Answering Questions About Herpes in Pregnancy

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ABSTRACT

Herpes during pregnancy is a common concern. Because one in every five women is infected with the herpes virus, it is likely that herpes may be a topic that will be raised during a prenatal class, or afterward in private. An expectant mother who has a history of herpes may have concerns about protecting her baby from this virus. She may also have concerns about her own health, relationship issues including the support of her husband and family, or how to communicate with her health-care provider and make the best choices for a safe birth experience. Her childbirth educator can be a source of support and empowerment.

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QUESTION FROM A READER

Recently, a mother in one of my childbirth classes asked me about herpes. She told me she had “heard” that herpes is very dangerous for newborn babies. I told her that it was a medical question, so she should talk to her doctor about it. Now, I am reconsidering whether I gave her the best answer. Is herpes a medical issue that I should send to the doctor, or should I have given the mother some information in addition?

COLUMNIST’S REPLY

One of a perinatal educator’s goals is to provide quality prenatal education. Being the one with the answers is not always easy. There can be times when you are asked a question or a statement is made for which you may not have an immediate answer. Sometimes, you will have to send a mother somewhere else for information or support. However, in this case, your “second guessing” seems better than your

first response. Herpes during pregnancy is a common concern. According to the American College of Obstetricians and Gynecologists (ACOG), one in every five women is infected with the herpes virus (ACOG Committee on Practice Bulletins, 2007); thus, herpes is a topic that may likely be discussed during a prenatal class, or afterward in private.

Especially since the woman came to you with the question, I think that it is advisable for you to listen to her and to respond to her concerns on whatever level you can. You will not be making a medical diagnosis or prescribing a treatment like a doctor does. The interaction with you may identify “nonmedical” issues, such as the reactions of family members. For example, 30 years ago, a diagnosis of herpes carried a significant stigma for some people. Could this be an issue with this woman’s mother? Or, is she concerned about telling the baby’s father? If the focus of the woman’s

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concern is a medical option, your interaction with her may help her to prepare for a more informed and meaningful discussion with her doctor.

Understanding Herpes Simplex Virus

The first question that you may need to answer is, “What is herpes?” Herpes simplex virus (HSV) is an incurable, recurrent viral infection that affects more than 45 million adolescents and young adults in the United States (ACOG Committee on Practice Bulletins, 2007). With a portion of this population being women of childbearing age, the risk of transmitting HSV to the fetus during pregnancy or labor and birth is a major concern. The highest risk of transmission is related to the mother acquiring HSV during pregnancy, especially during the last trimester.

To understand why the transmission of HSV is an issue for concern, one needs to have a knowledge of HSV transmission and infection. The spread of HSV is through person-to-person contact, with sexual contact being the main route of transmission. Passage of the infection from one partner to another can happen without the persons being aware of their infectious state (Kriebs, 2008). Infection can occur through viral shedding or mild episodic outbreaks. Symptoms of an outbreak can range from mild to severe local irritation. The characteristics of an outbreak may be tingling, burning, or pain prior to the appearance of vesicles that form ulcers that crust over, possible systemic malaise, or mild pubic irritation.

To assist with the diagnosis of HSV, doctors may collect cultures, which are most effective early in the outbreak (Kriebs, 2008). Other diagnostic methods include viral DNA by polymerase chain reaction and serology (Kriebs, 2008). Classification of HSV is designated as type 1 (HSV-1) or type 2 (HSV-2). Typing of the virus is diagnosed by serologic assay (Kriebs, 2008). Either type of HSV may cause genital herpes (Perozzi, Zalice, Howard, & Skariot, 2007). In the United States, HSV-2 is always the genital infection (ACOG Committee on Practice Bulletins, 2007).

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However, currently, up to 80% of new cases of herpes infection are being diagnosed as HSV-1 (ACOG Committee on Practice Bulletins, 2007). This information helps the obstetrical provider and the woman choose the best course of action for her pregnancy.

Many women may still have questions. As a trusted source of information, the perinatal educator can be another avenue for answers. A class participant concerned about herpes might ask the perinatal educator for information prior to the start of a class or just after. It is recommended that the educator be prepared to answer questions about herpes during pregnancy. It is also important for the perinatal educator to be nonjudgmental and to provide direct and accurate information. When giving any information, the perinatal educator must always refer the woman back to her obstetrical provider.

Preventing Herpes Transmission to Infant During Pregnancy

An expectant mother who has a history of herpes may well have concerns about protecting her baby from the virus. To help the woman have a safe and healthy pregnancy, her health-care provider can review treatment options with her. One option is to provide suppression therapy by using acyclovir (Zovirax) or valacyclovir (Valtrex) at 36 weeks’ gestation until birth (Majeroni & Ukkadam, 2007). Suppression therapy has been shown to be beneficial in decreasing viral shedding of HSV (Kriebs, 2008). The treatment regimens of acyclovir are 400 mg by mouth twice daily or valacyclovir, 500 mg to 1,000 mg daily (Kriebs, 2008). The other way to prevent transmission of herpes to the infant is cesarean surgery, which the woman must discuss with her health-care provider.

Another important feature of HSV in pregnancy is the timing and the rate of perinatal transmission to the neonate. There is about a 1% risk of asymptomatic viral shedding that can lead to about a 4% risk of transmission (Ural, 2010). The neonate at the highest risk is the one with the mother who has contracted herpes during pregnancy, rather than the mother who has a history of HSV (Corey & Wald, 2009). Understanding these risks and providing screening for HSV can help reduce the rates of transmission during pregnancy.

After talking with her health-care provider, the woman may remain apprehensive about the possible need for cesarean surgery. For women who have active lesions during the time of birth, cesarean surgery is the current recommendation (Ural, 2010).

The perinatal educator can encourage the woman to discuss what her health-care provider has told her and can help identify the need for any further information about her option of cesarean surgery. This approach can decrease the woman's confusion and fear, help her prepare for the best possible experience under the circumstances, and support her right to informed consent.

Researchers conducted a study to understand the importance of HSV serologic screening during pregnancy (Gardella et al., 2007). The results showed that obstetricians feel HSV serologic screening is important during pregnancy, yet many do not routinely provide screening during routine prenatal care. Baker (2007) suggests the reason for not screening in pregnancy is related to the lack of recommendations from the Centers for Disease Control and Prevention or from ACOG. Baker also supports the school of thought that all prenatal clients should have serologic testing for herpes to determine whether the client has or is susceptible to the disease.

When discussing herpes and pregnancy, it is important not to forget the effects of the virus on the neonate. The disease in neonates can be hard to diagnose. The symptoms may include fever, irritability, lethargy, or even a decreased desire to feed (Perozzi et al., 2007). The symptoms occur approximately 1 week after birth (Perozzi et al., 2007). The infection can manifest in three ways in the neonate: skin, eye, or mouth lesions; affects on the central nervous system, which may or may not have skin involvement; and disseminated infection involving multiple sites (Perozzi et al., 2007). Severe cases of herpes in the neonate can lead to lifelong complications; thus, prevention is the basis for decreasing the negative effects of herpes on the neonate.

Assuring a Safe, Healthy Birth

Armed with the previous information, the perinatal instructor can approach the conversation about herpes with confidence. By responding to concerns and providing information about herpes in pregnancy, the perinatal educator can help empower the expectant mother to make the best decision concerning her pregnancy and birth. For the expectant mother, knowledge and empowerment can lead to a rewarding perinatal experience.

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