What is the best treatment for the pain of acute herpes zoster?

**Evidence-Based Answer**

Valacyclovir is more effective for the acute pain of herpes zoster than acyclovir. Oxycodone provides additional acute pain relief for patients taking antiviral medication, but is associated with substantial adverse effects. Gabapentin is ineffective in managing acute herpes zoster. (SOR B, based on individual RCTs.)

A 1998 meta-analysis of 3 RCTs included 1,076 patients with acute herpes zoster (mean ages ranging from 52 to 68 years) who were randomized to acyclovir 800 mg 5 times daily for 7 days versus placebo. In each study, at least 60% of patients were treated within 48 hours of onset of symptoms. Subgroup analysis was done comparing patients who began treatment within 48 hours with patients whose treatment began between 48 and 72 hours.

Acyclovir led to complete resolution of pain sooner than placebo with either early or late onset of therapy (28 vs 62 days if initiated within 48 hours, \( P < .005 \); 28 vs 58 days if initiated between 48 and 72 hours, \( P = .04 \)).

In 1995, a single multicenter RCT involving 1,141 patients with acute herpes zoster (mean age 68 years) compared acyclovir with valacyclovir. Valacyclovir (dosed at 1,000 mg TID for 7 days) led to complete pain resolution sooner than acyclovir (dosed at 800 mg 5 times daily for 7 days). If started within 48 hours, the mean time to pain resolution was 44 days with valacyclovir and 51 days with acyclovir (\( P = .03 \)). If started between 48 and 72 hours, the mean time to pain resolution was 36 days with valacyclovir and 48 days with acyclovir (\( P = .02 \)).

In 2009, a single RCT of 87 patients with acute herpes (mean age 66 years) compared CR-oxycodone at a dose titrated to 60 mg BID, gabapentin at a dose titrated to 600 mg TID, and placebo. All patients also received famcyclovir 500 mg TID for 7 days.

The oxycodone group had significantly more patients with a \( \leq 30\% \) reduction in pain compared with placebo in the first 2 weeks (79% vs 45%, respectively; \( P = .02 \); NNT=2.9). Significantly more patients taking oxycodone discontinued treatment because of adverse effects compared with placebo (27.6% vs 6.9%, \( P = .02 \)), the most common being constipation, dizziness, and disorientation. No significant difference was noted in pain control between the gabapentin and placebo groups.³

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What is the best treatment for postinfluenza pneumonia?

**Evidence-Based Answer**

Cefotaxime, ceftriaxone, and respiratory fluoroquinolones are recommended for influenza-associated pneumonia. Oseltamivir and zanamivir can be used to reduce viral shedding in hospitalized patients with influenza, with or without pneumonia. (SOR C, based on consensus guidelines.) Early treatment of the influenza infection with oseltamivir or inhaled zanamivir is recommended for prevention of postinfluenza pneumonia. (SOR A, based on a meta-analysis.)

The Infectious Disease Society of America and the American Thoracic Society produced a set of guidelines for the treatment of community-acquired pneumonia in 2007.¹ Committee members were assigned topics and received input from the Mycobacterium Tuberculosis and Pulmonary Infection Assembly, as well as the Clinical Pulmonary and Critical Care assemblies. These topics were presented and revised, based on existing available medical literature, by committee members until consensus among the members were reached on each topic. The recommendations were reviewed by each organization independently.

They determined that influenza-associated pneumonia is commonly caused by *Streptococcus pneumoniae*, *Staphylococcus aureus*, *Haemophilus influenzae*, and group A streptococci, whereas *Legionella*, *Chlamydophila*, and *Mycoplasma* are not important causes. They recommended cefotaxime, ceftriaxone, and respiratory fluoroquinolones for