Post-herpetic Neuralgia

Research by Lev Neymotin

Re: Herpes Zoster sometimes followed by **post-herpetic neuralgia**

This should be treated as a **high-priority shingles/VZV complication until proven otherwise**, while also ruling out other nerve, spine, medication, and cancer-related causes. The usual medical issue would be **herpes zoster**, caused by reactivation of varicella-zoster virus, sometimes followed by **post-herpetic neuralgia**. CDC describes shingles as a painful rash illness caused by VZV, and people with weakened immune systems are more likely to have atypical, severe, generalized, or complicated cases.

Most likely mechanism: nerve injury + pain amplification

The symptom you describe — **large areas becoming exquisitely painful to touch** — sounds like **allodynia**, where normally harmless touch becomes painful. That points mainly to the **somatosensory nervous system**, not primarily lymph, circulation, or digestion. NICE describes neuropathic pain as pain from a lesion or disease of the somatosensory nervous system, and typical features include burning, stabbing, electric-shock pain, tingling, itching, and allodynia/hyperalgesia.

In shingles, the virus can reactivate in sensory nerve roots/ganglia. The immune suppression is relevant because VZV control depends heavily on cellular immunity; cancer-supportive guidance notes that VZV risk is particularly linked to impaired cellular immunity.

What needs urgent prioritization

1. Active or disseminated VZV must be ruled out first.
If he has any new blisters, spreading rash, rash on both sides of the body, fever, weakness, confusion, severe headache, neck stiffness, eye pain, facial rash, ear pain, hearing change, shortness of breath, jaundice, or new bladder/bowel dysfunction, this should be treated as **urgent/emergency**, not routine follow-up. CDC notes that disseminated zoster can involve generalized skin eruption and, in immunocompromised people, can involve the CNS, lungs, or liver.

2. If rash is present, ask for VZV PCR testing quickly.
PCR from vesicles, scabs, or cells from the base of a lesion is the preferred way to confirm VZV; non-skin samples such as saliva, urine, or CSF are more prone to false negatives, so testing strategy should be guided by infectious disease or neurology if there is no rash.

3. If there is no rash, shingles is still possible but harder to prove.
CDC explicitly notes that shingles can occur without a rash, called **zoster sine herpete**, and that

clinical diagnosis may not be possible without rash. In an immunosuppressed patient, this deserves specialist evaluation rather than dismissal.

4. Antiviral adequacy matters.
Standard shingles antivirals include acyclovir, valacyclovir, or famciclovir; CDC says antivirals reduce new lesions, viral shedding, lesion duration, and acute pain, especially when started early. In immunocompromised patients, NIH guidance for herpes zoster says antiviral therapy should be instituted as soon as possible, and if lesions are extensive or visceral/CNS involvement is suspected, **IV acyclovir** should be initiated; treatment duration may need to be longer if lesions resolve slowly.

5. Ask about antiviral prophylaxis after the acute episode.
If his immune system is still suppressed, his doctors should consider whether he needs ongoing valacyclovir/acyclovir prophylaxis. Cancer guidance uses risk-adapted HSV/VZV prophylaxis in immunocompromised adults and emphasizes dose adjustment in kidney dysfunction.

Practical symptom-control ladder to discuss with his doctors

A. Scheduled nerve-pain treatment, not only rescue treatment

For this type of pain, ordinary painkillers often underperform. NICE recommends **amitriptyline, duloxetine, gabapentin, or pregabalin** as initial options for neuropathic pain, with early review for dose titration, benefit, and adverse effects. The NHS similarly lists amitriptyline, duloxetine, gabapentin, and pregabalin for post-herpetic neuralgia when simple painkillers are insufficient.

Important practical point: if the attacks recur after “quiet periods,” that can sometimes reflect **medication troughs**. His doctor may need to adjust timing, dosing frequency, or add a planned rescue medication. Gabapentin/pregabalin require kidney-dose adjustment and can cause sleepiness, imbalance, cognitive slowing, and swelling, which matter in a 68-year-old. Mayo Clinic also notes these side effects for gabapentin/pregabalin.

B. Topical treatment for touch-triggered pain

For localized allodynia, ask about **lidocaine patches or gel/cream on intact skin**. The NHS lists lidocaine plasters as an option, and PHN reviews commonly include lidocaine 5% patch among first-line or early options because systemic exposure is low compared with oral drugs.

Avoid applying lidocaine, capsaicin, essential oils, DMSO, or other topical agents onto open blisters or broken skin unless his doctor specifically says to.

C. Cooling, but safer than repeated cold showers

Cold showers may be helping via “gate-control” pain modulation, but repeated emergency cold showers raise fall risk, chilling, and blood-pressure swings. A safer version is a **prepared cooling kit**: wrapped ice pack or cold gel pack, cool compresses, loose clothing, and a fan. The NHS suggests loose cotton or silk clothing, protecting sensitive skin with a light dressing layer, wrapped ice packs up to 20 minutes, and cool baths/showers for PHN symptoms.

D. Pain-clinic options when attacks are severe

If medication is not controlling the flares, this should escalate to a **pain specialist**, ideally one familiar with cancer and immunosuppressed patients. Options to ask about include:

Nerve blocks such as paravertebral, epidural, intercostal, sympathetic, or dorsal-root-related blocks, depending on the dermatome and imaging. These are not “alternative” treatments; they are pain-medicine tools, but infection risk and platelet/neutrophil counts must be checked first.

Capsaicin 8% patch can help some focal neuropathic pain but can be brutally irritating during severe allodynia and is usually specialist-applied. NICE advises not starting capsaicin patches in non-specialist settings unless advised by a specialist.

Botulinum toxin A injections are more unconventional for PHN but increasingly studied. A 2026 umbrella review concluded that botulinum toxin A may provide short-term relief in selected PHN patients and is generally well tolerated, but it should be considered an adjunctive third-line option with cautious expectations.

Pulsed radiofrequency, peripheral nerve stimulation, or spinal cord stimulation may be considered for refractory zoster-related pain. A 2026 network meta-analysis found that neuromodulation approaches, especially combinations such as spinal cord stimulation plus pulsed radiofrequency, may provide superior pain relief in herpes-zoster-related pain, but these are specialist procedures and not first steps.

E. Low-harm adjuncts worth considering

Electroacupuncture has newer evidence. A JAMA Neurology randomized clinical trial in 448 PHN patients found electroacupuncture produced a statistically greater reduction in pain than sham treatment at week 4, with higher responder rates and no clinically significant adverse events in that trial. It should still be avoided over active rash and used cautiously if he has low platelets, neutropenia, anticoagulation, or infection risk.

TENS may be worth discussing as a non-drug adjunct, especially for localized pain, but should be cleared first if he has a pacemaker/defibrillator, implanted devices, active lesions, or pain near tumor/radiation sites.

CBT, pain psychology, breathing training, and sleep treatment are not "it's in his head." They reduce central sensitization, panic escalation during flares, insomnia, and pain amplification. The NHS notes referral for CBT or pain clinic support when PHN pain is severe or function-limiting.

Mechanisms to consider and how I would prioritize them

Priority	Mechanism	Why it fits	What to do
Very high	Active VZV reactivation, including disseminated zoster	Recent immune suppression, severe shingles-like symptoms, possible atypical presentation	Same-day oncology/infectious disease review; VZV/HSV PCR if lesions; consider oral vs IV antiviral adequacy
Very high	Post-herpetic neuralgia / zoster-associated neuralgia	Severe touch sensitivity, burning/sharp flares, pain persisting or recurring after shingles	Scheduled neuropathic regimen; topical lidocaine; pain clinic
High	Zoster sine herpete	Shingles-like nerve pain without obvious rash can occur	Specialist diagnosis; consider VZV testing strategy, neurologic workup
High	CNS/spine/nerve-root complication	Severe flares, large areas, cancer history	Neuro exam; MRI spine/brain if weakness, bowel/bladder symptoms, bilateral/multilevel pain, confusion, headache
Medium-high	Cancer-treatment neuropathy or immune-mediated radiculitis	Experimental therapy may affect nerves or immune regulation	Review exact Swiss treatment, drug list, immune counts, imaging
Medium	Medication troughs or withdrawal between doses	"Quiet periods" followed by severe incidents	Adjust timing of pain meds; planned rescue strategy
Medium	Skin-barrier irritation/contact triggers	Clothing/touch triggering pain	Loose silk/cotton, dressings, avoid harsh soaps/topicals
Lower unless signs present	Circulation/lymph	Less likely to cause touch allodynia alone	Evaluate only if swelling, color change, cold limb, ulcers, pulse changes
Supportive	Digestion/sleep/nutrition	Constipation, insomnia, dehydration,	Treat constipation, sleep, hydration, protein intake,

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		malnutrition lower pain tolerance	B12/glucose/thyroid if relevant

Tests and information I would ask his doctors to review

Bring the exact treatment name from Switzerland and ask what “count went to 8” meant. Was it **white blood cell count, neutrophils, lymphocytes, CD4 count, PSA, radiation count, or something else?** That distinction matters.

Ask about: CBC with differential, absolute neutrophil count, absolute lymphocyte count, CD4/T-cell subsets if relevant, platelets, kidney function, liver enzymes, glucose/A1c, B12, thyroid tests, medication review, VZV/HSV PCR from any lesions, and MRI/neurology evaluation if pain is widespread, bilateral, non-dermatomal, or accompanied by weakness or bladder/bowel symptoms.

Things I would avoid unless a specialist explicitly approves

Avoid high-dose steroids, “immune boosters,” IV vitamin megadoses, ozone/peroxide infusions, aggressive massage over painful areas, sauna/ice-bath extremes, capsaicin on raw skin, cannabis extracts without specialist oversight, and starting/stopping gabapentin/pregabalin abruptly. In immunocompromised patients, even “natural” or needle-based therapies can become risky if platelets or neutrophils are low.

After the acute episode is controlled, ask about **Shingrix** timing. CDC recommends two doses of recombinant zoster vaccine for adults 19 and older who are or will be immunodeficient or immunosuppressed, but vaccination is prevention, not treatment of the current flare, and timing should be coordinated with oncology/infectious disease.