

Postherpetic Neuralgia

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Infection is highly prevalent in lupus, with Herpes zoster being the most common infection.

Herpes zoster-varicella virus is responsible for *chickenpox (Varicella)* and *shingles (Herpes zoster)*. Chickenpox occurs in children and sometimes adults who have never been exposed to the virus. Shingles is secondary to reactivation of the virus, years after the initial infection. In chickenpox, the virus is present in blood and infects the skin and other organs; before skin involvement, one may be contagious when shedding the virus in a sneeze. Chickenpox and shingles cause skin blisters containing clear fluid in a red background. At this stage the disease is quite contagious. Once the blisters dry, they cease to be contagious. The virus, after chickenpox runs its course, remains in a neural structure, the dorsal root ganglia and stays inactive (latent) for years.

Reactivation of the virus causes shingles.

Risk factors predisposing to shingles include: impairment of the immune system as seen in old age, malnutrition, connective tissue disorders, cytotoxic therapy, steroid therapy, AIDS and certain cancers. The incidence of shingles in the general population is 10% to 20%; in patients with lupus it is about 46%. In shingles the pain and blisters appear in the territory of the involved nerve or nerves and a diagnosis is relatively easy to make. Microscopic examination of the blister fluid is characteristic. Shingles usually last 4 to 6 weeks, with or without specific antiviral therapy.

Postherpetic neuralgia (PHN), characterized by persistent pain for more than a month after the onset of shingles, is the most common long-term complication of shingles. The pain in PHN can be of different types including a constant aching, a burning pain, a sharp pain, or abnormal increased sensitivity of the skin to touch.

The incidence of PHN after shingles varies from 10% to 70%. It appears to be lower among patients with active shingles who are treated with acyclovir. The most important risk factors for PHN are similar for all individuals affected, including those with lupus. Individuals who develop shingles with numerous blisters and severe pain are at high risk for developing PHN. The risk of developing PHN also increases with age, from less than 4% in children to between 27% and 68% among those over age 60. The older the person, the longer will the PHN last. Women have a slightly higher risk than men. PHN usually resolves spontaneously after a year, but it sometimes persists or recurs for many years. Eventually, however, it goes away.

Although numerous treatment modalities have been tried for PHN, none is effective for all patients. Some patients report that pain appears when they are tired or fatigued, but that improvement occurs with rest. In others, the pain is intolerable and the best approach in the situation is to consult with a physician.

Acetaminophen, ibuprofen and other over-the-counter painkillers are generally ineffective for PHN. Capsaicin, an ointment having an ingredient from hot chili peppers, has been found helpful in 1 of 4 individuals with PHN. Acupuncture and herbal treatment modalities are mostly ineffective. Hypnosis, stress reduction techniques and behavioral cognitive therapies sometimes are effective. Among the best treatment for PHN are tricyclic-antidepressants that relieve the pain in up to 67% of patients. These agents, however, many have undesirable side effects.

A small proportion of patients, less than 10%, may require stronger analgesic therapy such as oral opiates.

Analgesics, anticonvulsants and sympathetic blockade are not very effective. Sometimes, dual therapy, such as topical analgesia (lidoderm) combined with tricyclic antidepressant, is effective. When all else fails, pain management clinics can be of use.

There is a live, attenuated Herpes zoster-varicella vaccine, but it is used only for prevention of disease and not for treatment of PHN.

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