



# Refractory Post-Herpetic Neuralgia with Permanent Scar

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## Clinical Image Description

A 62-year-old man with a history of poorly controlled diabetes mellitus presented with left loin pain of 2 weeks' duration, initially misdiagnosed as ureteric colic, and failed to respond to the traditional non-steroidal anti-inflammatory drugs. The patient continues to experience lancinating and burning pain, primarily on the left loin, and he reported feeling pain even with a light touch of the clothes. When he was examined by the neurologist, he noticed the presence of an erythematous, maculopapular rash, but over the course of a week, it progressed to pustules and ulceration, with crusts that supported the diagnosis of shingles.

The patient tried different types of neurogenic pain killers, including gabapentin, pregabalin, amitriptyline, and carbamazepine, with no response. The pain continued to increase thereafter, confirming the diagnosis of post-herpetic neuralgia. The pain was preventing the patient from sleeping and affecting his daily life and activities. After subsequent visits, the neurologist noticed the presence of cutaneous scarring in an area of previous herpes zoster as well as hypersensitivity to even non-

noxious stimuli. A plan was to refer the patient to a pain management clinic as probably being a candidate for a nerve block.



**Figure 1:** The scar of post-herpetic skin lesions on dermatomal distribution.



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## Overview

Varicella-Zoster Virus (VZV) reactivation is the cause of the characteristic illness known as Herpes Zoster (HZ), sometimes known as shingles. When immune protection against VZV deteriorates due to aging or immunosuppression, this reactivation takes place. Although herpes zoster can infect anyone at any age, it most frequently strikes the elderly. Postherpetic Neuralgia (PHN), a crippling and challenging-to-treat side effect of HZ, is pain that lasts longer than three months after the rash has healed. On the basis of the rash's distinctive appearance, HZ is typically diagnosed clinically. Early diagnosis and therapy might lessen acute symptoms as well as PHN [1].

The nucleoside analogues acyclovir, famciclovir, and valacyclovir prevent the replication of VZV and other human herpes viruses. These medications, when taken orally, shorten the time that the virus is shed, speed up the recovery of rashes, lessen the intensity and length of acute discomfort, and lower the possibility that PHN may develop. Antivirals have to be taken into consideration for all HZ patients because they are secure and well-tolerated. Patients over 50, those with moderate to severe pain or rash, and those with involvement of non-truncal dermatomes are specifically advised to have antiviral medication (e.g., the face). Within 72 hours after the appearance of the rash, treatment should be administered [2,3].

HZ can lead to the incapacitating complication of postherpetic neuralgia. Age raises the risk of PHN following HZ. According to a significant population-based study, the prevalence of PHN (defined as at least 90 days of documented pain) rose from 5% in people under the age of 60 to 10% in people between the ages of 60 and 69, and to 20% in people 80 years and older. Damage to the sensory nerves, which leads to neuropathic pain, is a significant contributor to the pain. The discomfort is frequently sporadic and unrelated to outside influences. Paradoxically, parts of the skin that are less sensitive to touch could also cause more discomfort. Allodynia is the term for the condition in which a light touch or clothing brush is occasionally interpreted as painful. The pain from PHN frequently affects one's ability to sleep or enjoy leisure time and is linked to severe depression [4].

The gold standard for treating the suffering associated with PHN is tricyclic antidepressants. The two most widely used members of this class, nortriptyline and amitriptyline, have been demonstrated to be effective in several clinical investigations [5].

Neuropathic pain can be effectively treated with a number of anticonvulsants. Pregabalin and gabapentin are examples of newer-generation anticonvulsant medications that have fewer side effects and necessitate less hematologic monitoring than earlier anticonvulsants like carbamazepine and valproic acid [6].

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