SA Health

Herpes Zoster (Shingles)

Clinical Practice Guideline

September 2025

Herpes Zoster (Shingles) – Clinical Practice Guideline.
Printed copies uncontrolled.

Version 1.0 September 2025

Government of South Australia
SA Health

Authorisation

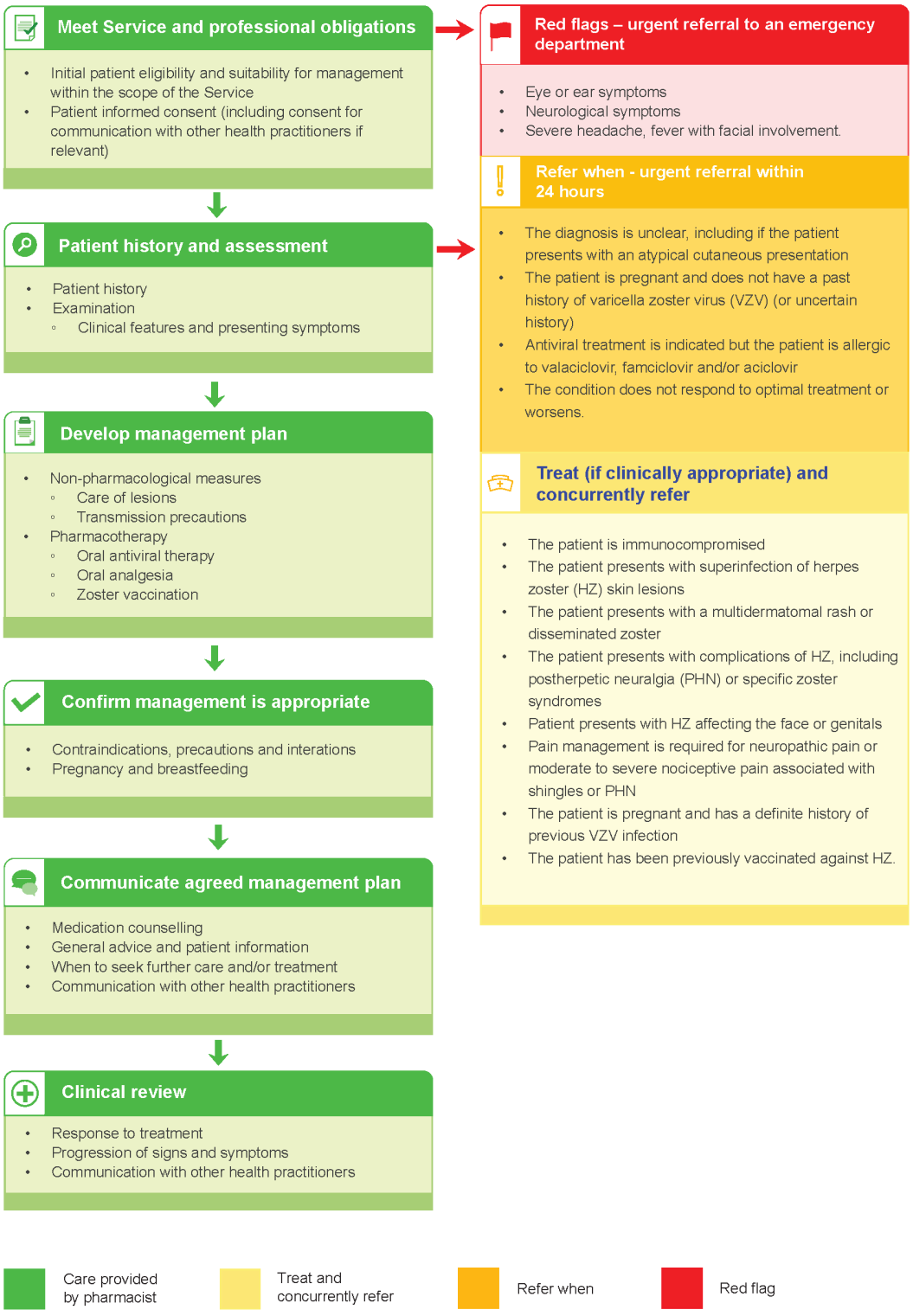
Community Pharmacy Expanded Scope of Practice Initiative

In accordance with regulation 17A of the *Controlled Substances (Poisons) Regulations 2011* (the Poisons Regulations) a pharmacist is authorised to prescribe a prescription drug (not being a drug of dependence) if the pharmacist is included on the register of authorised pharmacists and the drug is prescribed in accordance with the Community Pharmacist Prescribing Code.

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.

Guideline Overview



‘Red flag’ warning signs at patient presentation that necessitate referral to emergency medical care:

Urgent referral to an emergency department – patient may make their own way to the emergency department:

- Eye or ear symptoms
- Neurological symptoms
- Severe headache, fever with facial involvement.

Refer to a general practitioner (or other medical practitioner where appropriate):

Urgent referral within 24 hours:

- The diagnosis is unclear, including if the patient presents with an atypical cutaneous presentation
- The patient is pregnant and does not have a past history of varicella zoster virus (VZV) (or uncertain history)
- Antiviral treatment is indicated but the patient is allergic to valaciclovir, famciclovir and/or aciclovir
- The condition does not respond to optimal treatment or worsens.

Treat (if clinically appropriate) and concurrently refer:

Provide initial treatment (antiviral therapy and pain relief) and concurrently refer to a general practitioner (or other medical practitioner where approriate) in the following situations:

- The patient is immunocompromised
- The patient presents with superinfection of herpes zoster (HZ) skin lesions
- The patient presents with a multidermatomal rash or disseminated zoster
- The patient presents with complications of HZ, including postherpetic neuralgia (PHN) or specific zoster syndromes
- Patient presents with HZ affecting the face or genitals
- Pain management is required for neuropathic pain or moderate to severe nociceptive pain associated with shingles or PHN
- The patient is pregnant and has a definite history of previous VZV infection
- The patient has been previously vaccinated against HZ.

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 (3, 4).
- Early identification and management with antivirals and analgesia (within 72 hours of the onset of the rash) reduces the acute pain, rash duration, viral shedding and potential for ocular complications of HZ (6, 7).
- Vaccination is the most effective prevention for HZ and its complications (3, 6). The National Immunisation Program (NIP) recommends HZ vaccination for patients at risk (1).
- Under the South Australian Public Health Act 2011, VZV infection (chicken pox or shingles) is a pathological diagnosis notifiable condition; clinical notification is generally not required. See the Notifiable disease reporting page for more information (12, 13).

When applying the information contained within this clinical practice guideline, pharmacists are advised to exercise professional discretion and judgement. The clinical practice guideline does not override the responsibility of the pharmacist to make decisions appropriate to the circumstances of the individual, in consultation with the patient and/or their carer.

Gather information and assess patient's needs

Typical presentations of HZ can be diagnosed based on the patient history and examination for the characteristic appearance and distribution of the rash (2-4, 6, 14). The clinical presentation will vary depending on the patient's age, general health and affected dermatome (2).

Rural communities and Aboriginal and Torres Strait Islander people in South Australia are more likely to present late, atypically, or with complications of herpes zoster due to systemic healthcare access barriers.

Presenting signs and symptoms

Prodromal symptoms

- Prodromal symptoms may be observed between 48 to 72 hours before the localised, characteristic vesicular rash becomes evident (1, 2, 8, 14).
    - localised nerve pain (usually described as stabbing, prickling or burning)
    - lethargy, fever, headache
    - abnormal skin sensations such as burning, itching, hyperesthesia and/or paraesthesia
    - photophobia (approximately 80% of cases) (2, 6, 14).

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 (1, 2, 7, 8, 14).
- 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 (2, 4, 6, 14).
- The most commonly affected areas are the chest, neck, forehead (ophthalmic) and lumbar/sacral sensory nerve supply regions (2, 6, 8, 14).
- When the ocular nerves are affected (herpes zoster ophthalmicus), the patient will present with a blistering rash around the eye/eyelid with associated pain, swelling and redness (8, 14). Urgent referral to a medical practitioner is required.
- If the facial nerve is affected (herpes zoster oticus/Ramsay Hunt syndrome), symptoms include earache, blistering in and around the ear canal, with or without external ear and facial paralysis (14).

Complications of HZ

Complications occur in approximately 13% to 26% of patients with HZ (most prevalent in older people and those who are immunocompromised) and will require referral to a medical practitioner at presentation or at any stage if a complication develops (1, 6).

Postherpetic neuralgia (PHN)

- Neuropathic pain that persists for at least 3 months beyond the duration of the rash or reoccurs (occurs in 10 to 50% of patients, with the incidence increasing with age) (1, 4, 6, 8, 15).

- Postherpetic pain may be sharp/shooting and intermittent, or described as constant burning, often with extreme sensitivity to touch (allodynia) (2, 15, 16).

Herpes zoster ophthalmicus

- HZ affecting the ophthalmic branch of the trigeminal nerve with a high incidence of eye complications (6, 15).
- It occurs in 10-25% of cases and commonly causes keratitis (approximately two thirds of cases) as well as conjunctivitis, uveitis, retinitis and glaucoma (6).
- Vesicles on the nose have been found to be predictive of eye involvement (6).

Herpes zoster oticus (Ramsay Hunt syndrome)

- HZ affecting the facial nerve resulting in ear pain, taste loss, facial weakness or paralysis, and other neurological symptoms (6, 8).

Disseminated zoster (VZV dissemination)

- Whilst 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 (4).
- Viral dissemination to the central nervous system and viscera (lungs, gut, liver and brain) may occur.
- Occurs most frequently in immunocompromised patients, although rare overall (1).

Other complications

- Neurological complications such as meningoencephalitis and myelitis (particularly in the elderly).
- Secondary bacterial skin infections (referral to a medical practitioner for swab and culture is required).
- Scarring.
- Pneumonia (1).

HZ in pregnancy

- Pregnant women who are exposed to VZV (chicken pox or HZ) for the first time (no or uncertain history of previous chicken pox infection) may develop chicken pox which can have serious consequences, including maternal mortality and morbidity, fetal varicella syndrome and the associated abnormalities (10, 17). Urgent referral to a medical practitioner is required as zoster immunoglobulin (ZIG) should be given to all seronegative women within 96 hours (1).
- Unlike chicken pox, it is thought that HZ contracted during a healthy pregnancy is not associated with intrauterine infection or an increased fetal risk (10).

Patient history

Sufficient information should be obtained from the patient to assess the safety and appropriateness of any recommendations and medicines.

The patient history should consider:

- age
- pregnancy and breastfeeding 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 medications (including prescribed medicines, vitamins, herbs, other supplements and over-the-counter medicines)
- medication and other strategies tried to treat current symptoms
- drug allergies/ adverse drug effects
- immunisation status as per the Australian Immunisation Handbook (HZ and varicella vaccinations).

Aboriginal and Torres Strait Islander patients

Consider referring to the CARPA Standard Treatment Manual for further information for Aboriginal and Torres Strait Islander patients living in rural and remote communities (9).

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.

Examination

Apply standard and contact infection precautions when examining patients.

Conduct assessment of vital signs – temperature, blood pressure, heart rate, hydration status.

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.

Laboratory confirmation is generally not required for typical presentations and uncomplicated cases of HZ (6, 18). Confirmatory pathology testing (initiated by a medical practitioner) is required for cases where diagnosis is uncertain, or in cases of HZ in people who have been previously vaccinated against HZ. A low threshold for referral to medical practitioner for testing should be encouraged as it can be very helpful to test early to confirm or exclude herpes zoster as the potential cause, thereby potentially altering management, i.e., stopping antivirals and changing therapy. Arranging testing should not defer commencement of antivirals for suspected herpes zoster.

Management and treatment plan

Antiviral treatment can reduce acute pain, duration of the rash, viral shedding and ocular complications, if commenced within 72 hours of the first appearance of the rash but is not indicated in all patients (7).

Pharmacist management of HZ involves:

- **supportive management:**
  - Education and advice regarding care for lesions (use of dressings, cleaning and appropriate clothing).
  - Education and advice regarding transmission precautions in accordance with the SA Health - Chickenpox and Shingles - Including Symptoms, Treatment and Prevention (11).
- **pharmacotherapy:**
  - Antiviral therapy in accordance with the Therapeutic Guidelines: Shingles (Herpes Zoster)[NB1] (15).
  - Analgesia for **mild nociceptive shingles pain**[NB2] in accordance with the Therapeutic Guidelines: Acute pain associated with shingles (herpes zoster) and Mild, acute nociceptive pain (oral paracetamol or nonsteroidal anti-inflammatory drugs (NSAIDs) (4, 15).

NB1: Antiviral therapy is indicated for the following groups:

- immunocompetent adults who present within 72 hours of the onset of the rash
- all immunocompromised patients (including those with a HIV infection) regardless of the time lapsed since rash onset
- patients with zoster ophthalmicus, regardless of the time lapsed from rash onset (6, 7).

NB2: Patients reporting neuropathic pain or moderate to severe nociceptive pain should be referred to a medical practitioner.

Public health notification

Under the SA Health Notifiable disease reporting page (12), VZV infection (chicken pox or shingles) is prescribed as a pathological diagnosis notifiable condition (as opposed to a clinical diagnosis

notifiable condition) and must be notified in accordance with section 72 and 73 of the Public Health Act 2011 (13). Clinical notification (based on a diagnosis made on the basis of clinic evidence) is generally not required; however, 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.

- Cases of HZ confirmed by pathology testing must be notified by medical practitioners and pathology services.

Confirm management is appropriate

Pharmacists must consult the Therapeutic Guidelines, Australian Medicines Handbook, Australian Immunisation Handbook and other relevant references to confirm the treatment recommendation is appropriate, including for:

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

Communicate agreed management plan

Comprehensive advice and counselling (including supporting written information when required) as per the Australian Medicines Handbook and other relevant references should be provided to the patient regarding:

- medicine use e.g., dosing
- how to manage adverse effects
- recommendations for vaccination against HZ
- when to seek further care and/or treatment, including recognising superinfection and HZ complications
- when to return to the pharmacist for clinical review.

It is the pharmacist's responsibility to ensure the suitability and accuracy of any resources and information provided to patients (and parents/caregivers if applicable), 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

All patients should be advised to contact a medical practitioner if:

- they are not responding to treatment; and/or
- their clinical signs and symptoms worsen; and/or
- they are experiencing complications (as soon as the complications become evident); and/or

- they are having unmanageable adverse effects.

The incubation period of VZV ranges between 10 and 21 days (14 to 16 days on average) (11).

Skin lesions usually heal within 2-4 weeks although it may take longer, particularly for those that are immunocompromised or those with severe disease (4).

- As the rash resolves, the pain and systemic symptoms also subside with recovery complete in 2 to 4 weeks in most cases (2, 6).

Preventing transmission

The patient should be advised to inform any high-risk contacts (pregnant women, neonates in first month of life and immunocompromised individuals) who have had significant exposure to a person with active VZV (household contacts or where there has been direct face-to-face contact for 5 minutes or being within the same room for at least an hour) to seek medical care as soon as possible (11).

People with HZ are infectious from 2 days prior to the onset of the rash, until vesicles have dried and scabbed (at least 5 days after the onset of the rash) (11, 19).

- Rashes should be covered with appropriate dressings until the patient is no longer infectious and contact with pregnant women and immunocompromised people must be avoided (11, 19)
- A patient handout on Chickenpox and shingles can be found on the SA Health webpage (11).

Zoster vaccination

Vaccination against HZ is the best way to prevent HZ and reduce the risk of complications but is not indicated during an acute HZ episode or to treat PHN (1).

- 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 (1).
- Refer to the Australian Immunisation Handbook for HZ vaccination information and recommendations (1).
- The optimal age to be vaccinated against HZ and the vaccine type will differ based on immune status, duration of protection of chosen vaccine and the individual's choice (19).

Clinical review

Clinical review with the pharmacist should occur in line with recommendations in the Therapeutic Guidelines and other relevant guidelines. Clinical review is recommended **48-72 hours** after the initial presentation to assess for:

- progression of the rash (particularly if the patient presented with prodromal symptoms prior to rash onset)
- the clinical signs or symptoms of HZ
- screening for complications of HZ
- adverse effects.

Pharmacist resources

- Therapeutic Guidelines: Antibiotic
  - Shingles
  - Herpes zoster ophthalmicus
- Therapeutic Guidelines: Pain and analgesia
  - Pain associated with shingles (herpes zoster)
  - Postherpetic neuralgia
  - Mild, acute nociceptive pain
- Australian Medicines Handbook:
  - Antivirals (Guanine analogues)
  - Zoster vaccines
- Australian Immunisation Handbook - Zoster (Herpes Zoster) (1)
- National Centre for Immunisation Research and Surveillance - Zoster vaccines for Australian adults factsheet
- DermNet NZ:
  - Herpes Zoster (2)
  - Herpes Zoster images (2)
  - Blistering skin conditions (5)
- MSD Manual (Professional version) - Herpes Zoster (8)
- CARPA Manual: Chickenpox and shingles (9)
- SA Health Guidelines (10-13)

Acknowledgements

SA Health acknowledges and thanks Queensland Health for consent to use the *Queensland Community Pharmacy Scope of Practice Pilot Herpes Zoster (Shingles) – Clinical Practice Guideline v1.1* as the basis for this guideline.

Appendix 1 – References

1. Australian Immunisation Handbook [Internet]. Australian Government Department of Health and Aged Care. 2022. Available from: immunisationhandbook.health.gov.au.
2. DermNet. Herpes zoster 2015 [Available from: https://dermnetnz.org/topics/herpes-zoster.
3. Cunningham AL, Breuer J, Dwyer DE, Gronow DW, Helme RD, Litt JC, et al. The prevention and management of herpes zoster. Medical Journal of Australia. 2008;188(3):171-6.
4. Herpes Zoster [Internet]. Baylor College of Medicine, DynaMed Continuing Medical Education 2025. Available from: https://www.dynamed.com/condition/herpes-zoster#GUID-D685B0B2-2A61-46D3-AC91-65116C395AF6.
5. DermNet. Blistering skin conditions 2015 [Available from: https://dermnetnz.org/topics/blistering-skin-conditions.
6. Wehrhahn M, Dwyer D. Herpes zoster: epidemiology, clinical features, treatment and prevention. Australian Prescriber. 2012;35(5).
7. Antibiotic Treatment [Internet]. 2025. Available from: https://tgldcdp.tg.org.au/viewTopic/?guidelinePage=Antibiotic&etgAccess=true#.
8. Herpes Zoster [Internet]. Merck & Co., Inc. 2023. Available from: https://www.msdmanuals.com/professional/infectious-diseases/herpesviruses/herpes-zoster?query=herpes%20zoster.
9. Remote Primary Health Care Manuals. CARPA Standard Treatment Manual. 8 ed. Central Australian Aboriginal Congress CA, Inc RPA, editors. Alice Springs, NT: Flinders University; 2022.
10. Government of South Australia SA Health. Clinical Guideline Varicella Zoster (chicken pox) in Pregnancy. In: Health S, editor. Online: Government of South Australia SA Health; 2015. p. 12.
11. Government of South Australia SA Health. Chickenpox and Shingles - Including Symptoms, Treatment and Prevention. In: Health S, editor. Online: Government of South Australia SA Health; 2024.
12. Government of South Australia SA Health. Notifiable Conditions - What To Know When You Have One. In: Health S, editor. Online: Government of South Australia SA Health; 2023.
13. Government of South Australia SA Health. South Australian Public Health Act 2011. In: Health S, editor. 2011 ed. Adelaide: Government of South Australia; 2011. p. 92.
14. Corden E. How to identify and treat herpes zoster (shingles). 2014.
15. Shingles (Herpes Zoster) [Internet]. Therapeutic Guidelines Limited. 2025 [cited 7 July 2025]. Available from: https://tgldcdp.tg.org.au/viewTopic?etgAccess=true&guidelinePage=Antibiotic&topicfile=bartonella-infections&guidelinename=auto&sectionId=c_ABG_Shingles-herpes-zoster_topic_2#c_ABG_Shingles-herpes-zoster_topic_2.
16. Keung C, G H. The management of gastro-oesophageal reflux disease. Australian Prescriber. 2016;39(1):6-10.
17. Pupco A, Bozzo P, Koren G. Herpes zoster during pregnancy. Canadian Family Physician. 2011;57(10):1133-.
18. Werner R, Nikkels A, Marinović B, Schäfer M, Czarnecka-Operacz M, Agius AM, et al. 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. 2017;31(1):20-9.
19. Zoster (shingles) [Internet]. NCIRS. 2025. Available from: https://ncirs.org.au/ncirs-fact-sheets-faqs-and-other-resources/zoster-shingles.

For more information

Office of the Chief Pharmacist
Clinical System Support and Improvement Division
Department for Health and Wellbeing
Telephone: 08 8204 1944
Email: Health.CommunityPharmacyInitiatives@sa.gov.au
www.sahealth.sa.gov.au

Interpreter

www.ausgoal.gov.au/creative-commons

© Department for Health and Wellbeing, Government of South Australia. All rights reserved