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Shingles and Post-herpetic Neuralgia (PHN)

Acute Shingles (herpes zoster) is the focal recrudescence of the varicella-zoster virus (VZV) that has been dormant in sensory ganglia since an episode of chickenpox (Varicella). There are 500,000 new cases per year in the U.S.A. and one fourth of all Americans will contract shingles in their lifetime. Shingles most commonly appears as a unilateral painful rash in a single dermatome. The most common location is thoracic, then the first trigeminal division of upper face. Age is the largest risk factor, especially after age 40 when immunocompetence declines. The majority of patients are otherwise healthy older individuals. The lesions progress from discrete patches of erythema to grouped vesicles, which pustulate and crust in 7 to 10days. They may take a month to heal, often with anesthetic scars, changes in pigmentation and pain. Pain is often the most common symptom, and can precede eruption by days to weeks and occasionally the only manifestation. Deep aching or burning pain, parethesia, dysesthesia, hyperesthesia, allodynia, or electric shock like pains, unbearable itching may also occur.

Treatment of Shingles is with initiation of an antiviral as early as possible. A 50% reduction of PHN occurrence has been shown with any of 3 currently available antivirals (acyclovir, valcyclovir, famcyclovir). One should initiate and continue antiviral as long as new lesions are forming, even if uncertain diagnosis or prior to rash onset (due to low toxicity). Adjuvants such as NSAIDS and opioids are typical. Steroids have not been shown to reduce PHN, although they may help with pain of shingles and are standard treatment for zoster corneal keratitis. The antiviral is usually started within 72 hours of rash and tapered over a period of 21 days.

Post-herpetic Neuralgia is loosely defined as pain in the area of the shingles rash that persists after resolution of acute lesions. Pain that is still present 3 or more months after onset of shingles is the definition used for study comparison purposes. PHN occurs nearly 20% of all patients with shingles and in approximately 33% of patients over 79 years old with shin-

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About the Author

Steven Barna, MD

Dr. Steven Barna is ABMS Board Certified and ACGME fellowship trained in Pain Medicine. He is President and Co-Founder of the Spine & Pain Institute of New England and Co-Medical Director of the Pain Center at Cape Cod Hospital. Dr. Barna is the former Medical Director of the Massachusetts General Hospital Pain Clinic and former Assistant Professor at Harvard Medical School. He serves as Secretary of the Massachusetts Chapter of the American Society of Interventional Pain Physicians, as well as an editorial board consultant. Dr. Barna is recognized nationally, having authored 20 publications and presented over 70 invited lectures.

gles. Patients typically have stimulus independent pain or ongoing pain independent of activity, and also report tactile allodynia. Motor symptoms are not involved, as dermatomes are purely sensory. However, patients with arm or leg involvement may develop atrophy and loss of DTRs.

Most randomized controlled trials of chronic neuropathic pain have examined only two pain syndromes: PHN and diabetic neuropathy. Practice Parameter: Treatment of postherpetic neuralgia, an evidence-based report of the quality standards subcommittee of the American Academy of Neurology, published in Neurology, September 2004, provides an excellent overview of treatment options. Dubinsky et al searched Medline for peer-reviewed published articles from 1960 to January 2004. Overall, the group with the best efficacy with low side effects included: gabapentin, lidocaine patch, pregabalin, and tricyclic antidepressants. Opiates remain a controversial option for treatment of PHN or any chronic pain syndrome. In severe cases of either shingles of PHN, epidural steroid injection can be helpful. Finally, a zoster vaccine for adults has since been developed that significantly reduces the incidence of both shingles and PHN, as well as the severity of both. Furthermore, the zoster vaccine is likely cost-effective for immunocompetent patients over the age of 60 years.

Our Approach to Comprehensive Care

Our physicians provide a thorough initial evaluation to determine the specific cause of pain and create a personalized treatment plan. We offer ongoing care which may include medical management and minimally interventional diagnostic and therapeutic spine and pain management procedures. In order to minimize the time it takes for our patients to return to function, we coordinate a multidisciplinary treatment plan which may include physical therapy, chiropractic, behavioral psychological therapy and other modalities. Most importantly, we maintain open lines of communication with the healthcare providers to ensure we provide the highest quality of care for our patients.

CONDITIONS

- Back pain (and leg pain)
- Neck pain (and arm pain)
- Headache and facial pain
- Complex regional pain syndrome (RSD)
- Shingles and Post-herpetic neuralgia
- Shoulder, hip, and other joint pain

PROCEDURES

- Epidural steroid injection
- Facet joint injection
- Radiofrequency lesioning
- Sacroiliac joint injection
- Joint injections
- Discography

With over 30 years of combined experience, our caring, highly qualified, and skilled ABMS Board Certified and ACGME fellowship trained Interventional Pain Physicians are unique in New England.

OUR LOCATIONS