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Werner, RN; Nikkels, AF; Marinovi, B; Schfer, M; Czarnecka-Operacz, M; Agius, AM; Bata-Csrg, Z; Breuer, J; Girolomoni, G; Gross, GE; Langan, S; Lapid-Gortzak, R; Lesser, TH; Pleyer, U; Sellner, J; Verjans, GM; Wutzler, P; Dressler, C; Erdmann, R; Rosumeck, S; Nast, A (2016) European consensus-based (S2k) Guideline on the Management of Herpes Zoster - guided by the European Dermatology Forum (EDF) in cooperation with the European Academy of Dermatology and Venereology (EADV), Part 2: Treatment. *Journal of the European Academy of Dermatology and Venereology*, 31 (1). pp. 20-29. ISSN 0926-9959 DOI: <https://doi.org/10.1111/jdv.13957>

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European consensus-based (S2k) Guideline on the Management of Herpes Zoster

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guided by the European Dermatology Forum (EDF)
in cooperation with the
European Academy of Dermatology and Venereology (EADV)

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PART 2: Treatment

Citation: Werner RN, Nikkels AF, Marinović B, Schäfer M, Czarnecka-Operacz M, Agius AM, Bata-Csörgő Z, Breuer J, Girolomoni G, Gross GE, Langan S, Lapid-Gortzak R, Lesser TH, Pleyer U, Sellner J, Verjans GM, Wutzler P, Dressler C, Erdmann R, Rosumeck S, Nast A. European consensus-based (S2k) Guideline on the Management of Herpes Zoster - guided by the European Dermatology Forum (EDF) in cooperation with the European Academy of Dermatology and Venereology (EADV), Part 2: Treatment. J Eur Acad Dermatol Venereol. 2016 Nov 2. doi: 10.1111/jdv.13957. [Epub ahead of print]

Title: European consensus-based (S2k) Guideline on the Management of Herpes Zoster – guided by the European Dermatology Forum (EDF) in cooperation with the European Academy of Dermatology and Venereology (EADV), Part 2: Treatment

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Funding sources: The guideline project has been funded by the European Academy of Dermatology and Venereology (EADV) with a research grant specifically for the guideline project. The EADV did not influence the project development or conduct.

Conflicts of interest: Interests have been declared at various points of the guideline development by all participating professionals. The complete declarations of interests are published in the methods report.

Abbreviations

AGREE II - Appraisal of Guidelines Research and Evaluation Instrument II

ARN – acute retinal necrosis

CNS – central nervous system

EADV – European Academy of Dermatology and Venereology

EDF – European Dermatology Forum

HZ – herpes zoster

NRS – numeric rating scale

PHN – postherpetic neuralgia

QoL – quality of life

TK – thymidine kinase

UEMS - Union Européenne des Médecins Spécialistes (European Union of Medical Specialists)

VZV – varizella zoster virus

ZAP – zoster associated pain

Abstract

Background: Herpes zoster (HZ, shingles) is a frequent medical condition which may severely impact the quality of life of affected patients. Different therapeutic approaches to treat acute HZ are available.

Objective: The aim of this European project was the elaboration of a consensus-based guideline on the management of patients who present with HZ, considering different patient populations and different localisations. This interdisciplinary guideline aims at an improvement of the outcomes of the acute HZ management concerning disease duration, acute pain and quality of life of the affected patients and at a reduction of the incidence of PHN and other complications.

Methods: The guideline development followed a structured and predefined process, considering the quality criteria for guidelines development as suggested by the AGREE II instrument. The steering group was responsible for the planning and the organisation of the guideline development process (Division of Evidence based Medicine, dEBM). The expert panel was nominated by virtue of clinical expertise and/or scientific experience and included experts from the fields of dermatology, virology/infectiology, ophthalmology, otolaryngology, neurology and anaesthesiology. Recommendations for clinical practice were formally consented during the consensus conference, explicitly considering different relevant aspects. The guideline was approved by the commissioning societies after an extensive internal and external review process.

Results: In this second part of the guideline, therapeutic interventions have been evaluated. The expert panel formally consented recommendations for the treatment of patients with HZ (antiviral medication, pain management, local therapy), considering various clinical situations.

Conclusion: Users of the guideline must carefully check whether the recommendations are appropriate for the context of intended application. In the setting of an international guideline, it is generally important to consider different national approaches and legal circumstances with regards to the regulatory approval, availability and reimbursement of diagnostic and therapeutic interventions.

Keywords: Clinical practice guideline, consensus statements, European guideline, herpes zoster, immunocompromized patients, postherpetic neuralgia, pregnancy, Ramsay-Hunt-Syndrome, recommendations, shingles, zoster ophthalmicus, zoster oticus

Disclaimer

Guidelines are intended to assist clinicians in standardized clinical situations. The final judgement with regards to the selection and administration of therapeutic interventions lies within the responsibility of the treating physician and must be individualized in light of all presenting circumstances. Users of the guideline must carefully check whether the recommendations are complete, correct, up-to-date and appropriate considering approval status, dosing regimes, mode of application, contra-indications, adverse effects and drug interactions. European guidelines are intended to be adapted to national circumstances (e.g. regarding regulatory approval, availability, reimbursement issues).

Scope and purpose of the guideline

The quality criteria for guidelines development as suggested by the Appraisal of Guidelines Research and Evaluation (AGREE II) Instrument¹ were incorporated into the development of the guideline. Detailed information on the scope, purpose and methods is reported in the methods report (online supplement).

Five strengths of recommendations were differentiated, expressed by wording and symbols (strong recommendation in favour, ↑↑ / weak recommendation in favour, ↑ / no recommendation, 0 / weak recommendation against, ↓ / strong recommendations against, ↓↓)². Table 1 shows wording, symbols and implications of each strength of recommendation. The percentage of agreement among the guideline’s expert panel was noted and reported (≥50%, ≥75%, ≥90%).

Table 1: Strength of recommendation - wording, symbols and implications (modified from Andrews et al., 2013²)

Strength	Wording	Symbols	Implications
<u>Strong</u> recommendation for the use of an intervention	“We recommend ...”	↑↑	We believe that all or almost all informed people would make that choice. Clinicians will have to spend less time on the process of decision making, and may devote that time to overcome barriers to implementation and adherence. In most clinical situations, the recommendation may be adopted as a policy.
<u>Weak</u> recommendation for the use of an intervention	“We suggest ...”	↑	We believe that most informed people would make that choice, but a substantial number would not. Clinicians and health care providers will need to devote more time on the process of shared decision making. Policy makers will have to involve many stakeholders and policy making requires substantial debate.

<u>No recommendation</u> with respect to an intervention	“We cannot make a recommendation with respect to ...”	0	At the moment, a recommendation in favour or against an intervention cannot be made due to certain reasons (e.g. no reliable evidence data available, conflicting outcomes, etc.)
<u>Weak recommendation against</u> the use of an intervention	“We suggest against ...”	↓	We believe that most informed people would make a choice against that intervention, but a substantial number would not.
<u>Strong recommendation against</u> the use of an intervention	“We recommend against ...”	↓↓	We believe that all or almost all informed people would make a choice against that intervention. This recommendation can be adopted as a policy in most clinical situations.

This second part of the guideline is devoted to the treatment of patients who present with HZ. It is divided into three sections:

- 1) Antiviral medication [background texts and recommendations drafted by B. Marinović (lead author), A. F. Nikkels, A. M. Agius, Z. Bata-Csörgő, J. Breuer, G. E. Gross, R. Lapid-Gortzak, T. H. Lesser, U. Pleyer, P. Wutzler],
- 2) Pain management [background texts and recommendations drafted by M. Schäfer (lead author), R. Lapid-Gortzak (co-lead author), Z. Bata-Csörgő, G. E. Gross], and
- 3) Local therapy [background texts and recommendations drafted by M. Czarnecka-Operacz (lead author), A. F. Nikkels, A. M. Agius, R. Lapid-Gortzak, T. M. Lesser, U. Pleyer].

The final recommendations were formally consented within the expert panel of the guideline.

Antiviral medication

General considerations for an antiviral medication

In the absence of risk factors for complicated courses (see part 1 of the guideline), HZ usually is a self-limiting disease. Goals of treatment are to improve the outcomes concerning quality of life (QoL) of the affected patients, extent and duration of cutaneous symptoms, and intensity and duration of acute zoster-associated pain (ZAP). Since postherpetic neuralgia (PHN) is the most frequent sequela of HZ, reducing its incidence is a major secondary treatment goal. In immunosuppressed or otherwise susceptible patients, treatment goals extend to reducing the incidence and intensity of accompanying complications.

In controlled trials, a reduced duration of skin symptoms and duration or severity of ZAP could be demonstrated for the systemic application of aciclovir³⁻⁶, and famciclovir⁷ when compared to placebo. A meta-analysis of four placebo-controlled trials of oral aciclovir could demonstrate statically significant superiority over placebo regarding time to cessation of pain.⁸ Results from RCTs suggest superiority of valaciclovir over aciclovir considering duration and/or severity of ZAP^{9, 10}. In these studies, no statistically significant differences were seen for the resolution of cutaneous symptoms. No statistically significant differences regarding pain cessation and resolution of skin symptoms were seen in RCTs comparing famciclovir with aciclovir^{11, 12}, brivudin with aciclovir¹³, and valaciclovir with famciclovir¹⁴. One RCT, contrary to the previously mentioned trials, demonstrated superiority of famciclovir when compared to aciclovir regarding cessation of pain. However this difference only occurred in the 500mg famciclovir group and was of questionable clinical significance.¹⁵ Another RCT, contrary to the previously mentioned trial on valaciclovir versus famciclovir, found a statistically significantly earlier reduction of pain with famciclovir.¹⁶

QoL, as a central patient-reported outcome, was only addressed in a very limited number of trials. Due to the reduction of the duration and intensity of acute ZAP, it is presumed that an antiviral therapy may positively affect QoL. This presumption, however, is not based on scientific observations.

A systematic review demonstrated that neither aciclovir nor famciclovir statistically significantly reduced the incidence of PHN four to six months after the onset of acute HZ when compared to placebo.¹⁷ Brivudin was compared with aciclovir in a survey study follow-up of a previously conducted RCT¹³, which found a significantly lower incidence of PHN after brivudin than after aciclovir treatment.¹⁸ In an RCT comparing brivudin with famciclovir, however, no statistically significant between-group differences with respect to pain prevalence and duration were seen.¹⁹

Regarding ocular complications of HZ ophthalmicus, pain duration and resolution of cutaneous symptoms, systemic application of aciclovir was favourable when compared to topical application of aciclovir in an RCT.²⁰ No statistically significant differences were seen in RCTs of valaciclovir versus aciclovir²¹ and famciclovir versus aciclovir²².

Controlled studies on antiviral medication have also been conducted in immunocompromised patients: One RCT compared the efficacy of intravenous aciclovir and placebo in immunocompromised patients with localized or disseminated HZ; here, aciclovir was superior considering a reduced incidence of complications (including cutaneous and visceral dissemination).²³ Another RCT in 48 immunocompromised patients, comparing intravenous

aciclovir with oral brivudin did not find statistically significant differences regarding cutaneous or visceral dissemination.²⁴ When compared to vidarabine, aciclovir was statistically significantly superior in preventing cutaneous dissemination, time until cessation of pain and healing of skin symptoms.²⁵

Based on consensus and in line with previous guidelines^{26, 27}, the expert panel recommends the initiation of an antiviral medication in the presence of any of the conditions listed in recommendation #18 (Table 2). Due to the relatively low risk of complications associated with an antiviral medication, the initiation of an antiviral medication should also be considered in patients who are at low risk of sequelae or a complicated course (Table 2).

Table 2: Health question 2, Antiviral medication, Recommendations #18 and #19

	Recommendation	Supporting literature	Strength	Consensus
#18	<p>We recommend treating the following patient subgroups with an antiviral medication:</p> <ul style="list-style-type: none"> - HZ of any localization in patients ≥ 50 years of age - HZ of the head and/or neck area - HZ of any localization with <ul style="list-style-type: none"> o moderate to severe zoster-associated pain o haemorrhagic or necrotizing lesions o >1 segment involved o aberrant vesicles / satellite lesions o involvement of mucous membranes - Zoster in immunocompromised patients - Zoster in patients with severe predisposing skin diseases (e.g. atopic dermatitis) - Zoster in children and adolescents under long-term treatment with salicylic acid or corticosteroids 	Clinical consensus; Tyring et al. 1995 ⁷ ; McKendrick et al. 1986 ³ ; Huff et al. 1988 ⁴ ; Wood et al. 1988 ⁵ ; Beutner et al. 1995 ⁹ ; Lin et al. 2001 ¹⁰ ; Shen et al. 2004 ¹¹ ; Shafran et al. 2004 ¹² ; Wassilew et al. 2003 ¹³ ; Tyring et al. 2000 ¹⁴ ; Degreef et al. 1994 ¹⁵ ; Ono et al. 2012 ¹⁶ ; Balfour et al. 1983 ²³ ; Wutzler et al. 1995 ²⁴ ; Shepp et al. 1986 ²⁵	↑↑	$\geq 90\%$
#19	<p>In patients younger than 50 years of age who present with HZ of the trunk or extremities, without being at risk of or displaying signs of a complicated course, we suggest initiating an antiviral medication.</p>	Clinical consensus; Tyring et al. 1995 ⁷ ; McKendrick et al. 1986 ³ ; Huff et al. 1988 ⁴ ; Wood et al. 1988 ⁵ ; Beutner et al. 1995 ⁹ ; Lin et al. 2001 ¹⁰ ; Shen et al. 2004 ¹¹ ; Shafran et al. 2004 ¹² ; Wassilew et al. 2003 ¹³ ; Tyring et al. 2000 ¹⁴ ; Degreef et al. 1994 ¹⁵ ; Ono et al. 2012 ¹⁶ ; Balfour et al. 1983 ²³ ; Wutzler et al. 1995 ²⁴ ; Shepp et al. 1986 ²⁵	↑	$\geq 90\%$

Based on consensus, an antiviral therapy using intravenous aciclovir is suggested in patients who present with complicated HZ or who are at risk of a complicated course (conditions specified in recommendation #20, Table 3).

Table 3: Health question 2, Antiviral medication, Recommendation #20

	Recommendation	Supporting literature	Strength	Consensus
#20	<p>We suggest using intravenous aciclovir in patients who present with complicated HZ or who are at risk of a complicated course. This includes the following patient groups:</p> <ul style="list-style-type: none"> - HZ of the head and/or neck area, particularly in 	Clinical consensus	↑	$\geq 90\%$

	elderly patients - HZ with haemorrhagic/necrotizing lesions, >1 segment involved, aberrant vesicles / satellite lesions, involvement of mucous membranes, or generalized zoster - HZ in immunocompromised patients - HZ with signs of visceral or central nervous system involvement (dosage escalation up to 15mg/kg bodyweight 3x/d possible, treatment for up to 21 days)			
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Although limited evidence suggests superior efficacy of valaciclovir, famciclovir and brivudin over orally administered aciclovir regarding different outcomes, this evidence was not consistently reproduced. Brivudin offers the advantage of a reduced dosing frequency. However, other factors should also be considered in choosing among an antiviral medication (Table 4). Costs are the lowest for aciclovir. Brivudin is not available in all countries. It is contraindicated for immunosuppressed patients and patients who have been treated with 5-fluoropyrimidine drugs (e.g. 5-fluorouracil, flucytosin) within the last 4 weeks due to possible life-threatening drug-interactions.

Table 4: Health question 2, Antiviral medication, Recommendation #21

Recommendation		Supporting literature	Strength	Consensus
#21	In patients who do not present with an indication to initiate an intravenous treatment with aciclovir, we suggest shared decision making with respect to using oral aciclovir, valaciclovir, famciclovir or brivudin, taking e.g. practicability (dosage frequency), costs, contraindications, comorbidity and drug interactions into consideration.	Clinical consensus	↑	≥ 90 %

Adaptation of dosages to the renal function according to the product information is necessary for aciclovir, valaciclovir and famciclovir. For these agents, creatinine should be checked in patients with known or suspected renal insufficiency at the time of treatment initiation (Table 5).

Table 5: Health question 2, Antiviral medication, Recommendation #22

Recommendation		Supporting literature	Strength	Consensus
#22	We suggest checking creatinine in patients with known or suspected renal insufficiency at the time of initiation of an antiviral medication with aciclovir, famciclovir, or valaciclovir.	Clinical consensus	↑	≥ 90 %

Due to the lack of trials evaluating the initiation of a systemic antiviral medication more than 72 hours after onset of the rash, there is no evidence basis to recommend the administration of antivirals in this setting. Based on consensus and as recommended in guidelines previously^{26, 27}, we suggest an initiation of an antiviral medication at a later point in time in the

presence of any of the conditions listed in recommendation #23 (Table 6), if treatment within 72 hours after the onset of cutaneous symptoms was not possible.

Table 6: Health question 2, Antiviral medication, Recommendations #23 and #24

	Recommendation	Supporting literature	Strength	Consensus
#23	<p>We suggest initiating antiviral medication as early as possible, within 72 hours after the onset of symptoms, or at a later time</p> <ul style="list-style-type: none"> - as long as new vesicles appear - in patients at risk of a complicated course or with manifest complications - in patients with signs of cutaneous, visceral or neurological dissemination - in the case of HZ ophthalmicus or HZ oticus - in all immunocompromised patients 	Clinical consensus	↑	≥ 90 %
#24	<p>We suggest against initiating an antiviral medication in patients who have ‘uncomplicated’ HZ (classical, unilateral thoracic or lumbar HZ in patients younger than 50 years of age, without signs of a complicated course) who present >72 hours after the onset of skin symptoms.</p>	Clinical consensus	↓	≥ 90 %

There are few trials evaluating whether an extended period of intake of antivirals provides benefit over the standard administration for seven days. These trials found no clinically relevant difference⁹ or a benefit of questionable clinical importance with prolonged treatment²⁸. Antiviral medication should be prolonged until no more vesicular lesions appear. If vesicle formation extends to more than seven days, the diagnosis should be reassessed and resistancy to the antiviral medication considered.

Specific situations

Renal function impairment

For HZ in patients with renal function impairment, we suggest initiating an antiviral medication with brivudin in the case of indication for oral treatment or with intravenous aciclovir with dosage adaptation in the case of indication for intravenous treatment as defined above (Table 7). This recommendation is based on consensus among the expert panel and on the reasoning that brivudin is relatively less dependent on renal excretion than other antiviral agents and intravenous (in-patient) treatment with aciclovir allows for close examinations of the renal function during the course of treatment.

Table 7: Health question 2, Antiviral medication, Recommendation #25

	Recommendation	Supporting literature	Strength	Consensus
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#25	In patients with renal function impairment, we recommend using oral brivudin (if oral antiviral medication is indicated) or intravenous aciclovir with dosage adaptation (if intravenous treatment is indicated as defined above).	Clinical consensus	↑↑	≥ 90 %
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Ophthalmic HZ

The treatment strategy in case of HZ ophthalmicus and necessity for an ophthalmologic reassessment should be determined by an ophthalmologist. Generally, treatment recommendations as specified above apply. Acute retinal necrosis (ARN) as complication of HZ ophthalmicus is an ophthalmic emergency that has to be managed under close supervision of an ophthalmologist. Since ARN is rapidly progressive and may spread to the contralateral eye, it requires immediate treatment with an intravenous induction and oral treatment continuation of antivirals for 3–4 months (Table 8). The prolonged treatment is recommended in order to prevent involvement of the second eye.^{29, 30} The additional use of systemic corticosteroid in these patients is still controversial in respect to its appropriate initiation. A loading dose of 0.5-1.0 mg/kg/day of corticosteroids (prednisolone) for the first 7–10 days of treatment has been suggested^{30, 31}. We suggest using topical and systemic corticosteroids as adjunctive anti-inflammatory treatment (Table 8). Caution should be taken to use corticosteroids in the absence of antiviral medication, since this may promote viral replication and even initiate ARN.

Table 8: Health question 2, Antiviral medication, Recommendations #26 and #27

	Recommendation	Supporting literature	Strength	Consensus
#26	In patients who present with acute retinal necrosis (as complication of HZ ophthalmicus), we recommend induction treatment with intravenous aciclovir (10mg/kg bodyweight 3x/d for 7-10 days)* followed by oral aciclovir (800mg 5x/d for 3-4 months)*. *Dosage adaptation may be necessary	Wong et al. 2013 ³⁰ ; Pleyer et al. 2015 ²⁹	↑↑	≥ 90 %
#27	In patients who present with acute retinal necrosis (as complication of HZ ophthalmicus), we suggest to use topical and systemic corticosteroids as adjunctive anti-inflammatory treatment.	Wong et al. 2013 ³⁰ ; Tibbetts et al. 2010 ³¹	↑	≥ 75 %

Otic HZ

The treatment strategy in case of HZ oticus with involvement of the facial nerve (i.e. Ramsay-Hunt syndrome) or with severe pain and cranial nerve palsies should be determined by an otorhinolaryngologist. The expert panel suggests initiating a combination therapy of intravenous aciclovir and oral corticosteroids (Table 9). Corticosteroids are still considered

the best treatment in viral inflammatory processes of the facial nerve.³² In HZ oticus with severe pain and cranial nerve palsies, intravenous aciclovir followed by oral treatment for one to two weeks has been used with success.³³⁻³⁵ Combination treatment is more effective in restoring facial nerve function after HZ oticus³⁶ and seems to offer better prognosis.³⁷

Table 9: Health question 2, Antiviral medication, Recommendation #28

	Recommendation	Supporting literature	Strength	Consensus
#28	In patients with HZ oticus with involvement of the facial nerve (Ramsay-Hunt syndrome) or with severe pain and multiple cranial nerve palsies, we suggest combination therapy of intravenous aciclovir with systemic corticosteroids.	de Ru et al. 2011 ³⁶ ; Coulson et al. 2011 ³⁷	↑	≥ 90 %

Pregnancy

Due to the lack of systematically assessed data on the safety of antiviral medications during pregnancy, careful consideration of possible harms and benefits is recommended. In the absence of the risk of complications (see part 1 of the guideline), we suggest against initiating an antiviral medication in pregnant women who present with HZ (Table 10). In a large population-based retrospective controlled cohort study and in a study including data from registries, the risk of birth defects in children whose mothers had been exposed to aciclovir was not increased. For other antiviral agents (valaciclovir and famciclovir), the number of cases was too small to draw conclusions.^{38, 39} Therefore, the initiation of an antiviral medication in pregnant women using aciclovir may be suggested in the presence of risk factors for complicated courses of disease, if potential benefits to the mother outweigh the potential risks to the fetus (Table 10).

Table 10: Health question 2, Antiviral medication, Recommendations #29 and #30

	Recommendation	Supporting literature	Strength	Consensus
#29	In the absence of the risk of complications, we suggest against initiating an antiviral medication in pregnant women.	Clinical consensus	↓	≥ 90 %
#30	We suggest the initiation of an antiviral medication in pregnant women in the presence of risk factors for complicated courses of disease, if potential benefits to the mother outweigh the potential risks to the fetus. In this case, aciclovir should be used preferentially.	Clinical consensus, Pasternak et al. 2010 ³⁸ ; Reiff-Eldridge et al. 2000 ³⁹	↑	≥ 90 %

Children

Due to the lack of data on the safety in children, we recommend careful consideration of possible harms and benefits of an antiviral medication. Generally, HZ in children presents with less morbidity than HZ in adults.^{40, 41} In the absence of the risk of complications (see part

1 of the guideline), we suggest against initiating an antiviral medication in children (Table 11). The initiation of an antiviral medication in children is suggested in the presence of risk factors for complicated courses of disease, if potential benefits outweigh the potential risks (Table 11).

Table 11: Health question 2, Antiviral medication, Recommendations #31 and #32

Recommendation		Supporting literature	Strength	Consensus
#31	In the absence of the risk of complications, we suggest against initiating an antiviral medication in children.	Clinical consensus	↓	≥ 90 %
#32	We suggest the initiation of an antiviral medication in children in the presence of risk factors for complicated courses of disease, if potential benefits of the treatment outweigh the potential risks.	Clinical consensus	↑	≥ 90 %

Therapy refractory / chronic HZ lesions

Clinical resistance of VZV infections to aciclovir should be considered in case of treatment failure of drug therapy for at least 10 to 21 days^{42, 43}, particularly in patients presenting verrucous VZV infections⁴⁴. When aciclovir resistance occurs, treatment with alternative medications, e.g. with brivudin or another TK dependent antiviral agent (famciclovir) may be required. In small retrospective case series of immunocompromised patients with aciclovir-resistant HZ, a response to intravenous foscarnet therapy has been observed.^{42, 45} Anecdotal reports exist which demonstrate responses of aciclovir-resistant VZV-strains to cidofovir.⁴⁶⁻⁴⁸ Both agents are not licensed for the treatment of HZ. They should only be used in very severe cases, with caution due to the risk of severe adverse effects, and only following discussion with virologists, pharmacists and intensive discussion of the risk-benefit balance with the patient. In the case of chronic HZ lesions, we refer to a review article by Wauters et al (2012)⁴⁴ on chronic mucocutaneous HZ lesions.

Acute pain management

Introduction

HZ rash is often preceded and accompanied by continuous or episodic sensory sensations such as pain, paresthesias (e.g. burning and tingling), dysesthesia (altered or painful sensitivity to touch), allodynia (pain associated with nonpainful stimuli), or hyperesthesia (exaggerated or prolonged response to painful stimuli).^{49, 50} Acute ZAP occurs in ≥95% of patients aged >50 years, and 60-70% of patients continue to have persistent pain one month

after the episode, 40% of those considering it severe^{51, 52}. While there is abundant literature on PHN^{53, 54}, evidence on the treatment of acute ZAP is scarce.

Assessment of pain

Pain intensity should be assessed by a validated assessment scale [e.g. Visual Analog Scale or Numeric Rating Scale (NRS)]^{55, 56} (Table 12). Additionally, validated assessment tools may be used to assess neuropathic pain characteristics [Douleur Neuropathique 4 (DN4), PainDETECT (PD-Q), or Leeds Assessment of Neuropathic Symptoms and Signs (LANSS)]^{55, 56} and QoL [SF36 or short form SF12]^{55, 56}.

Table 12: Health question 3, Pain management, Recommendations #33 and #34

	Recommendation	Supporting literature	Strength	Consensus
#33	We recommend assessing pain intensity by a validated pain assessment scale, e.g. Visual Analog Scale, Numeric Rating Scale (0 = no pain, 10 = worst possible pain).	Clinical consensus, Erlenwein et al., 2016 ⁵⁵ ; Haanpää et al., 2011 ⁵⁶	↑↑	≥ 90 %
#34	We suggest using additional tools (questionnaires) in selected patients as described in the background text.	Clinical consensus, Erlenwein et al., 2016 ⁵⁵ ; Haanpää et al., 2011 ⁵⁶	↑	≥ 90 %

Further tools may be used to assess response to treatment [e.g. minimum and maximum pain during the last 24 hours, pain intensity during movement, and satisfaction with pain management (NRS, 0, not satisfied to 10, very satisfied)]^{55, 56} (Table 13). Such tools have been recently validated for acute postoperative pain Europe wide⁵⁷.

Table 13: Health question 3, Pain management, Recommendation #35

	Recommendation	Supporting literature	Strength	Consensus
#35	We suggest assessing patients' satisfaction with pain management (NRS: 0 = not satisfied to 10 = very satisfied).	Clinical consensus, Erlenwein et al., 2016 ⁵⁵ ; Haanpää et al., 2011 ⁵⁶	↑	≥ 75%

Treatment of acute zoster-associated pain

Apart from improving functional status and health-related QoL, controlling acute ZAP is presumed to reduce the risk of PHN, although evidence from controlled studies to support this presumption is not available. Distinct to the treatment of PHN, acute ZAP should preferentially be treated by systemic analgetics and not by local agents (Table 14). It should be taken into account that a process of neuroinflammation is in part responsible for the painful sensations^{58, 59}.

Table 14: Health question 3, Pain management, Recommendation #36

Recommendation		Supporting literature	Strength	Consensus
#36	We recommend an early initiation of acute ZAP treatment, using systemic analgesics.	Clinical consensus	↑↑	≥ 90 %

Analgetic treatment of acute ZAP should follow the three-step WHO pain ladder⁶⁰ as based on the severity of pain (Table 15) and the individual considerations: in situations of mild pain intensity, NSAIDs or other non-opioids are appropriate; with moderate pain, non-opioids in combination with weak opioid analgetics might be sufficient; with severe pain, non-opioids combined with strong opioids may be required^{27, 55, 61}. Treatment should start according to the severity of pain and not follow a time-consuming stepwise approach⁶¹. Because of the neuropathic component of pain, tricyclic antidepressant (e.g. amitriptyline) or antiepileptic drugs (e.g. gabapentin, pregabalin) may be added as supplement to the basic analgetic treatment^{60, 62}. Effective plasma concentrations are reached after several days and thus, the basic analgesic treatment should not be postponed. The mentioned antidepressants and antiepileptic drugs may not be approved for the indication of acute ZAP treatment. Supplementing pain medication should be considered if pain severity at baseline is moderate to severe or other risk factors for PHN are present (Table 15). The individual risk for PHN may be estimated taking various prognostic factors into account as suggested by Meister et al. 1998⁶³: female gender, age > 50 years, number of lesions > 50, cranial / sacral localisation, haemorrhagic lesions, and dermatomal pain in the prodromal phase.

Table 15: Health question 3, Pain management, Recommendation #37

Recommendation		Supporting literature	Strength	Consensus
#37	We recommend analgesic treatment of HZ pain according to the WHO pain ladder ⁶⁰ and, if pain severity at baseline is moderate to severe or other risk factors for PHN are present, consider supplementing with an antidepressant (e.g. amitriptyline) or antiepileptic (e.g. gabapentin, pregabalin) drug*. *The mentioned antidepressants and antiepileptic drugs may not be approved for the treatment of acute zoster-associated pain.	Clinical consensus	↑↑	≥ 90 %

Treatment of ZAP should aim at an optimal pain relief, or if not attainable, at a reduction of pain to a level acceptable for the patient. A follow-up of patients with acute ZAP is suggested, including the period after resolution of skin lesions. In case of persisting pain not acceptable for the patient, a referral to a pain specialist is recommended (Table 16).

Table 16: Health question 3, Pain management, Recommendation #38

Recommendation	Supporting	Strength	Consensus
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		literature		
#38	We recommend referral to a pain specialist in the case of persisting pain (e.g. after 4 weeks after the resolution of skin lesions).	Clinical consensus	↑↑	≥ 90 %

Local therapy

General considerations

There is insufficient evidence and expert agreement to make recommendations for a specific topical treatment of acute HZ (Table 17). Clinical practices vary largely among different countries. For all topical treatment decisions, the current status of the skin needs to be assessed. Some experts from the group apply sterile saline 0.9% solution, or mild antiseptics such as polihexanide 20% solution to the affected area for 20 to 30 Minutes four to six times daily. The application of local zinc oxide lotion is common practice at some centers. Some experts recommend to refrain from any topical treatment but to keep the lesions clean and dry.

Table 17: Health question 3, Local therapy, Recommendation #39

Recommendation		Supporting literature	Strength	Consensus
#39	We suggest selecting a topical treatment according to the current status of the skin lesions.	Clinical consensus	↑	≥ 75%

The topical application of antiviral agents remains a matter of debate in case of HZ of the trunk and extremities. There are no placebo-controlled RCTs to support using these agents (Table 18).

Table 18: Health question 3, Local therapy, Recommendation #40

Recommendation		Supporting literature	Strength	Consensus
#40	We cannot make a recommendation with respect to the application of local antiviral preparations for cutaneous herpes zoster.	-	0	≥ 90%

The topical application of local anaesthetics or capsaicin cream is not advocated. A systematic review of topical lidocaine for the treatment of neuropathic pain⁶⁴ concluded that there is no evidence from high quality studies to support its use. Based on consensus, the

expert panel recommends treating acute ZAP according to the above-mentioned recommendations, using systemic analgetics (Table 19).

Table 19: Health question 3, Local therapy, Recommendation #41

	Recommendation	Supporting literature	Strength	Consensus
#41	We suggest against the application of local anaesthetic agents or capsaicin for acute HZ.	Clinical consensus, Derry et al. 2014 ⁶⁴	↓	≥ 90%

Specific situations

The optimal topical treatment strategy for HZ ophthalmicus remains controversial since RCTs have shown conflicting results: In one RCT assessing the efficacy of topical aciclovir versus betamethasone in zoster-associated keratouveitis, ocular symptoms resolved significantly quicker and recurrences occurred less frequently in the aciclovir-treated group.⁶⁵ In another RCT, a prolonged time to resolution of ocular inflammation was seen when compared to steroid treatment.⁶⁶ Based on consensus, the expert panel recommends the application of ocular aciclovir preparations to the affected eye five times daily (Table 20), particularly in case of VZV-associated dendriform keratitis. Topical steroids should be used with caution in staining epithelial lesions.

In disciform keratitis, endotheliitis and anterior uveitis, topical steroids are the mainstay of treatment (Table 20). Steroids need to be used with caution and under close supervision of an ophthalmologist, as the disease process may cause thinning and even perforation of the cornea, secondary glaucoma, and superinfection of reactivated dendriform keratitis⁶⁷.

Table 20: Health question 3, Local therapy, Recommendations #42 and #43

	Recommendation	Supporting literature	Strength	Consensus
#42	In the case of HZ ophthalmicus, we recommend the application of local aciclovir preparations (e.g. aciclovir 3% ocular ointment) to the affected eye five times daily.	Clinical consensus	↑↑	≥ 90%
#43	In the case of HZ ophthalmicus with disciform keratitis, endotheliitis or anterior uveitis, we recommend the application of topical steroids under the management of an ophthalmologist.	Clinical consensus	↑↑	≥ 90%

For HZ oticus, evidence from trials supporting a specific topical treatment approach is not available.

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