# Herpes Simplex Information & Guidance

<table>
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<td>Division/ Department responsible for Procedural Document</td>
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<td>2355</td>
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## Controlled document

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**Associated Trust Policies/ Procedural documents:**
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Herpes Simplex

**In consultation with and date:**
Infection Control Operational Group: Review Date May 2021

**Contact for Review:**
Lead Nurse Infection control

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1. INTRODUCTION

1.1 Herpes simplex virus (HSV) infection most commonly presents as vesicles in and around the mouth (cold sore) or in the genital area, the infection may affect the fingers (Herpetic whitlow). Disseminated skin lesions may occur in the immuno-compromised. Rarely, the virus causes encephalitis.

2. PURPOSE

2.1 The purpose of this document is to provide guidance for staff on how to manage patients with Herpes simplex virus.

3 DEFINITION

3.1 There are two types of the virus:

3.1.1 Type 1 (HSV-1) commonly causes cold sores and is responsible for around half the cases of genital infection.

3.1.2 Type 2 (HSV-2) is responsible for the remainder of genital infections. Genital herpes infections often are associated with mild or no symptoms and most people are unaware that they have infection. Globally more women are infected by HSV-2 infection than men as sexual transmission of the virus is more efficient from men to women (WHO 2016).

3.2 Following primary infection with HSV, the virus migrates to the sensory neurones of the dorsal root ganglion where it remains for life. Under certain circumstances the latent virus may become reactivated leading to cold sores at the site of the original infection. Specialist advice should be obtained from paediatrics or obstetrics for the management in pregnancy or neonates. Please see clinical guideline for genital herpes in pregnancy.

4. DUTIES AND RESPONSIBILITIES OF STAFF

4.1 The Infection Prevention and Control Team are responsible for:

- Updating the guidelines to ensure advice is current
- Undertaking Audits to ensure the guidelines are adhered to

4.2 All Staff have a personal and corporate obligation to comply with best practice in the prevention of infection and comply with this and all other related policies.

5 TRANSMISSION

5.1 The virus is highly infectious and is most contagious when symptoms are present. However it can be transmitted to others by asymptomatic carriage. Transmission is via direct contact with active lesions in saliva or genital secretions. Infection may also be transferred on unwashed hands. Aciclovir, famciclovir and valaciclovir all suppress symptomatic and asymptomatic viral shedding, with asymptomatic shedding being reduced by about 80-90% (Patel et al 2014). However the treatment is not a cure for the infection.
6. **INFECTION CONTROL MEASURES**

6.1 Isolation is not required unless the patient has extensive infection e.g. eczema herpeticum. The most important infection control measure is to use gloves when dealing with lesions, secretions or discharges and hand hygiene must be undertaken after glove removal and in accordance with the five moments for hand hygiene (WHO 2009).

7. **INFECTED STAFF**

7.1. Oro-facial

7.1.1 The risk of transfer to patients is small but can be further reduced by the following:
   I. Early use of topical aciclovir.
   II. Avoidance of direct hand contact with the lesions.
   Staff who are symptomatic with oral herpes should not work in areas with highly susceptible patients, i.e. newborn and highly immunosuppressed patients and they should contact Occupational Health. They can be redeployed to work in lower risk areas.

8. **HERPETIC WHITLOW**

8.1 Staff with Herpetic whitlow must not have direct patient care until lesions are healed. In exceptional circumstances they may resume work after 4 days of topical aciclovir providing the lesions are dry. Gloves must be worn for any patient contact until the lesion is completely healed.

9. **ARCHIVING ARRANGEMENTS**

The original of this guideline will remain with the author, Lead Nurse, Infection Control. An electronic copy will be maintained on the Trust intranet, P – Policies – H – Herpes Simplex Information & Guidance. Archived electronic copies will be stored on the Trust’s “archived policies” shared drive, and will be held indefinitely. A paper copy (where one exists) will be retained for 10 years.

10. **PROCESS FOR MONITORING COMPLIANCE WITH AND EFFECTIVENESS OF THE GUIDELINE**

10.1 To monitor compliance with this Guideline, the auditable standards will be monitored as follows:

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<th>No</th>
<th>Minimum Requirements</th>
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<tr>
<td>1.</td>
<td>Annual Audit</td>
<td>Appropriate isolation of patients with extensive herpes infection during the annual patient placement audit</td>
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10.2 **Frequency**

In each financial year, the designated infection control nurse will as part of the patient placement audit ensure that this guideline has been adhered to. A formal report will be written and presented at the Infection Control Operational Group meeting.

10.3 **Undertaken by**

Infection Prevention and Control Team
10.4 **Dissemination of Results**
At the Infection Control Operational Group meeting which is held quarterly.

10.5 **Recommendations/ Action Plans**
Implementation of the recommendations and action plan will be monitored by the Infection Control Operational Group which meets Quarterly.

Any barriers to implementation will be risk-assessed and added to the risk register.

Any changes in practice needed will be highlighted to Trust staff via the Governance Managers’ cascade system.

11. **REFERENCES**


