

Genital Herpes: What Patients Might Not Know

BY DIANA MAHONEY
New England Bureau

BOSTON — “Genital herpes is a recurrent, lifelong viral disease. This is the one thing that patients and clinicians don’t like to say, but there’s no way around” it, Laura J. Mulcahy said at a conference on contraceptive technology sponsored by Contemporary Forums.

Other difficult truths about infection with herpes simplex virus (HSV) type 2? The overwhelming majority of people infected with the virus don’t know that they have it, and people with asymptomatic or unrecognized disease shed the virus intermittently in the genital tract, said Ms. Mulcahy, a certified family nurse practitioner who is assistant medical director of the STD Center for Excellence at Montefiore Medical Center in New York.

“When we ask patients prior to screening for HSV-2 if they have a history of genital herpes . . .

‘Symptoms are easily confused with other conditions or may present atypically, for example, as redness rather than sores.’

about 90% of those who ultimately test positive for HSV-2 antibodies reported having no history or symptoms of the infection,” she said. This underrecognition can be attributed to the fact that the leading cause of HSV-2 infection is asymptomatic shedding of the virus.

“There is a misperception and some clinicians are still telling patients that the infection is spread only through [HSV-2] sores. This is absolutely not true. The virus can shed even when the skin looks normal, and that’s when most infections occur,” she said.

Patient education about asymptomatic disease is critical to an effective screening protocol. “When patients come in and have no symptoms, it means nothing to us,” Ms. Mulcahy stressed.

Patients who come in for STD screening are told that, “from this day forward, the fact that you or your partner have no symptoms means nothing; the fact that you and your partner look fine means nothing; and the fact that you or your partner had a negative screen 6 months ago, if you’ve had partners in the interim, means nothing,” she said.

Another factor contributing to the high rate of unrecognized disease is that many patients who have been screened for STDs believe they have been tested for genital herpes. “A complete STD screen does not include testing for herpes. Clinicians don’t always tell this to patients, so many patients believe they are being tested for everything. If their STD screen is negative, they assume that means they don’t have herpes,” said Ms. Mulcahy.

For this reason, “clinicians who don’t routinely screen for herpes [as part of an STD screening protocol] must inform patients that they are not being tested and

chart that in the patient record so there is no confusion,” she added.

If a patient asks to be screened for HSV-2, there are several points that should be addressed before testing, Ms. Mulcahy stressed:

► The absence of symptoms does not predict a negative screen.

► In patients with lesions, a herpes culture has low sensitivity, especially as lesions heal. As such, a negative culture does not rule out HSV-2.

► In the event of a positive HSV-2 test in an asymptomatic person, it is not possible to determine how long the virus has been present, when or whether they will have outbreaks, or whether they will ever have a problem with herpes.

► In the event of a positive HSV-2 test, patients in some states have a legal obligation to inform current and future sexual partners of their infection status before genital to skin contact. “It is a misdemeanor in New York state, for example,

to knowingly pass on or put someone else at risk for a sexually transmitted disease,” said Ms. Mulcahy.

Counseling patients on these points before testing is imperative. “If you wait until after a positive screen, I can guarantee patients will no longer be listening. They need to know what to expect before they hear the word positive,” she said.

Among the tools used to screen for HSV-2, clinical examination and history are insensitive and nonspecific. “Symp-

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toms are easily confused with other conditions or may present atypically, for example, as redness rather than sores,” Ms. Mulcahy said. Viral culture is the most valid test available, despite the high rate of false negatives.

Polymerase chain reaction assays are another diagnostic option. They have increased sensitivity but are not approved by the Food and Drug Administration, nor are they available in all laboratories. Cellular detection methods, including Tzanck test and Pap smear, are not recommended for HSV detection because of their low sensitivity, she said.

Many type-specific serology tests, such

as the older enzyme-lined immunoabsorbent assay tests, can result in false-positive results because of problems with cross reactivity. The newer type-specific HSV glycoprotein G1 (HSV-1) and G2 (HSV-2) tests are more reliable, but their sensitivities vary, she said, noting that a positive test should be confirmed with another test to reduce the risk of false-positive diagnoses. The Western blot is the reference standard serology test, but it is not approved and is only available from one laboratory at the University of Washington, Seattle.

“Do not underestimate the impact of this diagnosis on your patients. They will require extensive, thoughtful counseling

[because] the physical impact of genital herpes is nothing compared to the psychological one,” Ms. Mulcahy said.

Such counseling should include information about the natural history of disease, the ability to bear children, the transmission risk to sexual partners, and the variations in severity of primary vs. recurrent episodes. It also is important to dispel cancer myths, reiterate the fact that the virus can be transmitted in the absence of symptoms or lesions, remind patients of their obligation to inform current and future partners, and recommend counseling and testing for sexual partners, she said.

Risk-reduction strategies also should be

discussed, including avoiding sexual contact when symptoms or lesions are present and using latex barrier protection and suppressive therapy. There are three oral antiviral drugs—acyclovir, valacyclovir, and famciclovir—approved for the treatment of genital herpes. Topical treatments, she stressed, “absolutely do not work and have no role in the treatment of genital herpes.” ■

Experimental HPV Vaccine Shows Promise

TAMPA — An experimental vaccine against human papillomavirus appeared to have therapeutic potential in a study of 20 women with HPV-16 positive vulvar intraepithelial neoplasia.

Treatment with the vaccine resulted in important T-cell responses in most patients after two vaccinations in the phase II study of women with histologically proven vulvar intraepithelial neoplasia (VIN). At 3 months, clinical efficacy was apparent in more than 50% of patients, and a complete response occurred in 25%, Dr. Gemma G. Kenter reported at the annual meeting of the Society of Gynecologic Oncologists.

The vaccine’s design is based on long, overlapping peptides that cover the complete amino acid sequence of the HPV-16 E6 and E7 oncogenic proteins. Patients in the study were vaccinated four times at 3-week intervals. Interferon-gamma enzyme-linked immunospot (ELISPOT) analysis indicated that nearly all of the patients mounted a T-cell response to multiple regions of HPV-16 E6, and 75% did so against HPV-16 E7. These oncogenes represent the best targets for therapeutic vaccination, said Dr. Kenter of Leiden University (the Netherlands) Medical Center.

The natural HPV-specific E6 and E7 immune response is different in healthy patients than in infected patients, and proliferation assays in this study showed that the T-cell reactivity that was demonstrated is associated with the production of IFN-gamma and interleukin-5, similar to the cytokine profile of the HPV-16-specific memory T-cell responses observed in healthy individuals, Dr. Kenter explained.

A local immune response, namely infiltration of both the vaccination site and/or the VIN lesion by HPV-16-specific Th1 and Th2 cells, also was demonstrated.

The findings are encouraging, because HPV infection is common in young, sexually active individuals, and although most will clear the infection without developing clinical disease, some people experience a failure of the immune system in controlling the virus, and in these patients, malignancy can develop. The current study followed a phase I study in which the vaccine was found to elicit a strong HPV-16-specific T-cell response in 35 patients with end-stage cervical cancer, with no toxicity greater than grade 2 occurring.

“To our surprise, even in this patient group with end-stage disease, vaccination induced a strong type I immune response,” Dr. Kenter said. A response to the E6 oncogene occurred in 90% of the patients, and a response to E7 occurred in 70%.

—Sharon Worcester

The development of young dermatologic researchers and educators is the gateway to enhanced patient care. The Board of Trustees of the Dermatology Foundation proudly acknowledges members of the Leaders Society and Annenberg Circle who contributed \$2.6 million in 2007 to shape the future of medical and surgical dermatology. Make your investment to secure dermatology’s future today. Call 847/328-2256 to join your colleagues in leadership giving.

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