



## CLINICAL GUIDELINE

# Ano-Genital Herpes

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

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### Important Note:

The Intranet version of this document is the only version that is maintained. Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

## ANO-GENITAL HERPES

### What's New

- Type Specific serology should only be requested after discussion with GUM DOD
- Changes to 10 Key points and Partner Notification

### Introduction

Genital herpes is caused by infection with the herpes simplex viruses (HSV) of which there are two types (HSV-1 and HSV-2).

### Definitions

- **Initial episode:** First episode with either HSV-1 or HSV-2. Dependent on whether the individual has had prior exposure to the other type, this is further subdivided into:
  - **Primary infection:** first infection with either HSV-1 or HSV-2 in an individual with no pre-existing antibodies to either type.
  - **Non-primary infection:** first infection with either HSV-1 or HSV-2 in an individual with pre-existing antibodies to the other type.
- **Recurrent episode:** recurrence of clinical symptoms due to reactivation of pre-existent HSV-1 or HSV-2 infection after a period of latency.

### Natural History

- Disease episodes may be symptomatic or asymptomatic. It is likely that the majority of infections are acquired sub-clinically as at least 80% of persons seropositive for HSV type-specific antibodies are unaware that they have been infected.
- Only 1/3rd of individuals appear to develop symptoms at the time of acquisition of infection with HSV2.
- Prior infection with HSV-1 modifies the clinical manifestations of first infection by HSV-2.
- Herpes simplex virus type 1 is the usual cause of oro-labial herpes and now the most common cause of genital herpes in the UK
- HSV-2, historically the most common cause of genital herpes in the UK, is the virus type that is more likely to cause recurrent ano-genital symptoms
- Following primary infection, the virus becomes latent in local sensory ganglia, periodically reactivating to cause symptomatic lesions or asymptomatic, but infectious, viral shedding.

- The median recurrence rate for genital herpes after a symptomatic first episode is 0.34 recurrences/month (i.e. approximately four recurrences per year) for HSV-2 and is four times more frequent than the recurrence rate for HSV-1.8 Recurrence rates decline over time in most individuals, although this pattern is variable

### **Signs and Symptoms**

- Blisters or painful ulceration of external genitalia, may also involve the cervix and / or rectum
- Dysuria
- Vaginal or urethral discharge
- Systemic symptoms of fever and myalgia are more common in primary infection
- In first episodes, lesions and lymphadenitis are usually bilateral. In recurrent disease, it is usual for lesions to affect favoured sites. They may alternate between sides but are usually unilateral for each episode
- Tender inguinal lymphadenitis occurs in around 30% and usually bilateral in initial episodes but may be unilateral
- HSV is significant cause of proctitis, especially HIV+ men.
- 70% of HSV proctitis in MSM had no visible signs of external anal ulceration

### **Potential Complications**

- urinary retention (result of severe pain or autonomic neuropathy)
- autoinoculation to fingers and adjacent skin e.g. thighs
- aseptic meningitis
- mother to child transmission perinatally – please refer to “*Pregnancy and STIs*” protocol for all pregnant females with suspected or confirmed ano-genital herpes

### **Diagnosis**

#### **Virus Detection & Characterisation**

Confirmation and typing of the infection is essential for diagnosis and counselling on prognosis, transmission and management. Laboratory diagnosis is based on direct detection by PCR of HSV from genital lesions; this yields the highest sensitivity of all tests and allows virus typing. The quality of sample is crucial; specimens should be collected using a swab taken ideally from a vesicle or, alternatively, directly from the base of an ulcer. Material from several lesions should be taken, to maximise diagnostic yield. Ensure that you use a VPSS vial (viral PCR sample solution) and that the virology request form is ticked for genital ulcers and includes appropriate information about lesions and risk-

behaviour groups (eg genital ulcer and MSM). Consider dark field microscopy for detection of syphilis, especially if there are systemic symptoms or lymphadenopathy: discuss with a senior clinician if uncertain.

Consider also Mpox – see protocol

Clients should be informed that a syphilis PCR is taken automatically on the sample. Please request the combined 'HSV/syphilis' PCR for the appropriate anatomic site(s) on NaSH.

The results of genital ulcer PCR tests will be available via telephonetics (green card), with all three results (HSV1, HSV2, syphilis) being read back to the caller separately. Turn round time is usually a few days. If the result is positive, the patient will also be sent a text message (where permission exists) stating:

"This is the Sandyford. Your recent test confirms Herpes Virus type 1. You can call 0141 211 8634 for more info or follow this link

<http://www.healthscotland.com/uploads/documents/3421-What%20do%20you%20know%20about%20Genital%20Herpes-06-16.pdf>"

"This is the Sandyford. Your recent test confirms Herpes Virus type 2. You can call 0141 211 8634 or follow this link

<http://www.healthscotland.com/uploads/documents/3421-What%20do%20you%20know%20about%20Genital%20Herpes-06-16.pdf>"

If either of the HSV results are negative the telephonetics will also say '**if these results do not explain your symptoms, please call 0141 211 8130 for further advice**'.

### Type Specific Serology

#### **Only to be requested after discussion with GUM DOD**

Key points in HSV serology:

1. A non type-specific HSV serology test is rarely useful
2. Type specific antibody tests can take time to become positive after infection
3. Up to 12% of patients with proven HSV infection can lose their HSV antibodies
4. HSV IgM testing is rarely useful
5. Serology can be useful for patients e.g., Recurrent genital symptoms and HSV-2 can be considered unlikely in the absence of type-specific antibodies  
Counselling of potentially serodiscordant couples In pregnancy when initial herpes is diagnosed in the third trimester

Type-specific serology is available in very limited situations via the Specialist Virology Centre, and is sent to the HPA lab in England. Send an EDTA sample to virology and they will forward to the HPA lab and complete HPA paperwork.

Clinical information can be added to a blue microbiology form and sent with the sample.

Several type specific commercial assays (mainly for HSV-2) are now marketed, including one near-patient test. However, even highly sensitive and specific assays have poor predictive values in low prevalence populations (see below).

Positive predictive values for HSV-2 antibody assays		
	Prevalence	PPV*
STI clinic	25%	86%
General population antenatal clinics	5%	50%

\* For an assay with 95% sensitivity and specificity

## **Management**

### First Episode Genital Herpes

**All clients with suspected first episode HSV should be reviewed by a practitioner competent to give all relevant information**

#### *Antivirals*

Patients presenting within 5 days of the start of the episode, or while new lesions are still forming, should be given oral antiviral drugs. There is no evidence of benefit for greater than 5 days but it can be considered if new vesicles are forming. Providing a patient with a 10 day course to be taken if still having new vesicles after 5 days can be considered. Aciclovir is the preferred treatment choice at Sandyford as there is no evidence of additional benefit from other antivirals.

**Immunocompetent: Aciclovir 400 mg three times daily for FIVE days**  
**Immunosuppressed (incl advanced HIV): Aciclovir 400mg five times daily for TEN days or Valaciclovir 1g bd for TEN days**

#### *Sexual Health Screen*

Chlamydia/gonorrhoea NAAT and Syphilis/HIV serology should be done at first presentation; full examination with eg speculum or proctoscope if needed may need to be deferred depending on local symptoms.

#### *Supportive measures*

If clients with first diagnosis HSV require more information or support, refer to the sexual health advisers on that day or at a follow up appointment when HSV type available.

Saline bathing and the use of appropriate analgesia is recommended. Topical anaesthetic agents (e.g. 5% lidocaine ointment) should be used with caution, because of the potential for sensitisation and delayed healing, but may help with severe dysuria.

### Management of complications

*Hospital admission may be required for:*

- severe pain or constitutional symptoms
- meningism (aseptic spinal meningitis and encephalitis rare complications)
- urinary retention (secondary to pain and sacral radiculopathy)

### *GP correspondence*

Clarify and document if GP can be contacted and informed of HSV diagnosis and management plan. A template letter can be sent by SHA office when they are texting/phoning the positive result. If diagnosis confirmed a letter can be sent to the GP advising to put treatment course on repeat prescription for any future outbreaks.

### *Immunosuppressed and HIV positive Individuals*

There are no recent data regarding optimum management of people living with HIV (PLWHIV) who are well established on effective antiretroviral therapy. It is therefore suggested, particularly if a patient is profoundly immunosuppressed, to seek advice from a senior GUM physician regarding management.

Recurrent Genital Herpes

Recurrences of genital herpes are generally self-limiting and usually cause minor symptoms. Management strategies include supportive therapy only, episodic antiviral treatments and suppressive antiviral therapy. The most appropriate strategy for managing an individual patient will vary over time, dependent on the patient’s psychological coping strategies, recurrence frequency, symptom severity and relationship status. Frequent recurrent episodes can be managed with *supportive therapy* only, *episodic therapy* or *suppressive therapy*. If patient re-attends service offer full sexual health screen if new contacts especially if they have not been tested for HIV previously.

– see Table below.

	<b>Management Options for Recurrent Genital Herpes</b>		
	<b>Supportive only</b>	<b>Episodic Treatment</b>	<b>Suppressive Treatment*</b>
Frequency of episodes	Infrequent/rare	Infrequent - frequent	Consider the clinical context and impact on patient quality of life; Recurrence rate >6/yr
Duration of each episode	Minimal	<b>&gt;4 days</b>	Clinical context
Severity of each episode	Minimal	Moderate/severe	Moderate/severe
Other factors	-	Patient opts not to take suppressive Rx; Recurrences respond rapidly	Distressed, relationship difficulties, underlying medical issues, immunosuppression; Special event i.e. holiday or exams
Regimen	-	<b>Aciclovir 800 mg three times daily for 2 days</b>	<b>Aciclovir 400 mg BD</b>

Supportive only

Saline bathing, Yellow soft paraffin (“Vaseline”), analgesia advice

**Episodic antiviral treatment**

Oral antiviral therapy shortens recurrent episodes in patients who have recurrences lasting more than 4 days and will abort approximately 10% of lesional recurrences when started early (within 24 hours of symptoms developing). This is best managed as a self-start medication. Patients are best arranging a supply via GP repeat prescription.

The regimen recommended is:-

**Aciclovir 800 mg three times daily for 2 days\***

PLWHIV may benefit from 5 day course of 400mg especially if CD4 count less than 500 cells/ mm, discuss patients with other immunosuppressive illnesses with a senior GUM physician



## Suppressive therapy

\*Patients with confirmed genital herpes and a recurrence rate of more than six episodes of genital herpes in 12 months will benefit from daily suppressive treatment. Patients do not have to have experienced 6 painful recurrences to be eligible – someone with a recurrence every month for 3 months meets this recurrence rate and should be offered suppressive therapy. There may also be psychosocial indications for initiating suppressive therapy.

All patients with genital herpes should be made aware of the option of suppressive therapy. **Patients do not need to see a consultant to start suppressive therapy if the above criteria are met.** GUM consultant clinic referral should only be offered to patients where *problematic* recurrence of HSV is an issue (or in pregnancy or women trying to conceive)

Experience with suppressive therapy is most extensive with aciclovir. Safety and resistance data on patients taking long term therapy now extend to over 20 years of continuous surveillance. There is NO need for any routine monitoring or baseline tests except in known severe renal disease

There is no evidence of clinical superiority of valaciclovir or famciclovir over aciclovir; on economic grounds, aciclovir is therefore the drug of choice at Sandyford.

The regimen recommended is:-

**Aciclovir 400 mg twice daily for 6-12 months (initial supply for ONE month)**

### *Prescription*

**Please give one month worth of aciclovir 400mg BD and send standard GP letter (“HSV Suppressive Therapy” on NaSH) with patients consent to request GP continue this on repeat prescription for up to one year.**

We do NOT supply multiple months of therapy to patients, but can give them a one month starter pack while they arrange to see their GP. If patients feel unable to disclose the diagnosis to their GP then these concerns should be explored and a senior clinician involved as we cannot provide an ongoing supply from limited clinic stock

### *Advice to patient*

If they experience flare up of symptoms whilst on suppressive therapy, they should increase the dose to 400mg TDS for 5 days and then step down again. If they have frequent recurrences on suppression, they should call sexual health department for a review appointment.

Dosage reductions are clinically inappropriate.

Twenty percent of patients will experience a reduction in recurrence frequency compared with pre-suppression symptomatic levels.

Please inform the patient that most people will have an episode on stopping suppressive treatment which should be managed symptomatically and to ensure they have medications for treatment on hand if needed. They should then monitor symptoms the recommended minimum period of assessment should include two recurrences. If they have persistent symptoms they should call sexual health department for a review appointment.

## **Counselling & Support**

In clinic counselling of patients with genital herpes should be as practical as possible and address the individual's particular personal situation; for instance, issues for someone in a long term relationship are likely to be different from those for someone seeking a partner. Diagnosis often causes considerable distress. Most people with recurrent genital HSV infection adjust over time, but antiviral treatment can reduce anxiety, assist adjustment and improve quality of life. Counselling should cover the following topics, and is most useful when the infecting viral type (HSV-1 or HSV-2) is known.

### **For symptomatic patients where tests are awaited:**

1. Presumptive diagnosis based on clinical findings (until HSV PCR result known) and limitations of HSV PCR including what to do if PCR is negative (return if symptoms recur)
2. How they will obtain HSV PCR results and direct them to written information (Sandyford website and BASHH PIL)
3. Explain benefits of writing to GP if diagnosed and document permission

### **For patients with strong presumption of HSV or where this has been confirmed:**

4. The natural history of HSV, including asymptomatic shedding and that rate of shedding reduces in most people. Low physical morbidity and high population prevalence should be stressed.
5. Recurrences; difference between type 1 and type 2
6. Treatment options; including short course (2 day) episodic therapy and availability of suppressive treatment if needed
7. Abstinence from sexual contact is recommended during lesion recurrences or prodromes
8. Transmission may occur as a result of asymptomatic viral shedding, male condoms may reduce transmission but their use cannot completely prevent it. Transmission does not occur via fomites (sheets, towels, toilets, etc.). Suppressive antiviral therapy in discordant couples can reduce the rate of acquisition of symptomatic genital herpes (\*see Partner Notification section)
9. Implications during pregnancy (to both male & female clients)
10. Disclosure is advisable in all relationships to promote trust and intimacy. Disclosure of herpes infection may reduce transmission by approx 50%.

It can be documented in clinical note that 'Key points of HSV diagnosis discussed'.

Direct patients to NHS inform website <https://www.nhsinform.scot/illnesses-and-conditions/sexual-and-reproductive/genital-herpes>

For patients who have significant distress they can be referred for counselling. Often one or two counselling sessions, with an invitation to return in case of difficulty, should be enough. Patients who have failed to adjust to the diagnosis within a year merit review for the consideration of more intensive counselling interventions.

Clients may consider seeking further information and advice via [www.herpess.org.uk](http://www.herpess.org.uk)

### **Partner Notification**

**Partner notification is not required as a public health measure.**

When counselling patients, it is worth bearing the following in mind:

- Telling partners of their diagnosis is recommended in all relationships. It has been shown that disclosure of the herpes infection to sexual partner may reduce risk of transmission by approximately 50%
- Individuals with a current or past history of HSV should understand the importance of not transmitting a new infection to someone who is pregnant
- Subclinical shedding plays a major role in the transmission of infection
- The legal responsibilities and requirements for disclosure remain unclear. Discussions around disclosure should be documented.
- Suppressive therapy with antivirals has been shown to reduce the rate of acquisition of symptomatic genital herpes in known discordant couples in certain circumstances. This is not routinely supplied and should be discussed with the GUM DoD if requested

### **Vaccination**

There is currently no commercially available vaccination for HSV-1 or -2.

### **References**

BASHH – 2024 UK National guideline for the Management of Ano-genital herpes

[British Association of Sexual Health and HIV UK national guideline for the management of anogenital herpes, 2024 \(accessed December 2025\)](#)

**Appendix 1.**

Letter to be sent to GP when starting suppressive HSV therapy - “*HSV Suppressive Therapy*” on NaSH:

This patient has been diagnosed with genital herpes simplex virus type \_\_\_\_\_. They have had frequent recurrences and are suitable for suppressive therapy as per national guidelines.

They have been given Aciclovir 400mg BD for 1 month, which they can increase to TDS for 5 days if symptoms occur on suppressive therapy.

Please would you kindly continue to prescribe this for up to one year, after which they will stop therapy and assess symptom recurrence. At this time, if they have persistent symptoms, we would be happy to review again in the sexual health service.

Many thanks for your help in this patient's management.

Yours sincerely

**Sandyford Services**