Introduction
Herpes simplex virus (HSV) causes only 2–4% of acute viral hepatitis but carries a high risk of morbidity and mortality. Pregnant women are at higher risk for HSV hepatitis. We describe a case of gestational HSV hepatitis.

Case
A 32-year-old G2P1001 at 38 2/7 weeks with low back and fetal tachycardia. Given suspicion for pyelonephritis, she was admitted for IV antibiotics. The next day, she ruptured membranes and cesarean delivery for breech was done. Postpartum was complicated by persistent fevers despite empiric treatment for endometritis. On postoperative day (POD) 1, she was anemic with a borderline elevated aspartate aminotransferase (AST). She continued with intermittent fevers and on POD 4 she became hypotensive. She developed pancytopenia with bandemia and worsening mild transaminitis. Cultures remained negative. Initial right upper quadrant (RUQ) ultrasound showed a normal liver, splenomegaly and thickened gallbladder with pericholecystic fluid. Biliary disease was ruled out. A CT scan on POD 5 showed signs of acute liver injury.

On POD 6, she had symptomatic hypotension and supplementary O2 requirement. Physical exam showed diffuse abdominal and back pain. Additionally, new white tongue lesions were noted. We sent labs for potential viral and autoimmune etiology. Disseminated primary HSV-1 infection was diagnosed. Antiviral therapy resulted in rapid improvement. The neonate was admitted for prophylactic acyclovir. There was no evidence of neonatal seroconversion.

Unique aspects of this case:
- Subtler transaminitis
- No identifiable risk factors
- Slow clinical deterioration
- Post-operative state making dx challenging

Teaching Points
1) HSV hepatitis should remain in the differential diagnosis for any pregnant patient presenting with acute hepatitis.
2) Primary HSV hepatitis can present without the pathognomonic rash and can occur without marked transaminitis.
3) Acute febrile hepatitis in pregnancy warrants a low threshold for empirical treatment for HSV with IV acyclovir while awaiting confirmatory testing.

Conclusion
Diagnosing gestational HSV hepatitis is often delayed. There should be a low threshold for HSV testing in peripartum women with acute febrile hepatitis. Initiate IV acyclovir once diagnosis is confirmed.