Post Herpetic Neuralgia / Herpes Zoster FAQS

What is Herpes Zoster?

It is a rash generally occurring on one side of the body. It is also known as the "shingles". It is caused by reactivation of dormant chicken pox virus within specific nerves of the body.

How common is Herpes Zoster?

The incidence of acute Herpes Zoster is 1.3-4.8 cases per 1,000 person-years.

Who gets Herpes Zoster?

Children account for 5-8% of cases. Adults ages 50-70 years account for 40%. Over age 80 accounts for most of the rest. It is especially seen in patients with cancer, particularly in patients with hematological or reticuloendothelial cancers. Also frequently seen in immuno-compromised or immunosuppressed patients, such as those on chemotherapy or corticosteroids. Herpes Zoster occurs in 35% of patients with Hodgkin's disease, and 8% of patients after a kidney transplant get it within three years of the transplant. Many studies report up to 38% of patients had a history of local trauma before the onset of Herpes Zoster. There is no influence by gender, race, or season.

How and where does the Herpes Zoster usually occur?

The Herpes Zoster pain and/or itching typically precedes the appearance of rash by several days. Pain has little or no bearing on the severity of lesions (and visa versa). It is seen in the chest area 50% of the time, the face (trigeminal ophthalmic nerve) 3-20%, the lumbar/cervical area 12-20%. It is usually only on one side of the body, but 1% of cases can affect both sides of the body. With advancing age, the incidence of trigeminal Herpes Zoster increases. In addition, the incidence of Post Herpetic Neuralgia may be higher with trigeminal eruptions.

Can it come back?

Herpes Zoster reoccurs in 1-8% of patients, of these 50% are in same location.

What is the rash like?

The rash is usually a strip of redness, followed by pimply eruptions that crust over. The crustiness can continue for 1 month, and the skin remains red or purplish for quite a while.

You should decrease the possibility of skin infection by protecting the skin from scratching, rubbing, or any additional trauma. Wash the skin gently and pat

dry to promote cleanliness and decrease trauma. Finally, wash your hands frequently to prevent spread of infection.

What is Post Herpetic Neuralgia?

It is defined solely as persistence of pain 4-6 weeks after Herpes Zoster.

If I have Herpes Zoster, what is the chance of getting Post Herpetic Neuralgia?

If you define Post Herpetic Neuralgia as pain lasting more than one month after the start of the Herpes Zoster, then you have a 16% chance if you are younger than 60, and a 47% chance if you are older than 60.

How long does the pain last?

Your chance of having pain more than a year is 4% if you are younger than 20, and 48% if you are older than 70. In general, there is an increased incidence and increased severity with increased age.

What is the cause of the pain?

In short, the pain is due to damage to nerves from reactivation of dormant chicken pox viruses. The pain is in some way similar to that experienced by amputees. This is known as “deafferentation” pain.

How is Acute Herpes Zoster treated?

1. 5% idoxuridine ointment for several days after the eruption can reduce healing time, and control the pain. It will not reduce the risk of getting long term pain however.
2. Interferon may reduces healing time, and controls the pain. It may reduce the severity of PHN.
3. Intravenous Acyclovir or oral antiviral agents reduce healing time, and controls the pain. It does not change in the incidence of PHN. They should be started as early as possible.
4. Sympathetic block: If begun within 2 weeks of onset of rash, 85-90% of patients experience relief of pain. If completed > 2 weeks after onset of rash, only 40% experience relief of pain. There has been a reported, but not confirmed, decrease in the incidence of PHN with sympathetic blockade. It is probably a good idea if you are in a high-risk group (you are over 50 years old) for developing long term pain.
5. Systemic Steroids (prednisone 60-80 mg/day for 10 days, then taper) accelerates the resolution of pain. The incidence of PHN may also be lower. At 3 months the incidence of pain is 30%, compared to 73%. However, in that study, the incidence of pain at 1 year was not different between those who

took the steroids and those that didn't. Thus steroids use is considered controversial.

6. TENS (transcutaneous electrical nerve stimulation).
7. Non-opioid analgesics, opioid analgesics as indicated.

How is Post Herpetic Neuralgia treated?

Long standing PHN is very difficult to treat if the symptoms are greater than 3-6 months in duration.

1. Antidepressants such as Amitriptyline (Elavil) can reduce pain and help increase sleep, but it leads to only a 25% incidence of moderate relief. Other newer antidepressants such as Cymbalta and Savella can also help.
2. TENS (electrical stimulation)
3. Analgesics as indicated, if helpful, such as tramadol, nonsteroidals (like celecoxib, ibuprofen), acetaminophen, opioids (morphine type medications).
4. Sympathetic blockade (early) for lancinating (sharp) pain
5. Anticonvulsants such as gabapentin, pregabalin, topiramate, carbamazepine, valproate, lamotrigine or others.
6. Adjuvant medications such as baclofen, clonidine, tizanidine.
7. Supportive therapy: behavioral medicine, psychological counseling.
8. Physical therapy. Exercise reduces pain in general.
9. Take lukewarm tub baths (lukewarm water is soothing).
10. Local anesthetic trial, such as mexiletine.
11. Neuroablative procedures: These should be avoided, as few, if any trials have shown them to be helpful for long-term improvement. If considering, consider DREZ and deep brain stimulation (some show studies promise).
12. Spinal Cord Stimulators
13. Topical creams such as capsaicin, EMLA, doxepin or a 5% lidocaine impregnated patch worn over the painful area of skin.

Make an appointment with Dr. H Rand Scott at Newport Pain Management Specialist to help with this difficult problem. 949 759-8400. For more information go to http://paindx.com/Nerve_Pain.html