BEST meeting
HSV in pregnancy, HIV and clinic services

Dr Sylvia Bates

HSV in pregnancy

New BASHH guidance - Main changes:

Much more emphasis on reduction of acquisition of HSV in 3rd trimester

Change in thinking on ‘recurrence’ in pregnancy

Earlier suppression with aciclovir

Stage of disease

- Initial (1/3 are asymptomatic)
  - Primary
  - Non primary
    - Prior infection with one type of HSV, now has the other.
- Recurrence

Tests

HSV 1+2 Antibody – serology

HSV PCR from lesion (pink swab for genital, green swab for extra genital)

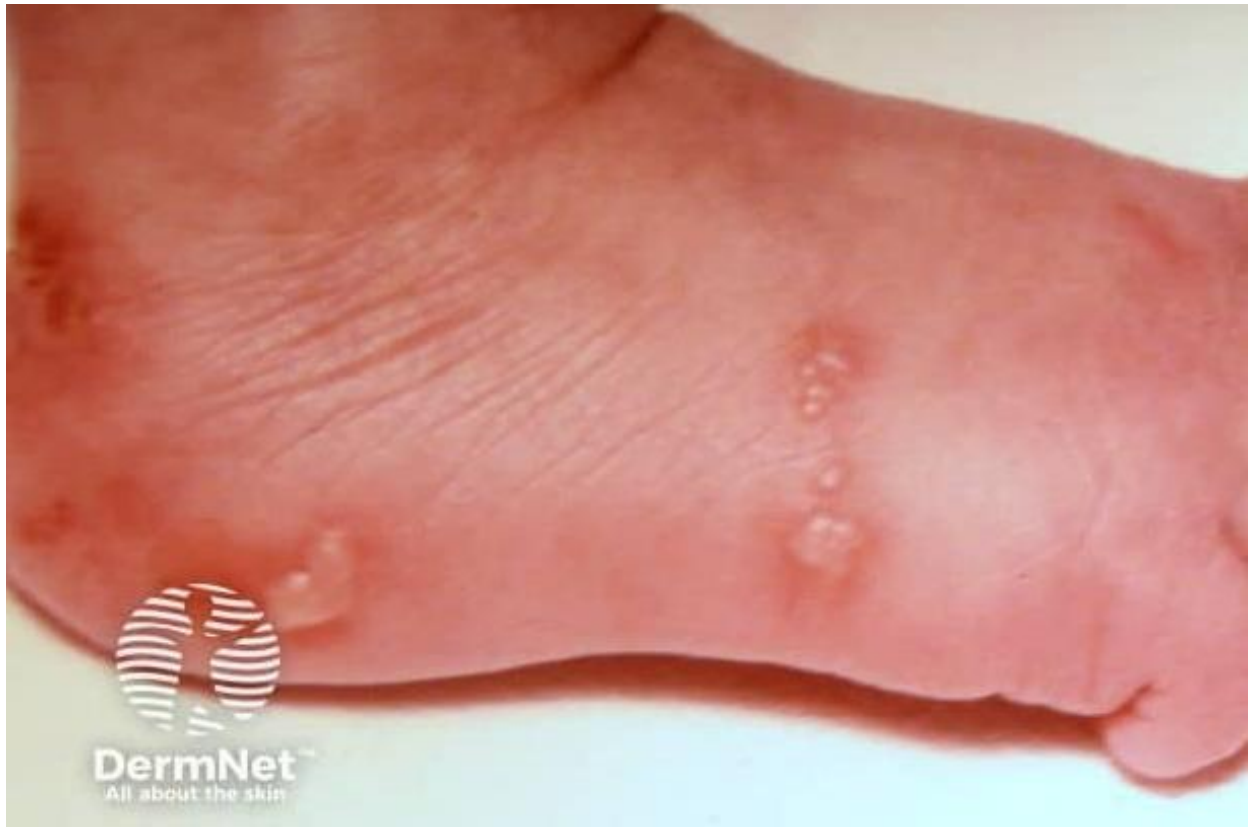
Neonatal HSV

- 75-85% at birth
- 10-25% postnatal
- 5% in utero

- 52% HSV 1, 48% HSV 2

- Highest risk if :
  - initial episode within 6 weeks of delivery
  - absence of transplacentally-acquired maternal neutralising antibodies
  - Prolonged duration of rupture of membranes before delivery
  - mode of delivery - vaginal greater risk
  - use of assistance (vacuum, forceps or foetal scalp electrodes).

Neonatal HSV



- 1/3 SEM – Skin eyes mouth
  - 0% mortality, 6% Morbidity (neurological, ocular)
- 1/3 CNS
  - 15% mortality, 64% morbidity (epilepsy, blindness, cognitive function, developmental delays)
- 1/3 disseminated
  - 66% mortality, 41% morbidity

BASHH / RCOG guidance

At the first antenatal (booking) appointment all mothers and pregnant people should have a discussion and be given information on infections that can impact on the baby in pregnancy or during birth (including herpes simplex virus).

A careful history should be taken to identify any previous possible herpetic symptoms or diagnoses as per NICE guidance

Those with suspected genital herpes should be referred to genitourinary medicine (GUM)

Identification of women with partners who have HSV (**Discordant couples**)

Advice in pregnancy

- to seek immediate medical advice if they develop genital ulcers during pregnancy.
- to avoid any sexual contact from 26 weeks gestation*
- about risk reduction post-delivery*
- to report symptoms in baby within the first 6 weeks immediately (Skin, eye and mucous membrane lesions, lethargy/irritability, poor feeding, fever).
- that suppression will be offered to those with confirmed HSV, usually from 32 weeks (22 weeks if risk of premature delivery). Advice should be sought if outbreaks occur whilst on suppression.
- If discordance, to seek immediate medical advice if they get genital ulcers for the first time within 4 weeks of delivery

Risk reduction in pregnancy

Risk reduction

- Abstinence from sexual activity (including vaginal, anal and oral sex, and mutual masturbation) in the third trimester and the 2 weeks prior to this – From 26 weeks

- If unacceptable
  - Selective abstinence during recurrences and prodromes.
  - Male condoms used consistently and correctly
  - Antiviral suppression of the sexual partner

- Undertaking serology in this situation may help guide the discussion.

Risk reduction post delivery

- Everyone should wash their hands prior to touching the baby.
- The baby should not be kissed by people who are not very close family members or carers of the baby.
- Those kissing the baby should kiss the top of the baby's head and avoid kissing near the baby's mouth, nose and eyes (to avoid mucous membranes).
- People with current cold sores should never kiss the baby, and those with a history of cold sores should avoid kissing the baby.
- People with active herpes lesions at any site should avoid touching the baby unless they are very close family members or carers of the baby, and in this case, they should practice good hand hygiene.
- Health care professionals with current active lesions, or recurrent cold sores or herpetic whitlows who work on neonatal wards, other wards with babies should seek occupational health advice

Assessment in pregnancy – presents with symptoms

- New lesions? Do a swab, start acyclovir and refer urgently to GUM
- Signs disseminated HSV in mother – hepatitis, encephalitis, disseminated skin rash, viral sepsis – Admit to ward

- If recurrence, do a swab, refer to GUM and inform obstetric team of referral

Referrals by:

- Phoning us – 0800 055 6442
- Email - schcic.bishadmin@nhs.net

Discordant partners

- Mother doesn’t have HSV – partner does
- Antibody testing of both partners MAY be helpful
  - Interpretation needs to be in context of clinical presentation
  - False negatives / loss of antibody response

- Partners may attend with a letter requesting HSV 1+2 antibody testing
- Please email BISH if antibody testing is done

HIV Advances in care

U=U*

UNDETECTABLE
viral load means HIV IS UNTRANSMITTABLE

www.i-Base.info/u-equals-u

Michelle Rees, clinic

Angelina Namiba, Salamander Trust

"A person with sustained undetectable levels of HIV in their blood cannot transmit HIV to their sexual partners."

Simon Collins, HIV i-Base

Chloe Orkin, Chair, British HIV Association (BHIVA)

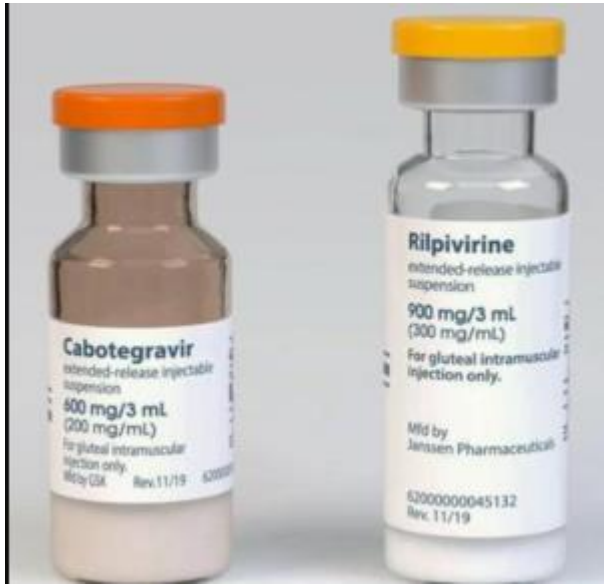
*** Undetectable = Untransmittable**

Poster produced by HIV i-Base for Kobler@CWH (July 2018)

Injectable therapy

- Cabotegravir / rilpivirine
- Initial oral lead in
- Injections at 0,1 and then every 2 months

- Significant need
- No prior failure on NNRTI / INSTI
- Increased failure rates with some subtypes



BHIVA advice on Statins

We recommend that all people living with HIV aged 40 years or older should be offered a statin for primary prevention of CVD irrespective of lipid profile or estimated CVD risk (Grade 1B)

We suggest that people living with HIV aged 40 years or older with an estimated 10-year CVD risk of 5% or greater are prioritised for primary prevention with a statin (GPP)

- We suggest that atorvastatin 20 mg daily can be used (pitavastatin 4mg used in REPRIEVE)

- We suggest that people on a low-intensity statin should switch to one of moderate intensity if clinically appropriate and tolerated (GPP).
- For people unable to tolerate a statin, we advise offering an alternative lipid-lowering agent in line with national guidelines (GPP). (eg *Ezetimibe / bempedoic acid*)
- It is best practice for statins for primary prevention to be prescribed and monitored in primary care (GPP)

The 5-year number needed to treat to avoid one MACE

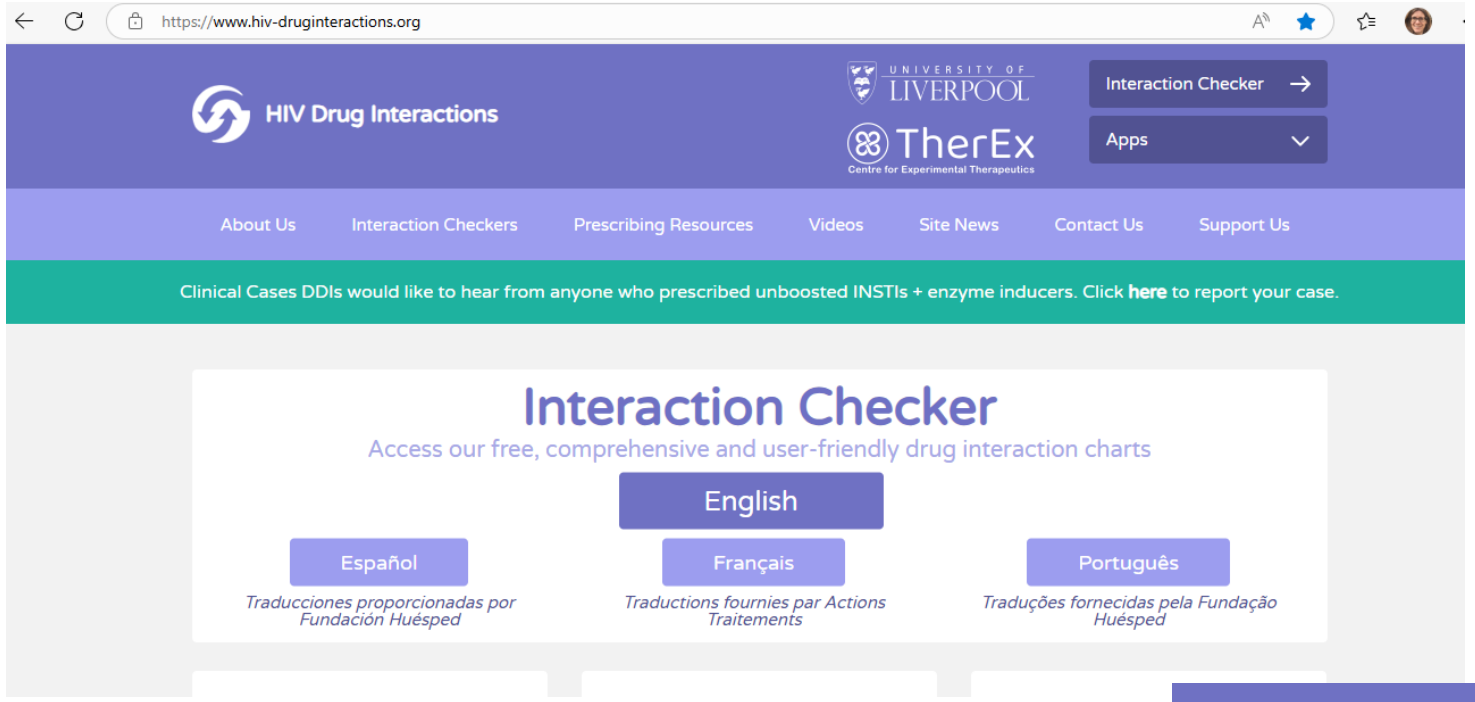
- risk score >10% 35
- 5–10% 53
- 2.5–5% 149
- 0-2.4% 199

- NICE advises to not rule out lipid modification therapy if a person's 10-year QRISK3 score is less than 10% if risk may be underestimated - as is the case for people living with HIV

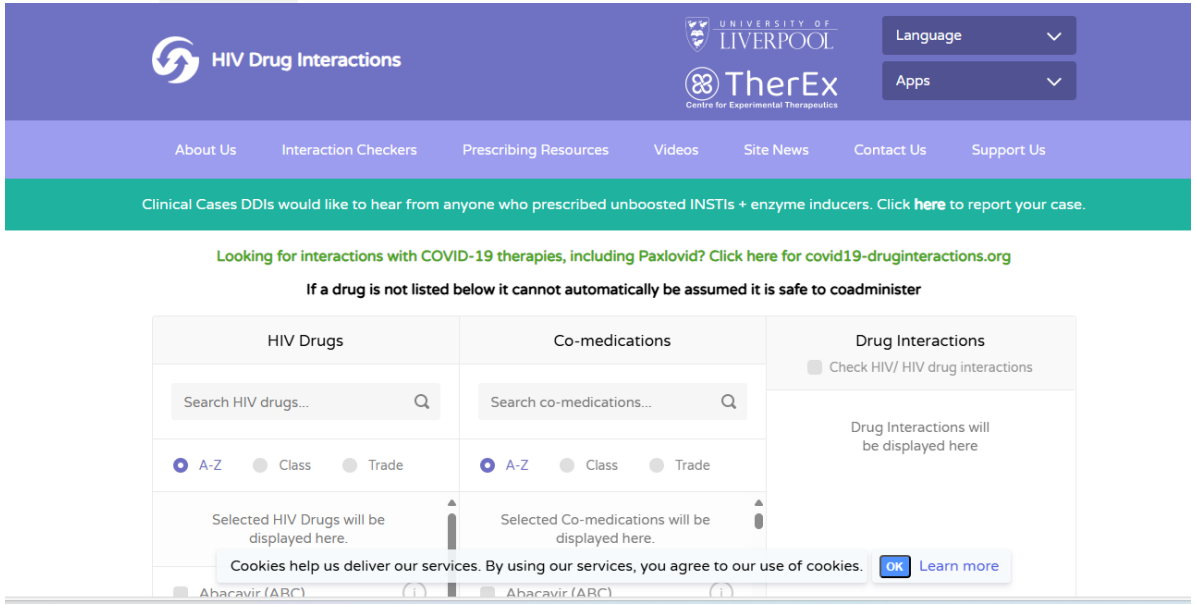
Drug interactions

- Darunavir, atazanavir, ritonavir, cobicistat (CYP3A inhibitor), Elvitegravir
  - Increases levels of statins
- Efavirenz
  - Reduces levels of statins

- Co-administration of ritonavir- or cobicistat-boosted atazanavir with atorvastatin is not recommended
- Co-administration of ritonavir- or cobicistat-boosted darunavir or elvitegravir results - start at the lowest possible dose of atorvastatin, not exceeding 40 mg per day and careful safety monitoring.
- Co-administration of lopinavir/ritonavir, not exceeding 20 mg per day and careful safety monitoring.



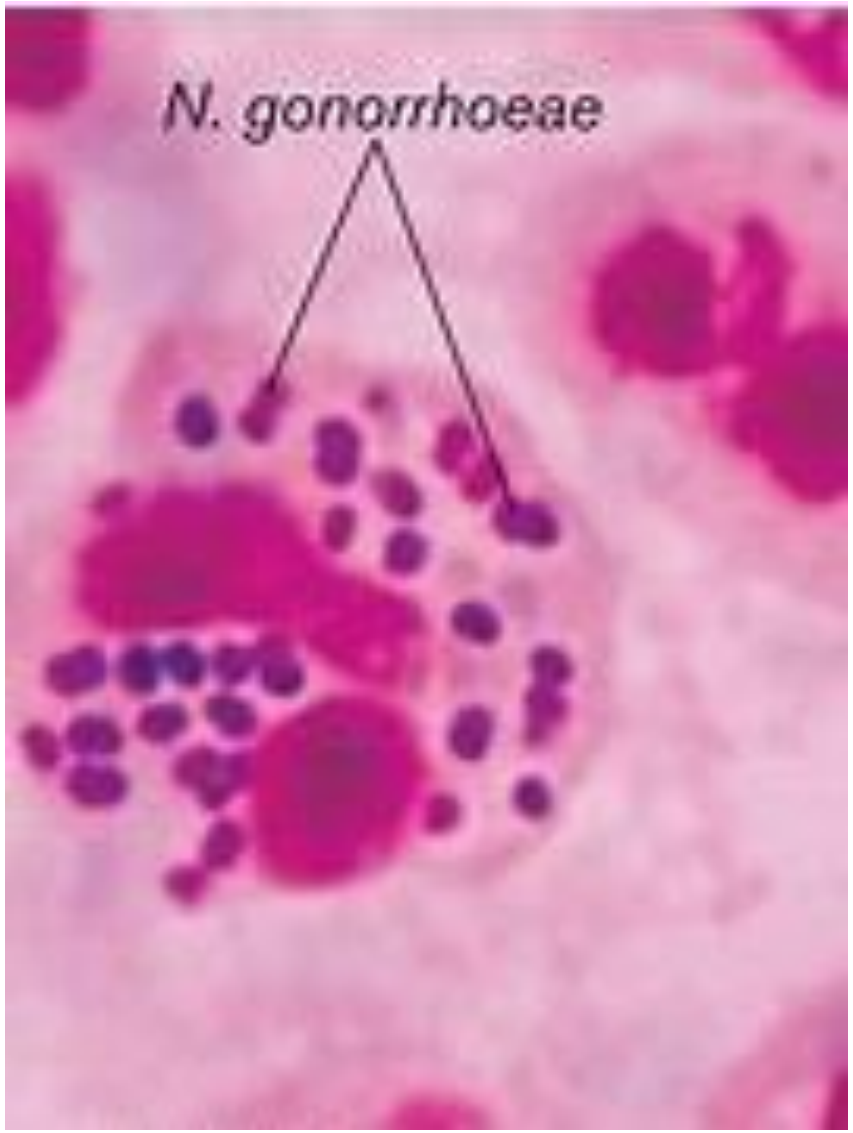
WWW.hiv-druginteractions.org

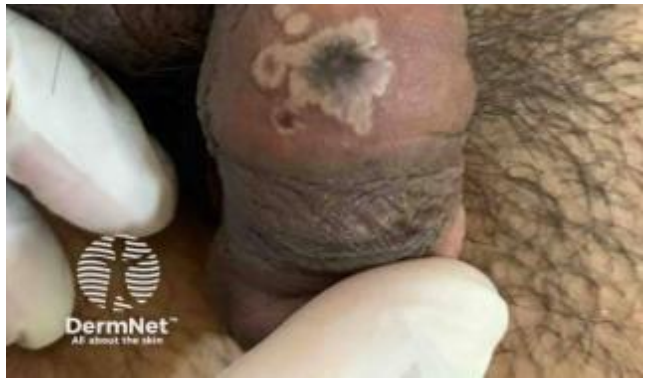


Bexero 4CMenB

- 32-42% Effectiveness at protecting against gonorrhoea
- 80-90% sequence homology between N meningitidies and N. gonorrhoea
- 2 doses 1/12 apart

- Criteria:
- GBMSM with at least 5 parterns in last 3/12
- GBMSM with bacterial STI in last 12/12
- Others at equivalent risk





Mpox

- Clade 1 – few cases UK, travel related, 10% fatality (First UK case Oct 2024)
- Clade 2 – Sexual transmission GBMSM, 3% fatality

- Vaccine approved for routine use for those at increased risk.

GBMSM with :

Multiple partners

Group sex

Bacterial STI in last year

And Sex on premises workers

Services at Gateway Clinic

Commissioned services at Gateway include:

- Management of STI's
- Delivery of HIV related care
  - Medication for HIV only
- Health promotion
  - Provision of PrEP, Vaccinations
  - MI
- Initiation of contraception
- Continuation of contraception for under 25's

Not commissioned:

- Non STI causes of genital symptoms
  - UTI
  - Candida, BV
  - Genital dermatology
- Repeat contraception for over 25’s
- Coil fitting for any reason other than contraception eg HRT / Menorrhagia

New services this year

- Doxy Prep
- GC vaccination
- Routine Mpox vaccination
- HSV in pregnancy management

- New commissioning guidance

- Moving to requesting tests under name
- Electronic prescribing

In recent years:
Small pox vaccination, Mpox management, PreP, HPV vaccination
EPR, greater move to home delivery of medication, Statins

How can we help?