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## EDITORIAL

# HERPES SIMPLEX VIRUS (HSV) INFECTION IN CLINICAL PRACTICE

The incidence of genital herpes simplex infections is not known, however, the physician and patient awareness of this problem has increased dramatically in recent years, and it is recognized as one of the commonest sexually transmitted diseases encountered in clinical practice. David Barclay reports that 10% of women seen in private practice demonstrate serologic evidence of prior exposure to the virus.

The infection is generally caused by direct sexual contact by either HSV type I or HSV type II. More than 90% episodes of genital herpes are a result of either primary or recurrent infection due to HSV type II. HSV type I infection usually reflects orogenital contact. Non-sexual transmission by fomites or aerosal has not been documented. Despite the presence of adequate humoral and cell mediated immunity the DNA viruses of the herpes group reactivate periodically. Between recurrent infections, the virus persists in a latent phase in the sensory sacral ganglia. HSV type II virus has been recovered from the cervices of asymptomatic women, from the urethras and prostate of asymptomatic men, transmission to a sexual partner or a new born can occur in the absence of symptoms. The virus is often associated with other sexually transmitted diseases.

The frequency of antibodies to HSV - It is influenced by age, sexual activity and socio-economic status.

HSV infections have been associated with genital neoplasia in a number of studies. Women with antibodies have a higher incidence of cervical dysplasia, carcinoma in Situ (CIS) and invasive cancer as compared to women without HSV antibodies.

Neonatal herpes can be caused by HSV - I or HSV - II, though the latter is predominant. Women with primary infection are at high risk of transmitting the virus to the newborn during childbirth than those with recurrant disease. Neonatal herpes still carries with it the risk of mortality of 40-60%.

Primary HSV infections tend to run a longer clinical course than recurrent episodes. Patients present with numerous vesicular or ulcerative very painful lesions accompanied by vaginal discharge due to accompanying urethritis and cervicitis. Fever, myalgia, malaise, and photophobia occur in 40-50% of patients. Accompanying symptoms are more pronounced in patients with primary disease. The symptoms last 1-2 weeks, and the lesions heal without scarring in 3-4 weeks.

Complications of primary herpes genitalis infections include viral meningitis, occassionally encephalitis, autonomic nervous system dysfunction leading to urinary voiding difficulties and constipation.

Diagnosis can be established by viral culture taken from material obtained from vesicles, pap smear from material taken from scraping of lesions show presence of giant cells, serological tests for antibodies indicate active lesion when a 4 fold increase in titre is demonstrable.

To treat the first clinical initiate treatment with 200 mg. acyclovir, 5 times daily for 5 days combined with 3-4 applications of acyclovir ointment locally on the lesions daily, helps to shorten the attack and possibly reduces the frequency of recurrences. Some patients who get recurrent attacks can predict the recurrent episode because they experience tingling and burning of the genital skin prior to occurrance of lesions. In such women, administration of 400 mgs. b.i.d. of acyclovir prophylactically may help to mitigate the attack. Parenteral acyclovir has been successfully used in patients hospitalized with severe lesions.

## Counselling

(1) Patients should be told about the nature of the disease.
(2) Abstain from sexual contact when lesions are present.
(3) Asymptomatic patients are recommended the use of condoms.
(4) Women with herpes simplex infection should have annual pap smears.
(5) Early in pregnancy, the patient must inform the Obstetrician of history of genital herpes.

– Shirish N. Daftary