

Herpes and Pregnancy

Preventing herpes simplex transmission to the neonate.

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Neonatal herpes simplex virus (HSV) infection can have severe consequences. Skin, eye and mouth infection is rarely fatal, but disseminated or central nervous system (CNS) disease has a mortality rate of 80% in the absence of therapy, and most surviving infants have neurological sequelae. Aciclovir therapy can improve the outcome of neonatal herpes, but is often delayed due to the early non-specific symptoms of the disease. Even with early therapy, some infants develop disseminated infection or CNS complications. The virus is usually vertically transmitted to the neonate from an infected mother during delivery. As such, the optimal strategy for reducing the morbidity of neonatal herpes is to prevent the neonate from acquiring HSV infection at delivery. The highest risk of neonatal infection occurs when the mother sheds HSV at labour, which happens more frequently in women who acquire genital herpes in the third trimester. Therefore, one approach for reducing maternal-fetal transmissions is to prevent HSV acquisition in late pregnancy. Definitive classification of genital HSV infection during pregnancy as either primary, non-primary first episode or recurrent can be accomplished only when clinical evaluation is accompanied by laboratory testing, including the use of gG-specific serological tests. The serological status of the mother's sexual partner should be considered when determining her risk of infection. The use of weekly viral cultures in pregnant women with confirmed genital herpes is not warranted, as they do not predict an infant's risk of acquisition of HSV at delivery and are not cost-effective. High-risk susceptible women should be counselled about abstinence and reducing oral-genital contact near term. Observational studies suggest that caesarean section can reduce transmission of neonatal herpes, and is warranted for women who shed HSV at delivery, although different countries vary in their approach to caesarean sections and so universal recommendations are not available. If maternal antiviral therapy is considered, the potential benefits of treatment should be balanced against potential adverse outcomes for mother and fetus, although it may be warranted when the mother has severe or life-threatening disease. Studies on the use of antiviral prophylaxis in women with known recurrences at labour are ongoing. Invasive fetal monitoring can increase the risk of neonatal herpes, and should only be used in HSV-2 seropositive women for defined obstetrical indications.