

By Tayo Fasuan



Genital herpes is caused by Herpes Simplex Virus (HSV) and it is one of the most common sexually transmitted disease in the world. HSV is of two types: Type 1 (HSV-1) is mostly acquired during childhood via non-sexual ways, while type 2 (HSV-2), the predominant type in sub-saharan Africa, is the usual cause of most genital herpes. Recent findings have nevertheless indicated that HSV-1 is now a causative agent of genital herpes in developed and developing countries, especially among tertiary institution students. Both virus types, together with others in their family (Herpesviridae) are notoriously known associated with asymptomatic infections and recurrent infections.

The greatest incidence of HSV infections have been shown in recent times to occur in women of reproductive age and the risk of maternal transmission of the virus to the foetus or neonate (newborn) has become a major health concern. Some authors have stated that the pregnant woman, who acquires genital herpes as a primary infection in the latter half of

pregnancy, rather than prior to pregnancy, is at greatest risk of transmitting these viruses to her newborn. Perhaps, the most relevant risk factors for this infection in Africa has been shown to be underage pregnancy, as pregnant women under the age of 21 has been shown to be at the greatest risk of having herpes-related infections and complications such as spontaneous abortion, preterm labour and neonatal herpes infections.

Genital herpes may be symptomatic or asymptomatic. In women, primary symptomatic genital herpes causes blistering and ulceration of the external genitalia and cervix (leading to vulval pain), dysuria, vaginal discharge and local lymphadenopathy, together with vesicular and ulcerative lesions of the internal thigh, buttocks, perineum or in perianal skin. Complications by systemic symptoms such as fever, headache and myalgia, and occasionally meningitis can arise. Autonomic neuropathy resulting in urinary retention mainly occurs in women.

Findings by some studies have shown that the most important HSV infection during pregnancy is the primary genital HSV infection, although, in the majority of pregnant women, the first manifestation of genital herpes is not a primary infection. This is perhaps more dangerous in pregnant women than non-pregnant women as it can lead to severe and complicated due to dissemination of the infection.

In these women, this can lead to development of disseminated skin lesions associated with visceral involvement such as hepatitis, encephalitis, thrombocytopenia, leucopenia and coagulopathy. Though this dissemination is rare during pregnancy, the mortality rate of such infection is as high as 50%. Infection during the third trimester of pregnancy could lead to transmission of HSV to the baby during vaginal delivery.

There are asymptomatic phases between clinical outbreaks of genital herpes during which the majority of sexual HSV transmission occurs between unsuspecting partners. This is called asymptomatic virus shedding, and this has been shown to be higher in women with HSV-2 infection compared with those with HSV-1.

As reported by a group of reviewers led by Elena Anzivino,, although there is a small risk of vertical transmission, recurrent genital herpes must be regarded as the most common cause of neonatal infections and the passage through an infected birth canal is the most probable route of transmission. According to them, “In recurrent infections associated with clinical symptoms, the risk of neonatal disease is reduced dramatically by caesarean section. Transmission of HSV by women with asymptomatic viral shedding is of greater significance, since neonates mostly acquire infection without being recognized.”

Although diagnoses is often complicated by the presence of common disease symptoms and their non-specificity, it is necessary to have correct laboratory diagnosis due to their importance for clinical management, counselling, treatment, management of pregnancy and assessment of the risk of transmission. Any patient presenting with lesions and blisters should immediately go for specific tests to determine their real cause.

For treatment regime, pregnant women with first clinical symptoms of the infection or a recurrence may be treated with acyclovir or valacyclovir as recommended by the physician. Though, both drugs are officially not approved for treatment of pregnant women, consent of the patient must be sought before the administration. Experimental studies have shown that treatments with acyclovir and valacyclovir from 36th week of pregnancy until delivery significantly reduces the frequency of clinical manifestations and the virus shedding at the time of delivery decreasing the need for caesarean delivery and probably the risk mother-to-child transmission.

Mother-to-child transmission can be prevented by close observation with simultaneous tests. Caesarean section might not be needed by those infected in their first two trimester because the infection would likely have resolved before delivery date. However as stated earlier, infection in the third trimester might require CS because the infection might not have resolved before delivery. In either case, periodic tests are however needed ascertain the presence of the virus. According to some authors, when vaginal delivery is irreversible, since the risk of vertical transmission is high (41%), a maternal and neonatal intravenous acyclovir

therapy is recommended.

Women who are having recurrent genital herpes several weeks before the expected delivery date are advised to undergo a suppressive therapy with acyclovir or valacyclovir during the last 4 weeks of pregnancy, with simultaneous tests, carried out from the 36<sup>th</sup> week of pregnancy. If there are no clinical herpes lesions but virus detection tests result positive at the time of delivery, an elective caesarean section is recommended. However, if there are no genital herpetic lesions and all tests have returned negative at the time of delivery, vaginal delivery can be done.

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