

Airing Pain Programme 129: Shingles & PHN (Post Herpetic Neuralgia)

Determining what Shingles really is and why vaccine uptake is so low?

*This edition of **Airing Pain** has been funded by a grant from The RS Macdonald Charitable Trust and The Stafford Trust.*

What exactly is Shingles? We often hear it thrown into conversation alongside a virus many of us have already had: Chickenpox. So how are the two linked? Why is one more associated with young people and the other with older people? The answer is they are both infections caused by the varicella-zoster virus. The vast majority of us had the Chickenpox virus when we were children, with many parents even intentionally exposing their children to the virus. Shingles, on the other hand, occurs after someone has already had Chickenpox when the virus (which remains in the body) is reactivated.

One of the main worries people have about having Shingles is the potential to develop Post Herpetic Neuralgia (PHN). This is defined as persistent pain 3 months after the initial rash developed. Unfortunately PHN is a chronic condition which causes burning neuropathic pain. This condition is caused by the damage the virus inflicted during its reactivation.

Paul Evans speaks to health professionals and somebody with lived experience of Shingles & PHN in order to illuminate the intricacies of the varicella-zoster virus, how it works and how it affects us throughout our lives.

Issues covered in this programme include: Shingles, Chickenpox, varicella-zoster virus, neuropathic pain, Post Herpetic Neuralgia, pain management, virus reactivation, insomnia, vaccination, vaccine uptake, side effects, amitriptyline, Gabapentinoids and depression.

Paul Evans: This is **Airing Pain**, a programme brought to you by Pain Concern, the UK charity providing information and support for those of us living with pain, and for those who care

for us. I'm Paul Evans, and this edition of *Airing Pain* is funded by The RS Macdonald Charitable Trust and The Stafford Trust.

Dr. Richard Johnson: 30% of us will get Shingles during our lifetime. But if we live to eighty, it's 50%. So, your chance of getting Shingles is actually pretty high.

Jan Fisher: 24/7, for eight years, I never have a minute that I don't have pain. It's been there for so long, they know now it's not going to clear up because it's really damaged all the nerve endings.

Johnson: Now not everybody is going to get post herpetic neuralgia. But the chance of getting Shingles is high. And you can't choose whether you get post herpetic neuralgia or a not. So really, the only choice you can make is to prevent getting Shingles.

Evans: Chickenpox, one of those childhood illnesses most of us had, whether we knew it or not, causes few problems in childhood. But it-, or the herpes varicella zoster virus that causes it-, can come back to bite us for want of a better word, as a much more serious illness in later life as Shingles. And the trouble doesn't necessarily end there. Because nerve damage caused by having Shingles can lead to intermittent or continuous nerve pain, the condition called post herpetic neuralgia. But, and here's the good news, a vaccine introduced in 2013 will help avoid getting the infection in the first place. The bad news is that the take-up by those eligible for the vaccine-, that's people in their seventies-, is poor. Dr. Michael Serpell, is a consultant in anaesthesia and pain medicine at Queen Elizabeth Hospital in Glasgow, and for the past twenty-five years has worked within its multidiscipline pain team.

Serpell: Shingles is a reactivation of a virus, which you've already been infected by, in the form of chickenpox. Usually, as a youngster. That virus remains dormant within your body, usually within the nerve tissue. And at some point, it can be reactivated generally when you're older. And it causes a rash and pain in a certain part of your body. And this usually causes a particular rash with little vesicles that can be painful in itself for several weeks.

Evans: Let me take you back a little bit. In fact, in my case, take me back about sixty-four years. I had chickenpox and, certainly with my parents, my children and my grandchildren, it was considered to be a good thing for your child to have chickenpox. So perhaps it's not such a good thing.

Serpell: Getting chickenpox is better when you're younger, because you do recover much quicker, and with less complications than you do as an adult. Once you get over the age of twenty, there are quite uncommon, but very serious complications like meningitis, sterility, you know, which can really, you know, be quite significant for the adult. But children seem to breeze through chickenpox illness over a matter of a week or so.

Evans: My parents were obviously... and we were obviously right to get our children and me to have chickenpox. But then you say the virus stays dormant and can come out as Shingles. So why is that?

Serpell: It's only reactivated, in most cases, when the immune system you have starts to subside. That often happens as you get elderly, that's just the general process of getting elderly a lot of your organ systems and immune system in particular do get less active and so the virus can emerge. It can also emerge if you are rundown, you know, a very severe illness from another cause, which runs your body down. Or if you're given drugs like steroids, which can suppress your immunity. These are opportunities for the virus to suddenly become reactive.

Evans: Now I have two experiences of Shingles in my family, one with my daughter in law, who was in her thirties and didn't even know she'd had Shingles, and my grandmother in her mid-eighties, who really did know she had Shingles, it looked as if her face had been burned in a fire. So, the severity might come with age.

Serpell: It's much less common in the younger people. So, with age, the incidence of having a flare up of Shingles increases. And we also know that generally speaking, it tends to be more severe during the actual flare up but also there is a higher incidence of developing this chronic pain condition called post herpetic neuralgia, the older you are compared to a

younger person. So, the example you gave me there, it shows you, you know, the rash was not obvious in your daughter law, she's younger. It's less common, but it's not unknown for people just to have an itch or a funny feeling and have no rash. But they have had Shingles if you do the tests to prove it. Your older relative had a much more pronounced reaction, the skin rash that's typical of older people, demonstrating more sensitivity to a flare up.

Evans: How long should Shingles last?

Serpell: The skin flare up, the vesicles usually subside after a few weeks, you can be left with painful, sensitive skin for several more weeks after that, but it should generally heal by a month to six weeks. But the real worry is developing what we call post herpetic neuralgia.

Evans: That's Dr. Michael Serpell, consultant in anaesthesia and pain medicine at Queen Elizabeth Hospital in Glasgow. So, what is post herpetic neuralgia? As a consultant anaesthetist, Dr. Robert Johnson ran the pain clinic at the Bristol Royal Infirmary with a particular interest in post herpetic neuralgia. Since retiring from clinical work, he continues with research, writing and teaching.

Johnson: We've had to create a definition for post herpetic neuralgia, because in the past people have called any pain that follows Shingles-, even a week after Shingles-, post herpetic neuralgia. But in fact, almost invariably, that's going to get better. And post herpetic neuralgia is now pain three months or more after developing the rash of Shingles, so all the results of studies that you might read are based on that definition of post herpetic neuralgia.

Evans: And that's a standard definition for chronic pain, pain that remains three months after the initial injury should have healed.

Johnson: That's right. But with Shingles, the Shingles virus will have ceased to be active a long time before three months after developing the rash. And in fact, much of the virus will have migrated back along the nerves from the skin back to the spinal cord where it had been ever since having chickenpox usually as a child.

Evans: So just explain the process... chickenpox is a virus.

Johnson: Yes. The varicella-zoster virus.

Evans: And that sticks around?

Johnson: Yes, from the rash that we have with chickenpox, which is, you know, can be pretty widespread. It migrates literally [within nerves] that carry sensation, back to some specialised nerve tissue around the spinal cord, and indeed, around certain parts of the brain as well. And it just stays there. You're unaware of it, it's not doing any harm. As it happens, we know that it *does* reactivate intermittently during life not causing any symptoms, but it does cause an immune response, which is very valuable because that delays the chance of getting Shingles.

Evans: So, we might not even know that it's been reactivated?

Johnson: Absolutely not. No.

Evans: So, what happens to make it reactivate into Shingles?

Johnson: Oh, there's a big question. Simply put, we grow older, the part of our immune system that deals with this particular virus [gets] weaker as we get older, and we get to a point where we get below a critical level of immunity, and the virus is able to reactivate, it takes advantage of the situation and then it spreads along the nerves that carry sensation to the skin and you've got Shingles.

Evans: So, if I get this right, one of the downsides of us living longer, which we think is a good thing, and then the advances of medicine have helped us to live longer, but the downside is our immune system is going and we may well catch it.

Johnson: I'm going to quibble with the [term], 'Catch it', but yes... (laughs)

Evans: Reactivated.

Johnson: Reactivated. Exactly.

Evans: So once it's reactivated, what happens?

Johnson: It replicates, so it divides, within cells so there's more and more virus as the acute Shingles continues, and it spreads along within nerves that carry sensation to the skin [into something that] we call [a] dermatome. Almost invariably, it only reactivates in one little segment of the body on one side of the body. It can be anywhere from the top of the head to your big toe, but it's usually only in one area. During the reactivation during the immune response, which there will be to the virus having reactivated, there is damage done to the tissues where the virus is. And that means to parts of the sensory nerves and even sometimes part of the spinal cord itself. And that is what leads to the long-term pain. It's not the virus still remaining active, it's the damage that was done during the actual attack, if you like, of Shingles,

Evans: Hence, the term *post-herpetic*.

Johnson: Exactly. That's right.

Evans: The virus has wrecked some part of the nervous system.

Johnson: Yes. And it isn't always the same nerve fibres, in every patient, every person who gets Shingles, some people have total numbness in the area. Some people have extreme sensitivity in the area such that a breeze or touching [of] the clothes is painful, we call that allodynia. So, it can differ a lot and the nature of the pain differs. You can get constant pain, which could be an aching or a burning pain. You can get tingling. You can get shooting pains, sudden electric shock-like pains. Some people get all of them. Some people just get one. It varies a lot from individual to individual.

Evans: Dr. Robert Johnson. Jan Fisher has had post herpetic neuralgia since having Shingles eight years ago.

Fisher: I've had it in the left front quarter of my head, so from my left eye, through to that corner of the head.

Evans: How did it feel when it started?

Fisher: I just felt like a raging headache at the top of my head and I noticed two tiny little red spots on the brow right into the hairline itself. But the pain was excruciating. And we were aware with our friends, we were in Salisbury. And it happened when we were just walking around Salisbury just before we left. And we had to drive all the way back and I was just in mortal agony from Salisbury to Norwich.

Evans: And what steps did you take?

Fisher: Well, I somehow knew-, I don't know why-, but something... I think it was these red spots, I somehow knew that it was Shingles. Then after that, it just got worse and worse and worse to the extent that my eye completely closed over. And it was just all covered in scabs, for want of a better word, associated with herpes. So, I just couldn't open my eye. I couldn't get out of bed; I lost a stone in weight. For the first two weeks, I was practically bedridden, couldn't walk at all I was just so ill.

Evans: How long did that last?

Fisher: It took four weeks before my eye opened. But I got out of bed on a regular basis. I think after two and a half weeks, then we were due to go on holiday because we're keen sailors and we rented boats, our friends and us out in Greece. So, I thought, 'Right it's on the mend now, I'll go', and of course it wasn't like that at all. I was still ill while I was out there. [I was] not very well when I got back but, slowly, I felt better in myself because I never ever got rid of the pain in the head and the rash cleared up. I had the eye looked at the hospital

just to make sure there was no permanent damage done to the eye. But I was lucky it was just on the eyelid and round about the eye rather than the eye itself.

Evans: The outward signs-, the scabs as you call them-, did they go?

Fisher: Yes, they did. But because it was in my hair, it was very, very difficult to treat it. Fortunately, the old style calamine lotion was still available. I mean, it was the only thing that soothed my head and face, so I just had it caked on sort of day and night around the eye and all the way in the head and the hair. So, it wasn't very nice, but at least it stopped the itching because it itches. I mean that's what I'm left with today as well. It's not just pain, which is more like a... Now it's a light tingling effect until about six o'clock and then it ramps up. But I break out with a rash every so often and I have at the moment. So last night I never slept because [of] this rash all over my head like an eczema. But of course [the pain] being in my head... The natural reaction when you've got pain is to cuddle yourself or [hold] a hot water bottle. But when it's on your head-, it's like having an earache or toothache-, you can't comfort it in any way.

Evans: Jan Fisher, the Shingles Support Society has been running since 1987. with the aim of giving advice to people who have Shingles and to raise awareness of the Shingles vaccine. More on that later. Here's the society's Marian Nicholson:

Marian Nicholson: Anyone who suspects they've got Shingles needs to see a doctor right away. And therefore, awareness of what Shingles is, is very important. We've got leaflets that we send out to GP surgeries, just so that people who are vaguely interested and have vaguely heard of Shingles can pick it up and learn more about how to identify the beginning of a Shingles outbreak. It's that weird sensation in a small area of [the] body. And I can't be more specific, because for some people, it's a burning [sensation on the] skin, like an area of scalded skin. And for other people, it's a needling sensation, as though someone were hitting your skin with one of those wire brushes they use on rust. So, it could be absolutely anything. But a small weird sensation, and then that's followed by spots that appear in that same region. Little blistery things like chickenpox spots.

Evans: You're in charge of the Shingles Support Society. What do people want to know from you?

Nicholson: They read up on three different topics really about Shingles. One of them is the infectivity. So, people are worried, that, now they've got Shingles, are they allowed to mix with the public? And the answer is yes. Because only somebody who's never had chickenpox could catch anything from you. And there aren't many of those around. And anyway, they would have to actually rub against the area of Shingles. And as so often Shingles is on the ribs or is under clothing, people are not going to come in contact with it. If it's on the face, obviously, keep your face away from other people. But most people have had chickenpox and, therefore, most people are never going to be able to catch anything from you. The other topic is treatment. And then the final topic now is that people are ringing up to find out if it's okay for them to get the Shingles jab.

Evans: Marian Nicholson of the Shingles Support Society. So that's the infectivity of Shingles dealt with. We'll deal with the vaccine later. But treatment, Dr. Robert Johnson:

Johnson: There are drug treatments and there are non-drug treatments. The most common drug treatments these days would be amitriptyline, which is a drug which was originally introduced and used as an antidepressant, but in much higher doses. And it happens that in low doses, it has an effect on parts of the transmission of impulses within nerves, pain impulses in this case, which can be very beneficial. So, in nerve pain, it can be very helpful. And the other main class of drugs that are given are drugs called the gabapentinoids: gabapentin and pregabalin. They don't give benefit to everybody. Some people get side effects which are worse than the benefit. But they are helpful in many cases, there's no doubt about that.

Evans: Is that a long-term treatment?

Johnson: It can be. My practice was to use drugs until one had got control. Continue for at least another month, and then just gradually reduce the dose to see what happened.

Sometimes you had to go back to the original dose. Sometimes you could actually stop the drug. But the answer is to test it and see.

Evans: What happens when those drugs aren't effective?

Johnson: We've got problems. There are some topical treatments, one can apply local anaesthetic usually in special very expensive patches, which are helpful to some people. There are substances... there's one called capsaicin, which is actually derived from hot chilli peppers. And that can be applied as an ointment, which is a messy business because it's three times a day, and it stings for about twenty minutes or more each time it's applied. [It] can give help to some people, there's no doubt about that. There are again, skin patches, we're using capsaicin, which is a *much* higher concentration, which are applied maybe every twelve weeks or so. In some people, there is benefit but it's not hugely successful. And there are all sorts of other things which are really unproven. [Such as] botulinum toxin, Botox, is used in some centres. There's been some success with it, but I think not enormous. The truth is [that] probably less than 50% of people get really satisfactory effects from treatment of post herpetic neuralgia. Now, one thing to remember though, which is important. Post neuralgia starts at three months. It doesn't necessarily go on forever. It only goes on for as much as twelve months in about four in 100 people, something like that. Most people are still going to get a reduction over time, after it has developed.

Evans: Dr. Robert Johnson. Jan Fisher again:

Fisher: I was on medication for a number of years. I've been down to the specialist neurology research centre in London. And I had three infusions of lidocaine. And each infusion lasted, I think it was two or three hours, and he just had no effect whatsoever. So, I've had that, I've had all the pills, I've been on various antidepressants, because that's known to sort of treat nervous complaints. But in the meantime, had all of the side effects that you would get with taking these pills long term. So, I decided, well, I've got pain with the medication, I don't like taking the medication. So, I just stopped taking it all. And basically, that's where we are now. I'm no worse off for not taking it. And I was no better off for taking it. So, there's days when it's really, really bad. And I just cry, more out of

frustration than anything. And then, you know, it'll go away. And I just think, 'Okay, fine, it's gone. Get on with it with your life.' I know I've got for the rest of my life. All the experts have told me this. It might go away. It might not. But chances are, it won't.

Evans: Jan Fisher, Dr. Michael Serpell, consultant in anaesthesia, and pain medicine, with a multidiscipline pain team at Queen Elizabeth Hospital in Glasgow:

Serpell: A lot of people do come expecting the pain, you know, to be completely taken away with drugs or other treatments that we might do, injections, for example. But the reality is often, it's only helped a little bit, if at all, and maybe only one in five to one in ten get a worthwhile improvement in the pain. So, the majority of people are going to have to accept their degree of pain and learn to cope with it, learn to live with it, and get as useful a life as possible. That's quite a difficult thing for a patient to understand and [accept], but that's what education and talking helps to impart.

Evans: Now I know that in pain clinics like your pain clinic, I'm sure, it's not just drug management, pain is a bio psycho social business. How do you teach people to self-manage it, and how effective is it?

Serpell: There are specific techniques that we can train the patient in, once they accept that they're going to have to come to terms and cope with the degree of pain. So, there are specific techniques like mindfulness, cognitive behavioural therapy that we use, that will help people accept the degree of pain they're in, they can dissociate themselves somewhat from it. And they can sort of let the pain wash over them rather than become tense and fearful of the pain, which then amplifies the unpleasant experience of the pain.

Evans: You use term, 'Learn to live with it', that doesn't mean, 'Well, that's it, get on with it', there are approaches to self-management that really can help people with chronic pain.

Serpell: Absolutely, yes. 'Learn to live with it', is not just a passive throwaway statement saying, 'We're going to discharge you, learn to live with it', it is actually trying to empower patients with training and give them the tools to cope not just with the intensity of the pain

that they will experience-, during the daytime, there will be flare ups-, you can give them techniques to sort of get through that phase of the day. But also, other aspects like improving their sleep, you know, getting a good night's sleep can make such a difference to how you feel and what your pain levels are experienced like, so improving your sleep, improving your mood... We know that if you're depressed or anxious, that amplifies the pain response as well. So, it's trying to deal with these peripheral things which the pain makes worse, but they also make the pain worse.

Evans: Is it the circle of pain? [As in] you have the pain, you get depressed about it, you stop exercising, you stop eating properly, and that feeds into the pain and makes it worse. And then it goes round and round again, everything feeding into each other. And you have to break that circle, I guess.

Serpell: Yeah, absolutely. It's a vicious circle and it's a self-perpetuating one. So, trying to break the deleterious effects of the pain can help actually reduce the pain itself. So having better understanding and education, not being so anxious, seeing some hope, seeing some positivity, and, therefore, [belaying] depression. All these things will make the experience of pain, bad as it is less bad than it would otherwise have been. So, it allows some escape and by asserting or demonstrating to yourself that you have some control over the degree of pain that you suffer, that gives you confidence to actually start to move in a positive way and know that you can control to a degree, the amount of pain and, therefore, get on with your life and function as best as possible despite the pain still being there, but you hopefully are able to push it into the background.

Evans: And pain management programmes help you to break that circle.

Serpell: Absolutely. [A] pain management programme is a very intense structured programme done as a group, usually a dozen or so patients at a time, go through a prolonged course, it's usually a full day for twelve weeks in a row. So, it's a very intense programme as a group, with a lot of physiotherapy and psychology training along the way. We bring in CBT, cognitive behavioural therapy, mindfulness techniques. And we train

people up to understand that and start using the simple tools in order for people to come out [at] the end with empowerment to be able to control the pain as best as they can.

Johnson: There is only one answer to post herpetic neuralgia, and that's don't get it. And the only way we have of not getting it is by vaccination.

Evans: So, Dr. Robert Johnson has brought us to the third of those concerns we mentioned earlier, expressed [by] the Shingles Support Society, vaccines. Now, the vaccine was rolled out in the UK in 2013. And I must confess that I, like many of us, found guidelines of who was eligible to have it and why we should have it rather confusing. Marian Nicholson of the Shingles Support Society:

Nicholson: When it was first introduced, because there wasn't a great deal of supply, and because they didn't want to overwhelm GPs, they brought it in on a catch-up scheme, where people who were seventy and seventy-nine, were eligible for the drug. And then the next year, it was people who were seventy, seventy-one *and* seventy-nine. Slowly each year, they've been adding another year. And now finally, they've met in the middle. So now, the Shingles vaccine is available to anyone from their seventieth birthday through to the last day of their seventy-ninth year. And we are encouraging people to get that vaccine, because it prevents half the cases of Shingles. And in the other half where people do actually develop Shingles, it lessens the chances of this post herpetic neuralgia that we've been talking about.

Evans: Marian Nicholson of the Shingles Support Society. So, whilst the initial take-up of the vaccine in 2013 may have been satisfactory, the subsequent take-up has been poor. Robert Johnson:

Johnson: I think it's because of the lack of knowledge of us, as a population, about the disease and the potential problems. There have been one or two international studies of looking at knowledge of Shingles. And they all show that it's only people who've had a close relative, or a close friend who has developed Shingles and post herpetic neuralgia who really know anything much about it. Otherwise, it's thought of as a slightly painful rash that people sometimes get. And of course, 'Sometimes get', is an interesting point, because by the time

we get to eighty, eleven in every 1000, every year of the population will get Shingles. And to put that into an easier concept, perhaps, 30% of us will get Shingles during our lifetime. But if we live to eighty, it's 50%. So, your chance of getting Shingles is actually pretty high. Now, not everybody is going to get post herpetic neuralgia, but the chance of getting Shingles is high. And you can't choose whether you get post herpetic neuralgia or not. So really, the only choice you can make is to prevent getting Shingles.

Evans: So that vaccine is all-important?

Johnson: Yes. I don't like being a scare monger. But I have to say, I wouldn't want long standing post herpetic neuralgia. I think it's well worth avoiding. If the vaccine were a dangerous vaccine, I'd take a different, more balanced view on that. But the vaccine is not [dangerous]. It is a live attenuated vaccine. The virus has been treated in a way where it does not cause a disease of any interest at all. It's been used for many, many years in a much more dilute form to give to children in America. In fact, since 1995, I think. All children have been given this vaccine to prevent chickenpox and the one we use for Shingles is exactly the same virus, but in a rather larger dose. The only reason for the larger dose is, as we get older, as we've said, our immune systems are less effective. Therefore, to get a response to the vaccination, it has to be a stronger dose of the virus that's given.

Evans: Well, going back to childhood. It's the same chickenpox virus that resides in your body. If you don't get chickenpox as a child, you can't get Shingles.

Johnson: That is true. Most of us are not aware perhaps that we had chickenpox. And we rely on our parents to have told us that. But we do know from testing blood samples in large numbers of people that in this part of the world [over] 95% of people have had chickenpox by the time they reach the age of say, twenty. So it is almost universal, that we have had chickenpox, so virtually everybody is possibly going to get Shingles.

Evans: If you're vaccinated while you have Shingles, will that help stall the post herpetic neuralgia?

Johnson: No, it's too late. By the time the vaccine has actually had an effect... As we know with COVID vaccination, we're told that it's two to three weeks away before we get an effect, well, it's the same, and it wouldn't have any beneficial effect, no.

Evans: Well, the other thing is, you mentioned COVID. We're recording this towards the end of June 2021, where the UK, like many other countries, may be facing its third wave of COVID-19. If you have the Shingles vaccine, will it affect the COVID vaccine or vice versa?

Johnson: I don't think there's been any specific work on this. My opinion on this would be that it would be not sensible to have it within two or three months of the COVID vaccine for no particularly good scientific reason. But just a hunch that I think beyond that, yes, [it's] perfectly reasonable to go ahead with Shingles vaccination.

Evans: Dr. Roberts Johnson. I'll just remind you that whilst we in Pain Concern believe information and opinions on ***Airing Pain*** are accurate and sound based on the best judgments available, you should always consult your health professional on any matter relating to your health and wellbeing. They're the only people who know you and your circumstances, and therefore the appropriate action to take on your behalf. Do check out Pain Concern's website at painconcern.org.uk where you can download all editions of ***Airing Pain*** and find a wealth of support and information material about living with and managing chronic pain. So, the Shingles vaccine is a major step to avoiding having Shingles and, therefore, post herpetic neuralgia. But what's around the corner? Amitriptyline, a drug commonly used for the treatment of chronic pain, including Shingles was mentioned earlier. Robert Johnson:

Johnson: Well, there are two ways of using amitriptyline one is to treat the pain once it's occurred. But there is a view that amitriptyline in low doses may actually prevent post herpetic neuralgia if it's taken shortly after the Shingles has commenced. And there is about to be a large study testing whether this is true. People who present to their general practitioner with Shingles in certain parts of the country will be invited to take part in the study and they will then be offered a low dose amitriptyline or a dummy, a placebo, to assess whether it really works or not. We would then be looking at whether the

amitriptyline prevented post herpetic neuralgia or not. There have been studies-, not totally satisfactory studies-, which indicate that it may well do so.

Evans: So that, if it works, would be taking the amitriptyline... you wouldn't have to do that *before* you had the Shingles?

Johnson: No, you would start as soon as possible after having the Shingles. [It is a] little difficult to say how long [it] would go on for. We're testing it for seventy days, and then looking for post herpetic neuralgia. After that it would certainly not be intended to be a long-term use, it would be a short-term use to see if it prevents post herpetic neuralgia developing.

Evans: Dr. Robert Johnson. I recommend that you look at the Shingles Support Society website at Shinglessupport.org.uk. And there you can find a treasure trove of reliable information to support living with and managing Shingles and post herpetic neuralgia. There's information for patients and healthcare professionals. Now, if we've left you in any doubt about the importance of at least considering getting vaccinated against Shingles, I'll leave you with Jan Fisher.

Fisher: 100%, please get the vaccine. Do not risk having any sort of long-term after effects of it. And even if they're short-term effects, for that length of time that you have it, your life will change. It will change and there's no doubt about it. And yes, there could be more serious illnesses which could afflict you, but it really does dampen the spirit, it's depressing, it's painful. It's a social disease because you cannot go out, you cannot socialise once you've got it because you can't participate. So, 100%, 1,000% don't ever ever risk getting where I'm getting it. Once you're offered it, get it.

END

Contributors:

- Dr Michael Serpell, Consultant in Anaesthesia & Pain Medicine at Stobhill Hospital Glasgow.
- Marian Nicholson, Director of the Herpes Viruses Association & Shingles Support Society.
- Dr Robert Johnson, Honorary Senior Research Fellow, Bristol Medical School, University of Bristol.
- Jan Fisher, had the Shingles virus & lives with Post Herpetic Neuralgia.

More information:

- [Shingles Support Society](#)
- [Airing Pain 46: Post-Herpetic Neuralgia and Migraine](#)
- [Airing Pain 115: Neuropathic Pain 1](#)
- [Airing Pain 116: Neuropathic Pain 2](#)
- [Pain Concern's leaflet on Neuropathic Pain](#)
- [Herpes Viruses Association](#)
- [NHS Guidance for Shingles](#)
- [British Pain Society](#)
- [IASP Global Year Against Neuropathic Pain 2014-15](#)