and fingers and hand (herpetic whitlows).

In women, genital herpes can occur on the skin in and around the vagina, the vulva (lips around the opening of the vagina), the urethra (tube through which urine empties out of the bladder) and the anus (back passage). In men, it can occur in the skin of the penis, the scrotum, the urethra and the anal area.

How do you get genital herpes?

Genital herpes is usually passed from one person to another during sexual contact. Both women and men can get it. The virus enters the body through small cracks in the skin or through the thin skin of the mouth or genital area. Once you have the virus it stays in your body for life although it remains inactive for most of the time.

You may only get one episode or you may have repeated flare-ups. It can be passed on:

- through skin-to-skin contact with the affected area when the virus is active
- by having unprotected vaginal, anal or oral sex or by sharing sex toys.

What are the symptoms of genital herpes?

Some people have no signs or symptoms at all. Some people just get a few blisters in the genital area, which are not particularly painful. Flare-ups are usually mild. An early-warning tingling sensation often happens before the flare-up occurs.

However, for some people, the symptoms can be very painful. This is particularly so if it is your first episode when you may also feel unwell and notice very painful sores or watery blisters.

Symptoms can occur within a short time of coming into contact with the virus or it may take many weeks, months or years before any signs or symptoms appear.

What should I do if I think I have genital herpes?

Contact your doctor or a clinic that specialises in sexually transmitted infections (called genitourinary medicine clinics or sexual health clinics). You should have a check-up that will include testing, treatment and advice.

It is possible to have more than one sexually transmitted infection at the same time. You may be offered testing to check for other infections too.

What if I get genital herpes for the first time in pregnancy?

What treatment will I be offered?

You should be referred to a specialist genitourinary medicine clinic. You will be offered testing, treatment and support. You may be admitted to hospital if this first episode is very painful or you cannot pass urine.

Genital herpes can be safely treated during pregnancy. You will be offered a course of antiviral tablets. This medication is safe to take in pregnancy and while breastfeeding.

What will a first episode in pregnancy mean for me and my baby?

If your first episode happens in the first 3 months of pregnancy, your baby is not more likely to have developmental problems and your risk of miscarriage is not increased. Later in pregnancy, a first episode should not affect your baby unless you are in labour (see below).

If you go into labour less than 6 weeks after a first episode of genital herpes, your immune system won't have had time to produce antibodies to protect your baby. There is thus a high chance of passing the virus to your baby if you have a vaginal birth. If your first episode is earlier in pregnancy, your immune system will provide protection to your baby.

When a baby catches the herpes virus at birth, it is known as neonatal herpes. It can be serious but is very rare in the UK (1–2 out of every 100 000 newborn babies). Your baby will be looked after in a neonatal unit by a specialist team of doctors.

How can I reduce the risk to my unborn baby?

Medication for you and your baby should help prevent or reduce the chance of your baby being seriously ill:

- if your first episode is before 28 weeks of pregnancy, you may be offered antiviral treatment at that time and again from 36 weeks of pregnancy until your baby is born
- if your first episode is at or after 28 weeks of pregnancy, you will be advised to continue your treatment until your baby is born.

If your first episode is late in pregnancy (within 6 weeks of your due date), you should be offered a planned caesarean section to reduce the chance of your baby getting neonatal herpes.

If your first episode is earlier in pregnancy, the risk to your baby is low and you should be able to have a vaginal birth. Talk to your midwife or doctor if you have any concerns.

What if I have recurrent flare-ups?

- If you have caught genital herpes before you become pregnant, your immune system will provide protection to your baby in pregnancy. Flare-ups of genital herpes during pregnancy do not affect your baby.
- Even if you have a flare-up when you go into labour and give birth, the risk to your baby is extremely low. Most women who have recurrent genital herpes can have a vaginal birth. Your doctor or midwife will discuss this with you.
- If you have frequent flare-ups during pregnancy, you may be offered continuous antiviral treatment from 36 weeks of pregnancy to birth.

If my partner has HSV but I do not, what can I do to reduce the risk to my baby?

During pregnancy, if your partner has an episode of HSV (cold sores, genital herpes or herpetic whitlows), you should avoid skin-to-skin contact with the affected area.

There is a very small risk that a sexual partner who has genital herpes can pass on the infection even when there are no signs or symptoms. You may consider using condoms throughout your pregnancy, particularly in the last 3 months.

After your baby is born, make sure that you wash your hands after touching any sores.

Further information

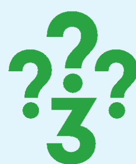
British Association for Sexual Health and HIV: www.bashh.org

Herpes Viruses Association: www.herpes.org.uk

Making a choice

Shared Decision Making

If you are asked to make a choice, you may have lots of questions that you want to ask. You may also want to talk over your options with your family or friends. It can help to write a list of the questions you want answered and take it to your appointment.



Ask 3 Questions

To begin with, try to make sure you get the answers to three key questions if you are asked to make a choice about your healthcare.

1. What are my options?
2. What are the pros and cons of each option for me?
3. How do I get support to help me make a decision that is right for me?

These resources have been adapted with kind permission from the MAGIC Programme, supported by the Health Foundation

* Ask 3 Questions is based on Shepherd HL, et al. Three questions that patients can ask to improve the quality of information physicians give about treatment options: A cross-over trial. Patient Education and Counselling, 2011;84: 379-85

AQuA Advancing Quality Alliance · Right Care Shared Decision Making Programme · NHS

http://www.advancingqualityalliance.nhs.uk/SDM/

Sources and acknowledgements

This information has been developed by the RCOG Patient Information Committee. It is based on the UK national guideline *Management of Genital Herpes in Pregnancy* (2014), a consensus document published by the Royal College of Obstetricians and Gynaecologists (RCOG) and the British Association for Sexual Health and HIV (BASHH). The guideline contains a full list of the sources of evidence we have used. You can find it online at: www.rcog.org.uk/en/guidelines-research-services/guidelines/genital-herpes.

The RCOG produces guidelines as an educational aid to good clinical practice. They present recognised methods and techniques of clinical practice, based on published evidence, for consideration by obstetricians and gynaecologists and other relevant health professionals. This means that RCOG guidelines are unlike protocols or guidelines issued by employers, as they are not intended to be prescriptive directions defining a single course of management.

This information has been reviewed before publication by women attending clinics in Burton on Trent, London and Oxford and by the RCOG Women's Voices Involvement Panel.

A glossary of all medical terms is available on the RCOG website at: www.rcog.org.uk/womens-health/patient-information/medical-terms-explained.

A final note

The Royal College of Obstetricians and Gynaecologists produces patient information for the public. The ultimate judgement regarding a particular clinical procedure or treatment plan must be made by the doctor or other attendant in the light of the clinical data presented and the diagnostic and treatment options available. Departure from the local prescriptive protocols or guidelines should be fully documented in the patient's case notes at the time the relevant decision is taken.

All RCOG guidelines are subject to review and both minor and major amendments on an ongoing basis. Please always visit www.rcog.org.uk for the most up-to-date version of this guideline.

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