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Herpes Zoster with Neurological Complications

Patient education guide · Infections · Madison Neurology LLC

What is it?

Shingles (herpes zoster) is reactivation of the chickenpox virus, which lies dormant in nerve roots for decades. Beyond the familiar painful rash, it can cause neurological complications: facial paralysis with ear involvement (Ramsay Hunt syndrome), eye inflammation (herpes zoster ophthalmicus), nerve-root weakness in a limb, meningitis, and — most commonly — post-herpetic neuralgia (persistent nerve pain after the rash heals).

How does it happen?

The varicella-zoster virus persists in sensory nerve ganglia after childhood chickenpox and reactivates when immune surveillance wanes — with age (especially over 50), immunosuppression, illness, or stress. The reactivated virus travels down the nerve, inflaming it and causing the stripe-like rash in that nerve's territory.

Common symptoms

- Painful, blistering rash in a stripe on one side of the body or face
- Ramsay Hunt syndrome: ear rash/pain with one-sided facial paralysis, hearing changes, vertigo
- Eye involvement: rash on the forehead/nose tip with eye pain — an ophthalmic emergency
- Limb weakness when motor roots are involved (zoster paresis)
- Post-herpetic neuralgia: burning pain and touch-sensitivity persisting after the rash heals

How is it diagnosed?

Diagnosis is usually clinical from the characteristic one-sided stripe-like rash; swab PCR confirms unclear cases. Eye involvement requires same-day ophthalmology. Neurological complications are evaluated by examination, and MRI/spinal fluid when meningitis or other involvement is suspected.

How is it treated?

Antivirals (valacyclovir, acyclovir) started within 72 hours of rash onset shorten the illness and reduce complication risk — early treatment is the whole game. Pain is managed aggressively from the start (gabapentinoids, sometimes short steroids with antivirals). Ramsay Hunt is treated with antivirals plus steroids. Eye involvement gets urgent ophthalmic antiviral treatment. Post-herpetic neuralgia is managed with nerve-pain medications and topicals. Prevention: the recombinant shingles vaccine (Shingrix) is >90% effective and recommended for adults 50+ and immunocompromised adults 19+ — even after a prior shingles episode.

What does the future hold?

Most shingles resolves in 2-4 weeks; facial palsy from Ramsay Hunt recovers in the majority, especially with early treatment. The main long-term burden is post-herpetic neuralgia, which is commoner with age and usually fades over months. Vaccination prevents the vast majority of cases.

Questions patients commonly ask

Q: Can I give someone shingles?

A: You can't transmit shingles, but the blister fluid can give chickenpox to a non-immune person — cover the rash and avoid pregnant or immunocompromised contacts until it crusts.

Q: I already had shingles — should I still get the vaccine?

A: Yes — Shingrix is recommended even after an episode, because shingles can recur.

Q: The rash is near my eye — how urgent is this?

A: Same-day evaluation: eye involvement can threaten vision and needs immediate antiviral and ophthalmic care.

National support groups & resources

- **American Academy of Neurology — Brain & Life patient resources** — brainandlife.org
- **Centers for Disease Control and Prevention** — cdc.gov
- **American Chronic Pain Association** — theacpa.org

(Organization contact details were current at the time of compilation; please verify online.)

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