Definition

Infection with herpes simplex-virus type I (h. labialis) or II (h. genitalis). New nomenclature: human herpes virus 1 (HHV-1) and 2 (HHV-2). HHV-1 widespread in the population (adults > 95% seropositive), HHV-2 depending on risk groups: about 10–15% in general population, > 25% in sexually promiscuous persons. Endogenous re-infections are typical, frequently based on the same influence factors such as cold, UV light, fever/infections, ‘stress’ and menstruation.

Coding (ICD-10): B00.100, herpes labialis; A60.010, herpes genitalis.

Clinics

HHV-1 and -2 are mostly transmitted by skin-to-skin or skin-to-mucosa contacts.

Typical findings: erythematous plaque, follow by grouped (‘herpetiform’) vesicles, erosions, crusts, pustules or – rarely – even ulceration and necrosis. Primary infection frequently is associated with painful gingivostomatitis.

Typical signs: burning, painful or itching lesions (prodromal signs), at primary infection also fever, headache, regional lymphadenitis, malaise, myalgia.

Most common sites: perioral, oral mucosa, cheeks, nose tip, fingers (HHV-1), genito-anal area (HHV-2). HHV-1 can also occur on genital sites, HHV-2 in the enoral and perioral area.

Complications: HHV-1 and HHV-2 in most cases lead to harmless infections which, however, can be associated with severe reductions of quality of life [12, 31, 32, 35]. Erythema multiforme is a typical, but mostly harmless complication. Severe complications (systemic dissemination) are mostly found in immunocompromized persons, e.g., patients in intensive care, post-transplantation, under immunosuppressive treatment or HIV-positive persons. Eczema herpeticatum can be a severe complication in patients with atopic eczema. HHV-2 acquired intrapartum may lead to severe infections in newborn children.

Dermatological Diagnostics

Required: Usually clinical diagnosis, extralabial or extragenital involvement possible.

Optional: Where appropriate, smears (Tzanck test on acantholytic giant cells), viral culture, serological diagnostics, immunostatus, clarification of underlying diseases.

Psychosomatic Diagnostics

For levels of evidence and recommendations (L1–4) see table 1.

Emotional Factors in Onset and Course (L1)

Emotional stress is known in clinical experience as possible cause of attack in all forms of herpes. Numerous clinical [16, 30] and experimental [3, 28, 33] studies support this. From a psychoneuroimmunological viewpoint, emotional stressors and herpes-exacerbations are closely related [2].

Herpes labialis

The question whether psychological variables may play a role in eliciting herpes labialis infections has no uniform answer. The estimate of personal success in attaining socially desirable goals, on the other hand, has a negative correlation with the onset of herpes recurrences. Significant connections between...
Education: Herpes labialis and genitalis

the stressor (everyday stress, life-altering events, anxiety) and a recurrence in the subsequent week were found in a study by Schmidt et al. [29]. By contrast, Luborsky et al. [24] found no psychosomatic relationship in the elicitation of herpes labialis. The experimental elicitation of herpes labialis recurrences in a group of patients who attributed their herpes attacks to disgust could be shown by Buske-Kirschbaum et al. [6]. After a visual presentation of disgusting pictures and objects, 8 of 10 patients in the test group developed a herpes recurrence in the following days, while this was not the case in any of the 10 patients in the control group.

Herpes genitalis

In a study to evaluate a relationship between stress and emotional well-being on the one hand and the onset of a herpes genitalis recurrence on the other hand, a correlation could be observed between depressive mood and viral infection, but no relationship to the degree of stress [18]. Other authors found psychological factors as predictors for recurrence of genital herpes infections [7, 20–22]. The retrospective casuistic studies also point to psychological triggers in a majority of cases [11, 25], but they should be evaluated with caution.

The demonstrated positive influence of various psychosocial interventions on the frequency of recurrence of herpes (see below: Therapy) also confirms the hypothesis of a psychosomatic relationship in a subgroup of patients.

Emotional Problems in Adjustment (L1)

All herpes illnesses may be accompanied by considerable physical and psychosocial stress [4]. In addition to the discomfort of symptoms like burning, pain and itching, there is stress from the visibility of the lip herpes, limitations in eating and drinking, in body contact and in social activities (public meetings, sometimes on the job). The variable ‘sadness’ could be associated with the frequency of herpes recurrence in the framework of a prospective study [17]. In herpes zoster, the post-zosteric neuralgias are the greatest persistent stress, with corresponding emotional suffering [13, 27].

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Diagnostic Measures

Obligatory: Discussion with the doctor about the psychosocial situation; exploration of eliciting, improving and exacerbating factors, comorbidity.

Optional: Psychometric inventories (e.g., STAI, SCL-90 or HADS in reference to psychological symptoms, MHF in reference to disease-specific adjustment, FKV with respect to coping, FLQA-H with respect to specific quality of life in herpes).

Therapy

Dermatological Therapy

External: Lotio alba, virustatic ointments, wound solutions in mucosal area.

Internal: In severe or relapsing cases virustatics (e.g., Aciclovir, Valaciclovir).

Psychosomatic Therapy

The therapeutic indication exists in that there is a relationship between herpes and emotional stress. This applies to both h. labialis and h. genitalis [23].

Psychosomatic Basic Therapy (L4)

Consolidation of a therapeutic relationship. Expansion of the causal model of the disease, clarification of the psychosocial effects of the disease, conflict-oriented discussions, relaxation procedures.

Indications for Psychotherapy/Psychopharmacology (L4)

No herpes-specific indications.

Relaxation (L2)

To reduce symptoms and for prevention of additional symptoms, stress-reducing measures like autogenic training, relaxation procedures and other behavior-oriented methods may be applied [34]. A decrease in recurrence among patients by means of psychological interventions has been confirmed in one-to-one- and group interventions. Both, combined therapies (relaxation procedures, group therapy, health education) [23] and relaxation procedures alone [5, 19] have been reported as successful.

Depth-psychological and Analytical Procedures (L4)

No controlled studies. Use according to general indication criteria for these procedures.

Behavior Therapy (L4)


Table 1. Levels of evidence and recommendations (modified after [1, 15])

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Hypnosis (L3)
No controlled studies. Fox et al. [14] describe significant reductions of recurrences for HIV-2 in HIV-positive patients after hypnotherapy. Efficacy analogous to studies of other diseases (e.g., atopic dermatitis) may be assumed.

Psychopharmacology (L4)
No disease-associated indication.

Training Program and Combination Therapies (L3)
Intensified consultation had a favorable effect on the recurrence rate in non-controlled studies [8, 10].

Self-help (L4)
Participation in self-help groups coupled with cognitive restructuring [26] may help to improve coping.

References
1 Agency for Healthcare Research and Quality (AHCPR) 1992, cited after Centre for Evidence-based Medicine, http://cebm.jr2.ox.ac.uk/docs/level.html
14 Fox PA, Henderson DC, www.herp.org.uk
15 German Cochran Center, 2001, http://www.cochrane.de/deutsch/cevsvendetherapie.htm