

Herpes Zoster in Older Adults: An Educational Approach

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ABSTRACT

Patients presenting with herpes zoster often have misconceptions of the pathophysiology and treatment options. Educating patients is a prime action of the treatment plan and can enhance patient satisfaction with the care they receive from the nurse practitioner. Realistically, nurse practitioners work within limited time with each patient; thus, patient education often loses priority. This article offers information of the clinical management of herpes zoster and recommendations for practical educational approaches that can be timely managed to help patients understand herpes zoster.

Keywords: disease management, herpes zoster, patient education, postherpetic neuralgia, zoster vaccine

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Herpes zoster (HZ), commonly known as shingles, is a painful viral infection that significantly affects older adults' morbidity and quality of life.¹ Up to 1 million new cases of HZ occur each year in the United States.² HZ is caused by the reactivation of the varicella virus, the same virus that causes chickenpox. Almost everyone in the United States has this virus in their body either from having chickenpox during childhood or from the chickenpox vaccine.³ The virus remains dormant on dorsal horn nerve cells near the spinal column but becomes reactivated when given the opportunity.^{2,4} This opportunity presents when a person's immune system is compromised either by age, negative life events, disease, medicines, or treatments albeit it is not predictable.^{1,4,5} With each decade of life, the incidence increases because of the gradual decline of the immune system as part of the natural aging process.⁴

Despite HZ being common, many patients do not understand its risk, complications, treatments, or prevention. NPs have an obligation to educate their patients, debunk any myths, and provide informational resources as part of the treatment plan. The purpose of this article is to discuss the clinical management of HZ and provide a practical approach to address patient education.

CASE EXAMPLE

Mr. E, an 83-year-old man, presented to the clinic with symptoms of painful blisters on his left anterior back that started 2 days prior. He described the pain as "intense and continuous; like a really bad sunburn. I can't stand clothes touching my skin." He denied fever, chills or cough. Lanacane (Combe, Inc, White Plains, NY) and over-the-counter pain medicine was ineffective for relief. He was having problems sleeping at night because of the pain and was feeling irritable. His past medical history was remarkable for a chronic atrial fibrillation and recent giant cell arteritis that was treated with prednisone 80 mg for 3 weeks. Mr. E had just finished the tapering dose regimen. His records indicated he had chickenpox when he was 7 years old. On physical examination, the nurse practitioner (NP) noted an erythematous maculopapular rash in the T6-T7 dermatome area on the left side only. The NP diagnosed shingles based on the patient's history of pain and classic presentation and distribution of the rash. When told he had shingles, Mr. E commented "I haven't been around anyone with shingles lately. I hope it doesn't spread in a complete circle around my body 'cause I heard you'll die if it does."

PHASE 1: ACUTE CARE NEEDS

The goal of treatment in the acute stage of HZ is to manage acute pain, speed healing of lesions, and prevent complications.⁶ Orally administered acyclovir, brivudin, famciclovir, or valacyclovir have all been proven to reduce the duration of viral shedding and new lesion formation and to accelerate rash healing in patients with HZ.⁷ The recommended antiviral treatments are valacyclovir 1,000 mg by mouth 3 times daily for 7 days, famciclovir 500 mg by mouth 3 times daily for 7 days, or acyclovir 800 mg by mouth 5 times daily for 7 to 10 days.⁷ Famciclovir and valacyclovir compared with acyclovir have the advantage of better absorption, resulting in higher antiviral activity and less frequent dosing.⁸ It is worth noting that patients taking antiviral medications should be encouraged to stay well hydrated because all 3 antiviral drugs have been associated with increased creatinine levels in poorly hydrated patients.⁶ Also, patients should be advised to avoid consumption of alcohol, which has diuretic properties and interacts with pain medications. General recommendations for the timing of treatment are to initiate treatment within 72 hours of rash onset.^{8,9} However, if ≥ 4 days has passed since onset of the rash and new lesions are still appearing at the time of clinical presentation, treatment should be considered. There is likely minimal benefit of antiviral therapy in the patient who has lesions that have encrusted.^{8,9}

HZ may have unusual presentations such as zoster multiplex, which occurs in multiple contiguous or noncontiguous dermatomes.² Zoster sine herpete, a variant form of shingles, is diagnosed based on clinical presentation. Zoster sine herpete is an uncommon manifestation of herpes zoster virus infection and presents with pain in a dermatomal distribution without the rash of cutaneous zoster.^{2,10} Therefore, in the absence of a rash, clinicians should pursue a diagnostic workup.¹¹ Positive immunoglobulins A and M are serologic indicators to help diagnosis, although there are challenges to interpreting the results because they can be indications of primary infection, reinfection, or reactivation.^{11,12}

Pain

Patients often describe a prodromal period to the rash of 1 to 3 days of deep aching and or general malaise.^{1,2} At times, thoracic pain can be so severe that

patients perceive they are having a myocardial infarction.² Although antiviral therapy reduces the pain associated with acute neuritis, pain syndromes associated with HZ can still be severe. The pain associated with HZ often has a distinct quality for each patient and is commonly described as “burning,” “shooting,” “stabbing,” or “throbbing.” Some patients describe the pain only when the involved area is touched; others complain primarily of pruritus.⁷ Nonsteroidal anti-inflammatory drugs and acetaminophen are useful for mild pain, either alone or in combination with a weak opioid analgesic (eg, codeine) or tramadol.⁷ For moderate to severe pain that disturbs sleep, stronger opioid analgesics may be needed (eg, oxycodone or morphine). To achieve a constant level of analgesia, pain medications should be dosed regularly rather than on an as-needed basis.

Patients unresponsive to treatment with opioid agents may benefit from the addition of a medication more specific to the treatment of neuropathic pain, such as gabapentin or pregabalin. Initiating concomitant treatment of antiviral and gabapentin as soon as the rash develops may diminish the severity of complications although there is lack of evidence that these medications prevent the development of postherpetic neuralgia (PHN).⁹ Although tricyclic antidepressants are also used for the treatment of neuropathic pain, they may be less well tolerated in older adults.⁶

Preventing Spread

During the period when the lesions are erupting and before crusts form, the HZ lesions are contagious. The virus can be spread both by direct contact and by the airborne route and cause varicella (chickenpox) in susceptible individuals who have not had chickenpox. Patients with HZ should be cautioned to avoid contact with pregnant women, premature infants, and immunocompromised individuals of all ages until the lesions are healed.⁶

In addition to discussing treatment options and preventing the spread of HZ, it is important to promote self-care strategies. Encourage them to get extra rest, drink plenty of fluids, and eat balanced nutrition foods to boost their immune system. Application of cool damp compresses made with washcloths with aluminum acetate can be applied twice a day to help dry out the

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