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Postherpetic Neuralgia: Clinical Update

"**C**hickenpox" used to plague entire classrooms of elementary school aged children. While unpleasant, the sequela was usually mild and the children recovered fairly quickly. Unfortunately, recovery is not always so complete or rapid when the chickenpox virus, varicella zoster, reappears later in life.

Postherpetic Neuralgia (PHN) is the most common complication of Herpes Zoster (HZ) defined by pain persisting three months after the onset of the classic shingles rash. Long after the typical dermatomal rash has cleared, lingering pain can occur secondary to ongoing nerve destruction, deafferentation and inflammation. Sleep, appetite, libido, mood and overall quality of life can all be negatively affected as a result of PHN. Paresthesias or dysethesias ranging from a dull aching pain to a numbing, burning, tingling sensation can be present. A prodrome of general malaise, fever, GI upset or paresthesias may be present prior to the shingles rash.

Predisposing factors can include advanced age, use of immunosuppressants including corticosteroids, surgery, trauma, malignancy or local irradiation. The incidence of developing PHN after shingles in a 50-year-old patient is approximately 50%; in a 70-year-old patient, the incidence approaches 70%. Although controversial, prompt treatment for HZ may reduce the incidence of PHN. Once PHN has occurred, therapy should continue for at least 3-6 months after symptoms are controlled.

OTC analgesics including acetaminophen and NSAIDS are often used first line but generally are ineffective. Topical analgesics including Lidoderm®patches, or capsaicin in conjunction with antiepileptic drugs and tricyclic antidepressants often prove very valuable in reducing discomfort. Opioids can also be used as part of a multi-medicinal approach to decrease pain. Antiviral therapy such as Zovirax®, Valtrex® or Famvir® can also be initiated soon after viral recrudescence in an effort to limit VZV replication. In theory, Spinal Cord Stimulation can be used to modulate afferent nerve transmission and decrease pain, however, it has not been found to be extremely effective in this practice.

In resistant cases, nerve blocks directed toward the affected dermatome may be of some benefit. Sympathetic blockade of the stellate ganglion or lumbar sympathetic plexus can be considered. Alternatively, Epidural Steroid Injections with local anesthetic may also be performed. Systemic corticosteroids have been used in the past but their use remains controversial and systemic steroids are not recommended for the treatment of PHN.

For Information and Referrals:

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