

key points

SELECTED BY

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Risk factors for postherpetic neuralgia (PHN) include:

increasing age; a prodrome of pain before rash onset; the degree of spread of the rash, particularly if it extends beyond a single dermatome; and severity of pain during the acute attack. Forty per cent of patients over 50 and 75% of those over 75 develop PHN following resolution of the rash. The exact pathogenesis of why some individuals go on to develop PHN is yet to be fully established but some evidence supports the theory that a chronic low-grade ganglionitis is responsible.

Patients develop persistent pain classified as PHN

120 days following rash onset. It can be either constant or paroxysmal and is commonly described as burning, stabbing or itching in character and located in the same dermatomal distribution as the shingles rash. Pain can lead to sleep disturbance, anorexia, reduced socialisation and reactive depression.

Antiviral agents are known to reduce the pain of acute

shingles and hasten the resolution of the skin lesions. NICE guidelines advocate the use of antivirals for all patients over 50 in the acute phase of herpes zoster reactivation. Corticosteroids prescribed during the acute stage can cause a significant reduction in symptoms but only when prescribed alongside an antiviral agent.

Paracetamol should be tried initially for mild to moderate

pain, either alone or in combination with codeine but there is no evidence to support the use of NSAIDs. Tricyclic antidepressants are the most likely to confer benefit in neuropathic pain, in frail elderly patients nortriptyline appears to be tolerated best.

Both gabapentin and pregabalin can reduce pain and

improve sleep patterns in patients with PHN. Strong opioids provide similar pain relief to tricyclic antidepressants but their use is complicated by a greater incidence of side effects including neuropsychiatric and gastrointestinal disturbance. There is evidence to suggest an additive or even synergistic effect when combined with gabapentin for neuropathic pain.

Capsaicin 0.075% can be applied four times per day once

the skin lesions have healed. The uncomfortable burning sensation tends to settle with ongoing use, but can be ameliorated by mixing the capsaicin with GTN paste or EMLA cream. Lidocaine 5% plasters are particularly useful where allodynia is a prominent feature, or in patients in whom other treatments are not tolerated. Patients with severe pain or those whose condition is affecting their daily activities and function should be referred to a specialist in pain management.