# SKIN AND SOFT TISSUE INFECTIONS
## Varicella-Zoster/ Herpes Zoster

**When to treat chickenpox (Varicella-Zoster):**

- In immunocompetent patients, the value of antivirals is minimal.
- If the onset of rash is <24 hours and the patient is either: >14 years, severe pain / dense rash, smoker, on steroids, or a secondary household case **AND** treatment can **start within 24 hours of the onset of rash**, consider aciclovir.
- Signs of severe infection include: respiratory symptoms, densely cropping vesicles, haemorrhagic rash, bleeding, neurological changes, persistent fever with new vesiclaes >6 days after onset.
- Regardless of immune function and use of any immunoglobulins, neonates with chickenpox should be referred for parenteral antivirals.

**Chickenpox in Pregnancy:**

- **Urgently** seek specialist advice regarding the need for diagnostic tests counselling on the risk of foetal varicella syndrome, antiviral treatment, and follow up.
- Only prescribe an antiviral medicine in primary care (with informed consent) on the advice of a specialist.
- All cases of chickenpox require close monitoring, and admission to hospital should be considered if there is any deterioration. (If in any doubt discuss with the duty Infectious Diseases doctor via NUH City Campus switchboard on 0115 9691169).
- If a pregnant woman is ***exposed*** to chickenpox or herpes-zoster and does not have a definite history of chickenpox, a serum sample should be taken **immediately** to determine their VZ immune status.
    - Liaise with the virology laboratory to ensure rapid testing.
    - Discuss with virology/microbiology specialist for further advice on whether VZ immunoglobulin is required if they are found to be non-immune.
- Ensure the pregnant womans midwife/obstetric team is made aware of exposure/infection.

**When to treat shingles (Herpes Zoster):**

- **Patients >50 years who present within 72 hours of the onset of rash.** Postherpetic neuralgia is rare in <50 years but occurs in 20% of >60 years.
- Always treat ophthalmic shingles (with valaciclovir and refer to Ophthalmology), Ramsay Hunt syndrome, patients with underlying eczema or if immunocompromised.
- Non-truncal distribution.
- Severe pain or severe rash.

**Immunocompromised patients:**

- Both varicella and herpes zoster can be life-threatening in the immunocompromised (including those on oral steroids) and immediate treatment is indicated.
- Recommended oral therapy for zoster in the immunocompromised is **aciclovir 800mg five times daily for 10 days.** Continue for 2 days after crusting of lesions.
- Phone the on-call Infectious Diseases doctor at NUH via switchboard on 0115 9691169, for advice if an immunocompromised patient develops severe varicella or herpes zoster infection or has significant exposure to other patients with these conditions.
- Immunocompromised patients require close monitoring and admission for IV aciclovir should there be any deterioration.

**Treatment - Varicella-Zoster (Chickenpox) *AND* Herpes Zoster (Shingles)**

| Treatment[1] | Dose | Duration |
|---|---|---|
| Aciclovir | **Child 1–23 months:** 200mg four times a day<br>**Child 2-5 yrs:** 400mg four times a day<br>**Child 6-11yrs:** 800mg four times a day<br>**Adult and child ≥12yrs**: 800 mg five times a day | 5 days<br>5 days<br>5 days<br>7 days |
| Valaciclovir<br>(**Only if compliance is likely to be poor.** 10 times the cost of aciclovir) | **Adults and children ≥12years:** 1g three times a day | 7 days |

[1]See BNF and BNFC for appropriate use and dosing in specific populations, e.g., hepatic, or renal impairment, pregnancy, breastfeeding.