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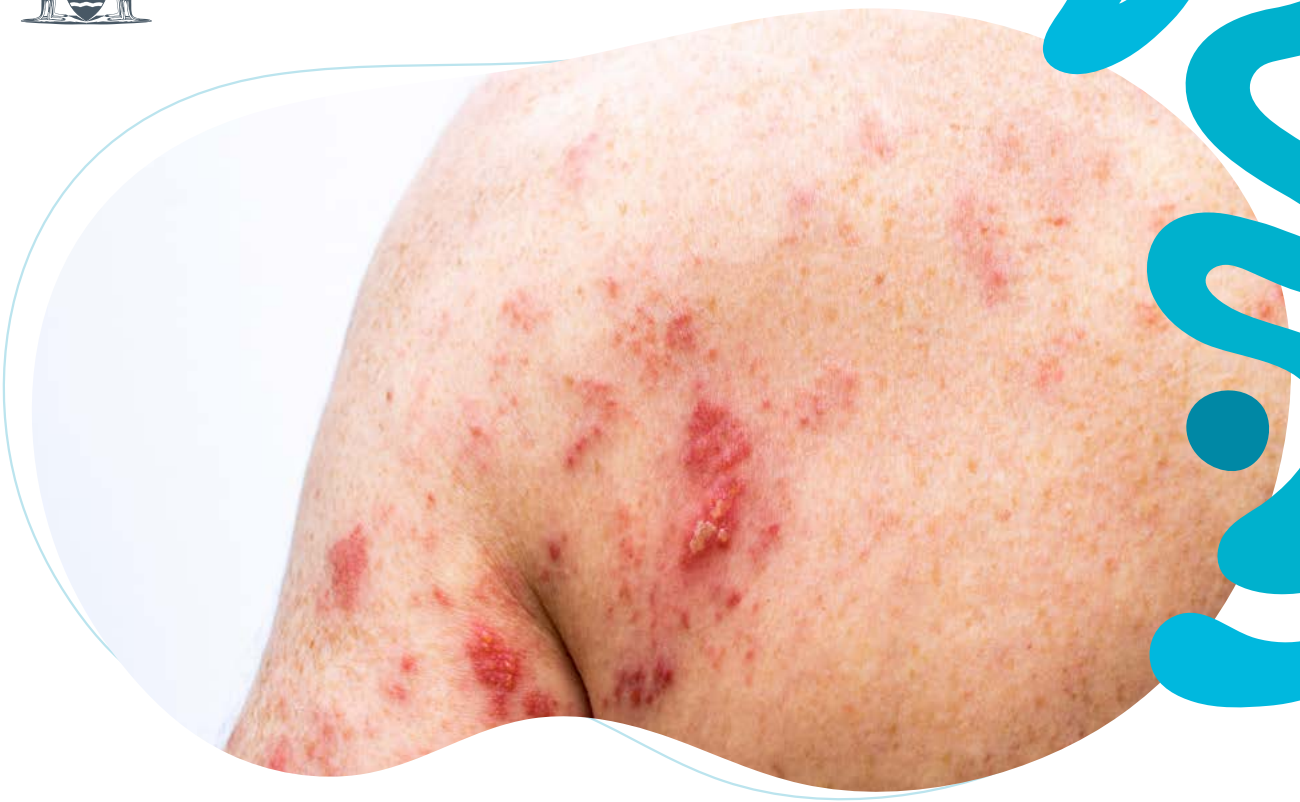

Enhanced Access Community Pharmacy Pilot

Herpes zoster (shingles)

Clinical practice guideline

Service restricted to patients aged 18 years or over.

Ineligibility for treatment as part of a prescribing service does not preclude a patient from accessing services provided as part of usual pharmacy care.

The information and content in this clinical practice guideline do not constitute medical advice, diagnosis, or treatment recommendations for individual patients. Pharmacists must exercise professional discretion and judgement consistent with their qualifications and legislative authority. This guideline does not override the responsibility of the pharmacist to undertake clinical assessments and to make decisions appropriate to the circumstances of the individual and the relevant standards of care, in consultation with the patient and/or their parent/caregiver. This clinical practice guideline may only be used by pharmacists who have been approved by the Department of Health to participate in the Enhanced Access Community Pharmacy Pilot (EACPP) and are authorised to prescribe under the *Medicines and Poisons Regulations 2016* (WA). This document alone does not provide an authorisation for a pharmacist to prescribe.

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- The patient is or could be pregnant and does not have a history of varicella-zoster virus (VZV) (or uncertain history).

Treat and concurrently refer

- Immunocompromised
- Superinfection of herpes zoster (HZ) skin lesions
- Multidermatomal rash or disseminated zoster
- Complications of HZ, postherpetic neuralgia (PHN), or specific zoster syndromes
- HZ affecting the face or genitals
- Pain management for neuropathic pain or moderate to severe nociceptive pain is needed
- Pregnant with a definite history of previous VZV infection
- Previously vaccinated against HZ
- Inadequate response to optimal treatment.

Key points

- Herpes zoster (HZ) can occur in anyone who has previously been infected with varicella-zoster virus (VZV) at any age, and the risk increases with age[1,2].
- Early identification and management with antivirals and analgesia (including all immunocompetent patients who present within 72 hours of rash onset as well as all patients who are immunocompromised regardless of rash duration) reduces the acute pain, rash duration, viral shedding, and potential for ocular complications of HZ[3,4].
- Vaccination is the most effective prevention for HZ and its complications[1,3]. The National Immunisation Program (NIP) recommends HZ vaccination for patients at risk[5].
- Under the WA *Public Health Regulations 2017*, VZV infection (including chickenpox and shingles) is a notifiable infectious disease.
- Under section 94 of the *Public Health Act 2016*, the legal obligation to notify the Department of Health of a notifiable infectious disease applies to medical practitioners, nurse practitioners, and pathologists. This requirement does not extend to pharmacists.

Refer when

Refer the patient to an appropriate healthcare provider (including emergency services if required) in the following situations:

- the patient is aged below 18 years (does not preclude a patient from accessing usual pharmacy care)
- unclear diagnosis
- the patient is or could be pregnant, and does not have a history of VZV (or uncertain history).

Treat (if clinically appropriate) and concurrently refer

Provide initial treatment (antiviral therapy and pain relief) and concurrently refer to an appropriate healthcare provider (including emergency services if required) in the following situations:

- immunocompromised
- superinfection of HZ skin lesions
- multidermatomal rash or disseminated zoster
- complications of HZ, including PHN or specific zoster syndromes
- HZ affecting the face or genitals
- pain management for neuropathic pain or moderate to severe nociceptive pain is needed
- pregnant with a definite history of previous VZV infection
- previous vaccination against HZ
- inadequate response to optimal treatment.

Patient history and assessment

Typical presentations of HZ can be diagnosed based on the patient history and examination for the characteristic appearance and distribution of the rash[1-3,6,7]. The clinical presentation will vary depending on the patient's age, general health, and affected dermatome[7].

Presenting signs and symptoms

Prodromal symptoms

- Prodromal symptoms may be observed between 48 to 72 hours before the localised, characteristic vesicular rash becomes evident[5-8]:
  - localised nerve pain (usually described as stabbing, prickling, or burning)
  - lethargy, fever, headache
  - abnormal skin sensations such as burning, itching, hyperaesthesia and/or paraesthesia
  - photophobia[3,6,7].

Rash

- The HZ rash is typically unilateral with a dermatomal distribution and distinct anterior and posterior midline cut-offs, however, some satellite lesions may also appear[4-8].
- New lesions will continue to erupt for 3 to 5 days within the locality of the affected nerve, becoming pustular, before scabbing and crusting over between 7 to 10 days[3,6,7].
- The most affected areas are the chest, neck, forehead (ophthalmic), and lumbar/sacral sensory nerve supply regions[3,6-8].
- When the ophthalmic division of the trigeminal nerve is affected (herpes zoster ophthalmicus), the patient will present with a blistering rash around the eye/eyelid with associated pain, swelling, and redness[6,8]. Urgent referral to an appropriate healthcare provider is required.
- If the facial nerve and subsequently, the vestibulocochlear nerve is affected (herpes zoster oticus/Ramsay Hunt syndrome), symptoms include earache, blistering in and around the ear canal, with or without facial paralysis[6]. Urgent referral to an appropriate healthcare provider is required.

Complications

Complications occur in approximately 13 per cent to 26 per cent of patients with HZ (most prevalent in older people and those who are immunocompromised) and will require referral to an appropriate healthcare provider at presentation or at any stage if a complication develops[3,5].

Postherpetic neuralgia (PHN)

- Neuropathic pain that persists for at least 3 months beyond the duration of the rash or reoccurs (occurs in 10 per cent to >70 per cent of patients, with the incidence increasing with age)[2,3,5,8,9].
- Postherpetic pain may be sharp/shooting and intermittent, or described as constant burning, often with extreme sensitivity to touch (allodynia)[7,9].

Herpes zoster ophthalmicus

- HZ affecting the ophthalmic branch of the trigeminal nerve with a high incidence of eye complications[3,10].
- It occurs in 10 per cent to 25 per cent of cases and commonly causes keratitis (approximately two thirds of cases) as well as conjunctivitis, uveitis, retinitis, and glaucoma[3].
- Vesicles on the nose have been found to be predictive of eye involvement[3].

Herpes zoster oticus (Ramsay Hunt syndrome)

- HZ affecting the facial nerve and subsequently, the vestibulocochlear nerve resulting in ear pain, taste loss, facial weakness or paralysis, and other neurological symptoms[3,8].

Disseminated zoster (VZV dissemination)

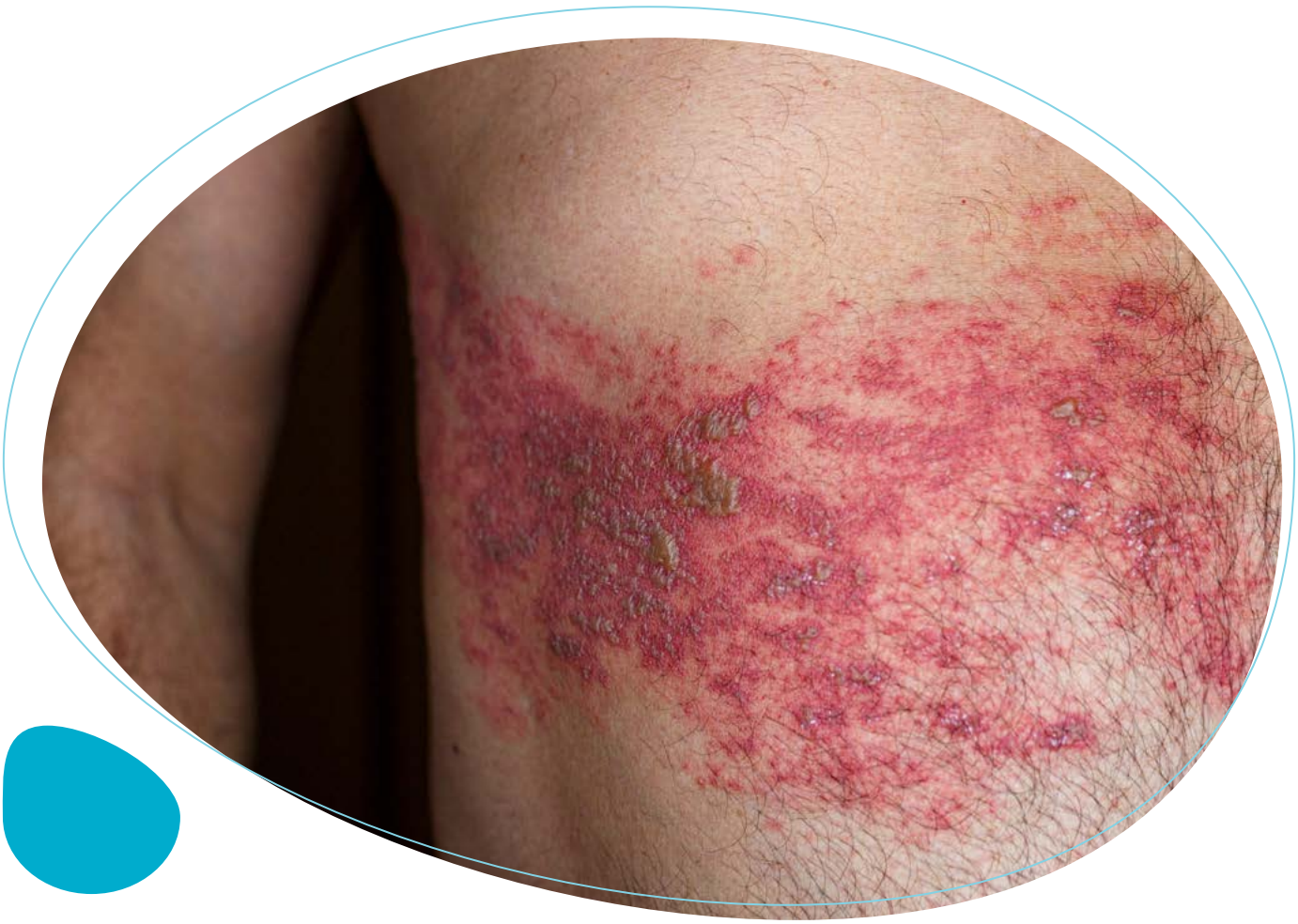
- While most individuals have some lesions external to the primary dermatome, disseminated zoster is defined as 20 lesions outside of the dermatome and may be clinically indistinguishable from varicella infection[3].
- Viral dissemination to the central nervous system and viscera (lungs, gut, liver, and brain) may occur[3].
- Occurs most frequently in immunocompromised patients, although is rare overall[5].

Other complications

- Neurological complications such as meningoencephalitis and myelitis (which is more likely in the elderly).
- Secondary bacterial skin infections (referral to an appropriate healthcare provider for swab and culture is required).
- Scarring.
- Pneumonia[5].

HZ in pregnancy

- Pregnant patients who are exposed to VZV (chickenpox or HZ) for the first time (no or uncertain history of previous chickenpox infection) may develop chickenpox which can have serious consequences. These include maternal mortality and morbidity, fetal varicella syndrome and the associated abnormalities[11,12]. Urgent referral to an appropriate healthcare provider is required as zoster immunoglobulin should be given to all seronegative women within 96 hours[5].
- Unlike chickenpox, it is thought that HZ contracted during a healthy pregnancy is not associated with intrauterine infection or an increased foetal risk[12].
- An unclear diagnosis of HZ in a pregnant patient must be referred immediately.



Patient history

Obtain sufficient information from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and lactation status (if applicable)
- nature, severity, and frequency of symptoms
- nature of rash (distribution, appearance, number of lesions)
- onset and duration of symptoms
- precipitating and relieving factors
- history of VZV infection
- underlying medical conditions e.g. immunocompromise (auto-immune diseases including diabetes, rheumatoid arthritis, HIV, cancer, conditions treated with immune suppressants, or renal impairment)
- current and recently ceased treatments (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- treatment and other strategies used to treat current symptoms and associated response
- drug allergies/adverse reactions
- immunisation status as per the Australian Immunisation Handbook (HZ and varicella vaccinations).

Examination

Examination of the rash and documentation of its characteristics and location, as well as any signs of complications is important for the diagnosis of HZ and the exclusion of other conditions with similar presentations.[NB1]

Laboratory confirmation is generally not required for typical presentations and uncomplicated cases of HZ[3,13]. Confirmatory pathology testing is required for cases where diagnosis is uncertain, or in cases of HZ in people who have been previously vaccinated against HZ[13,14].

NB1: Clinical presentations of herpes simplex virus infection can be similar to HZ, especially in the thigh and genital areas. Referral is recommended when the diagnosis is uncertain.

Reminder

Pharmacists can access a range of clinical information in a patient's My Health Record, including details about current and past medication history, allergies, and current medical conditions.

Develop management plan

Pharmacists must ensure that they are prescribing medicines according to the specified sections of the current online version of the Therapeutic Guidelines.

Antiviral treatment can reduce acute pain, rash duration, viral shedding, and the risk of ocular complications if started within 72 hours of rash onset in immunocompetent patients, and at any stage of rash duration in immunocompromised patients[4].

Pharmacist management of HZ involves:

- **non-pharmacological measures:**
  - education and advice regarding care for lesions (use of dressings, cleaning, and appropriate clothing)
  - education and advice regarding transmission precautions in accordance with the WA Department of Health Guideline[14]
- **pharmacotherapy:**
  - oral antiviral therapy in accordance with the Therapeutic Guidelines: Antibiotic (Skin and soft tissue infections – Shingles (Herpes zoster))[4]
  - oral analgesia for mild nociceptive shingles pain in accordance with the:
    - Therapeutic Guidelines: Pain and analgesia (Pain associated with shingles (herpes zoster) – Acute pain associated with shingles (herpes zoster))[9]
    - Therapeutic Guidelines: Pain and analgesia (Pharmacological management of acute pain – Mild, acute nociceptive pain)[15].

Confirm management is appropriate

Consult the *Therapeutic Guidelines, Australian Medicines Handbook, Australian Immunisation Handbook* and other resources to confirm that management is appropriate, including for:

- contraindications and precautions
- drug interactions
- pregnancy and lactation.

Zoster vaccination

Vaccination against HZ is the best way to prevent HZ and reduce the risk of complications, however it is not indicated during an acute HZ episode or to treat PHN[5].

- People who have had a previous episode of HZ can be vaccinated against a recurrence. The interval between the episode and vaccination is dependent on the patient's immune status[5].
- Refer to the Australian Immunisation Handbook for HZ vaccination information and recommendations[5].

Public health notification

Under the WA *Public Health Regulations 2017*, VZV infection (including chickenpox and shingles) is a notifiable infectious disease.

- Under section 94 of the *Public Health Act 2016*, the legal obligation to notify the Department of Health of a notifiable infectious disease applies to medical practitioners, nurse practitioners, and pathologists. This requirement does not extend to pharmacists.
- With the patient's consent, you should communicate your diagnosis of HZ to their nominated GP to support continuity of care and enable testing where appropriate, and any relevant clinical or public health follow-up.
- If the diagnosis is uncertain or the patient has previously been vaccinated against HZ, they should be referred to a medical practitioner who may initiate pathology testing.

Reminder

The prescribing and use of antimicrobials should be consistent with the principles described in the Therapeutic Guidelines: Antibiotic.

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) should be provided to the patient regarding:

- individual product and medication use
- non-pharmacological measures
- how to manage adverse effects
- recommendations for vaccination against HZ (see Australian Immunisation Handbook)
- when to seek further care and/or treatment, including recognising superinfection and HZ complications
- when to return for follow-up.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and/or parents/caregivers) and to ensure compliance with all copyright conditions.

The agreed management plan should be shared with members of the patient's multidisciplinary healthcare team, with the patient's consent.

General advice

At the time of initial consultation, patients (and/or parents/caregivers) should be advised to see an appropriate healthcare provider if:

- signs or symptoms worsen
- new signs or symptoms develop (e.g. superinfection of HZ lesions)
- the blisters spread to the face or genitals, or a new area
- they do not respond adequately to the recommended treatment or pain management is inadequate:
  - skin lesions usually heal within 2 to 4 weeks although it may take longer, particularly for those that are immunocompromised or those with severe disease[2]
  - pain and systemic symptoms subside as the rash resolves with recovery complete in 2 to 4 weeks in most cases[3,7]
  - pain can persist after shingles has resolved[4].
- they are experiencing complications, see Refer when and Complications of HZ
- they are having unmanageable adverse effects.

The incubation period of VZV ranges between 10 to 21 days (14 to16 days on average)[14].

Preventing transmission

The patient (and/or parents/caregivers) should be advised to inform any high-risk contacts who have had significant exposure to a person with active VZV to seek medical care as soon as possible[14].

High risk contacts include:

- pregnant people
- neonates in first month of life
- immunocompromised individuals
- non immune healthcare workers
- non immune persons who are in enclosed environments such as prisons, childcare, aged care, and disability settings.

Significant exposure includes:

- household contacts
- direct face-to-face contact for ≥ 5 minutes
- direct unprotected contact with fluid from lesions
- being in the same room for ≥ 1 hour.

People with HZ are infectious from the onset of the rash, until all vesicles have dried and scabbed[14].

Rashes should be covered with appropriate dressings until the patient is no longer infectious and contact with high-risk contacts must be avoided[14].

Considerations for healthcare workers:

- healthcare workers with HZ must cover all lesions with appropriate dressing or clothing
- healthcare workers with HZ lesions on their hands or face, or with disseminated shingles should be referred to a medical practitioner, and be excluded from work until all lesions have dried and crusted
- healthcare worker contacts of disseminated shingles (or direct unprotected contact with fluid from lesions) may also be advised to have vaccination, serology, or exclusion if they are non-immune.

Clinical review

Clinical review is generally not required unless the condition does not resolve or improve. Pharmacists should prescribe a quantity of medicine that aligns with the expected duration of therapy. Advise patients (and/or parents/caregivers if applicable) to see an appropriate healthcare provider if the condition does not improve or resolve (see Refer when and General advice).

Patient resources

- HealthyWA: Shingles
- Healthdirect: Shingles

Pharmacist resources

- Western Australia:
  - Clinician Assist WA: Herpes Zoster (Shingles)
  - Varicella-zoster virus infection (chickenpox and shingles)
- Therapeutic Guidelines: Antibiotic
  - Shingles (herpes zoster)
  - Treatment of herpes zoster ophthalmicus
- Therapeutic Guidelines: Pain and analgesia
  - Acute pain associated with shingles (herpes zoster)
  - Postherpetic neuralgia
  - Mild, acute nociceptive pain
- Australian Medicines Handbook:
  - Antivirals (Guanine analogues)
  - Paracetamol
  - NSAIDs
  - Zoster immunoglobulin
- Australian Pharmaceutical Formulary and Handbook: Treatment guideline for pharmacists (Shingles (herpes zoster))
- Australian Immunisation Handbook: Zoster (herpes zoster)
- DermNet NZ:
  - Herpes Zoster
  - Herpes Zoster (images)
  - Blistering skin conditions
- MSD Manual (Professional version): Herpes Zoster
- Skin Deep: An open-access bank of high-quality photographs of medical conditions in a wide range of skin tones for use by both healthcare professionals and the public.

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Feedback

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