Welcome to Today's Medical Education Program!

- I am pleased to be here with you on behalf of Merck & Co., Inc. who is sponsoring this medical education program.
- The program you are participating in is not an accredited Continuing Medical Education program.
- The information presented throughout the program will be consistent with FDA guidelines.

DR. EDGAR ROSS'S INSIGHTS ON ZOSTER

At the Pain Management Center at Brigham and Women's Hospital, we see about 23,000 patients a year, and among those patients, an increasing number of cases of zoster. Many physicians and patients think of zoster as a dermatological problem. But in our pain management center, we see herpes zoster patients whose disease may have progressed to significant neuropathic pain and complications. From a neurologic perspective, zoster can be considered a serious problem; and as the patient population ages, we need to actively address this disease.

Shingles, in the prodromal phase, can be very painful. For most people, the pain of zoster lessens as the rash heals. In some cases however, zoster can progress into postherpetic neuralgia or PHN. Some patients who develop PHN can develop severe pain that becomes their overwhelming life focus. The patients I see are healthy, active older people, but sometimes, when they develop PHN, their lives change, they may become homebound, depressed—essentially disabled. Though they may have been independent, now they have to rely on a caretaker.

Through my practice at the Pain Management Center I've seen some very severe cases of zoster. For example, I treated a woman with Ramsay Hunt Syndrome (postherpetic neuralgia of the sixth cranial nerve). She suffered from severe ear pain, she couldn't comb her hair and she couldn't go outside because even a mild breeze across the ear became excruciatingly painful for her.

On a personal level, my mother-in-law developed shingles (in the cervical area) and experienced hemi-diaphragm paralysis. The paralysis affected her for years, decreasing her ability for aerobic capacity because only half of her diaphragm was working.

For zoster patients who develop PHN, the best we can do is to try and manage the pain. Opiates are almost always involved, but opiates themselves are not enough. Polypharmacy may be required to get the pain under control, with analgesics, topical agents and anti-convulsants. We can stop other pain-related disorders from occurring, or at least decrease their frequency, and patients know that there is an end point. With PHN there is potentially no end point. It can be unremitting. Patients can take medications that help but then they may experience cognitive impairment or sedation.

The virus that causes zoster and zoster-associated pain change the physiology of the nervous system, potentially leading to nerve damage and permanent central sensitization.