Understanding Herpes Zoster

A Practical Guide for Nurses

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INTRODUCTION

This guide serves as a communication and information document for nurses wishing not only to know more about Herpes Zoster, but above all, to increase their competencies and ability to act professional.

This is the end result of a program, started with a workshop with Nurses from Europe during the ESNO congress in Zagreb, really June 2025, and based on the outcome, creating a three-edition podcast, speaking with patient representative, medical expert and a specialist nurse, specialised in Herpes Zoster and main management.

What became clear throughout this work is that Herpes Zoster is one of those conditions that hides in plain sight. It isn't new, and it certainly isn't rare, yet it still catches people off guard when it appears—painful, unsettling, and at times even life-changing. For nurses, it is becoming an increasingly frequent part of daily practice as populations age. Behind each case lies more than a reactivated childhood virus; there is a human story of discomfort, vulnerability, and the need for empathy.

Too often, though, Herpes Zoster remains underestimated. Information is scattered, sometimes shaped by opinion, sometimes buried in technical jargon. This leaves both professionals and families without the clarity they need and tools to communicate. As a result, the condition almost behaves like a silent endemic among older and vulnerable people, common yet rarely spoken about clearly and consistently.

This guide aims to change that. It brings together practical knowledge and lives experience in a way that is accessible, reliable, and easy to use. It is written for nurses and carers at the bedside, for health professionals across settings, and even for family members who simply want to understand what their loved ones are facing.

The core message is simple: with the right understanding, nurses can identify Herpes Zoster early, support patients through treatment and recovery pathway, and help reduce the burden of pain, uncertainty, fear, and above all, how to talk about it. By sharing this knowledge, we not only improve care but also help restore dignity and confidence to those encountering Herpes Zoster later in life.

This guide provides a clear overview of Herpes Zoster, its underlying mechanisms, clinical features, diagnostic steps, treatment pathways, infection-control considerations, and practical care strategies. It is meant to empower nurses with the knowledge and confidence needed to support patients through every stage of the condition.

Chapter 1

ABOUT HERPES ZOSTER

WHAT IS HERPES ZOSTER

Herpes Zoster is a viral infection that is brought on by the reactivation of the Varicella-Zoster Virus (VZV), we know as the same virus that is responsible for chickenpox that lot of people had during their childhood. It's the same virus hidden in the body, and in the nerve system and suppressed by the immune system throughout their lives, but while people are aging, the immune system is less effective. This leads to the virus slowly awakening and become active. What happens is that the position the virus was hidden, the nerve system gets infected and causing the infection at the region of the nerve, and with the skin infection, the most impactful burden is the pain.

The clinical presentation is a rash of the skin, and then the pain. The clinical presentation of herpes zoster (HZ) involves a variety of clinical presentations, and with therapeutic options, complication rates, and preventative strategies. It's crucial for health professionals to detect and diagnose this condition, as the sooner the treatment can start, including vaccination, the less likely it is that the disease get worse.

In the scope of the healthcare providers, today nurses play a vital role in the early identification of HZ, contribute to good management, patient education, and emotional support.

By enhancing knowledge and promoting evidence-based practices, this guide aims to empower nurses to deliver effective and compassionate care, minimize complications, and contribute to better health outcomes for patients with Herpes Zoster, but also contributes to education and health management.

THE FORMAL DEFINITION IN SHORT

Herpes Zoster may develop in individuals who have previously had chickenpox, typically during childhood. This is due to the reactivation of the chickenpox virus at a site where it has been in a dormant condition since the initial infection. Once the initial infection has been resolved, the virus typically remains in the dorsal root ganglia for an extended period (years or decades) until it is reactivated (Janniger, et al., 2021). The immune system can effectively suppress the virus's replication during the latent phase, and it is capable of doing so for an extended period (Perry, 2022).

Herpes zoster, or Herpes Zoster, is a neurocutaneous condition that can be exceedingly excruciating. After the lesions have fully healed, symptoms frequently persist for several weeks or months. The reactivation of the varicella zoster virus (VZV), which is responsible for chickenpox, is the cause of herpes zoster when immunity to the virus decreases
(de Oliveira Gomes, et al., 2023)

A HISTORICAL PERSPECTIVE

It's always good to learn about the historic context, and here there is nothing new to this. When digging into the ancient books, Hippocrates (ca. 460–370 BC) already described painful rashes, though not yet clearly distinguished as Herpes Zoster. Then, around the first century, the Roman physician Celsus (in De Medicina) gave the first clear description of a band-like painful skin eruption, later identified as herpes zoster. Then many years later, in the Middle Ages, the condition became known as zoster (from the Greek *zōnē*, meaning "belt" or "girdle") or *zona*, referring to its typical distribution. It was only in the 18th–19th century that Physicians began to distinguish herpes zoster from smallpox and other skin conditions. A breakthrough came in 1909 with the Hungarian paediatrician Von Bókay, who was the first to suggest the link between chickenpox and Herpes Zoster. Another breakthrough was in 1953, when virologist Thomas Weller research confirmed that both chickenpox and Herpes Zoster are caused by the same virus, now called varicella-zoster virus (VZV). So, in short, the first medical description in the 1st century AD by Celsus, but the connection with chickenpox and the virus was only confirmed in the 20th century.

On the prevention and the vaccination development, the first breakthrough came in 1995 with the development of a live attenuated varicella vaccine (chickenpox vaccine), followed by the Zostavax® Herpes Zoster vaccine in 2006. While Zostavax marked significant progress, its effectiveness was limited, particularly in older adults – the very group most vulnerable to Herpes Zoster. Later on, we dig deeper on the development of the vaccines.

ABOUT THE NAME HERPES ZOSTER

The name "herpesvirus" stems from the Greek word herpēs, which means "to creep." This refers to how these viruses often stay hidden in the body and can come back repeatedly. The word zoster is also Greek, meaning "belt" or "girdle," which describes the way the rash from Herpes Zoster often wraps around the body like a belt. The term Herpes Zoster comes from the Latin word cingulus (a form of cingulum), which also means "girdle."

WHY HERPES ZOSTER MATTERS NOW, THE AGING ISSUE

Unlike many infectious diseases that primarily affect children or are endemic in low-resource settings, Herpes Zoster emerges from within – a reactivation of a virus that already resides in the body. This makes it unique. It also means that Herpes Zoster doesn't spread through new exposure in the traditional sense, but rather manifests under conditions of weakened immunity, aging, or stress.

As populations in Europe and beyond continue to age, the public health relevance of HZ is increasing. It is a leading cause of long-term nerve pain (postherpetic neuralgia), which can severely impact quality of life. For nurses, particularly those involved in preventive care and patient education, Herpes Zoster represents both a clinical challenge and a teachable opportunity.

Chapter 2

CLINICAL PRESENTATION

EPIDEMIOLOGY AND MANIFESTATION

Approximately one in three individuals in the general population will develop Herpes Zoster during their lifespan, and most common in older adults. Herpes zoster is characterized by an acute, painful, localized, and in general terms, 'a blister-like rash that usually appears in a stripe along a nerve path on the skin' and in formal terms 'a vesicular rash that typically occurs along specific dermatomes'. The presentation can be mild and well-treated when a medical intervention is soon initiated. For example, by vaccination within 72 hours the quality of life of patients is significantly impacted when the impact is discovered too late, with delayed intervention, and then by the potential severe complications of acute zoster, which disable their ability to perform their daily activities to the maximum.

Nerve palsies are like a "nerve malfunction" that affects how muscles or skin respond. Nerve palsies are conditions where a nerve becomes damaged or compressed, leading to **weakness**, **loss of movement, or loss of sensation** in the area that the nerve controls. Although not occur very often occurs, **facial nerve palsy** can cause one side of the face to droop. **Radial nerve palsy** might make it hard to lift your wrist or fingers. There is also ophthalmology effecting impacting the visual quality, but this is rarely

A very impacting aspect is the post-herpetic neuralgia (PHN), it is a lingering nerve pain that can follow HZ, often lasting long after the rash is gone. It is the complication giving the most disabling impact, and can at least 90 days after the outbreak. This may persist for weeks, months, or even years following a zoster rash. This complication is more prevalent and severe in older patients, affecting approximately 20% of adults experiencing Herpes Zoster.

As elderly people are extra sensitive to HZ, we need to understand that age and immunosuppression are recognized as significant risk factors for HZ. In all, the incidence rate of HZ in Europe increased with age and varied among high-risk populations, but more interestingly, the highest rates were observed in patients who underwent solid organ and stem cell transplants, who have malignancies, and who have rheumatoid arthritis.

SIGNS AND SYMPTOMS

In general, four main phases are typically employed to characterize the disease course:

1. Early symptoms stage (Prodrome)

This stage typically occurs one to four days before the appearance of the rash. Patients often report pain, tingling, burning, or heightened sensitivity along the affected dermatome, reflecting viral activity within the sensory nerves. The pain may be constant or intermittent and described as searing, stabbing, or throbbing. In more severe cases, the discomfort can be intense enough to disturb normal sleep. Additional generalised symptoms such as malaise, fatigue, low-grade fever, or headache may also be present, sometimes leading to misinterpretation as other viral conditions before the rash confirms the diagnosis.

2. Acute infectious stage

The characteristics of the rash usually become visible two to three days after prodromal pain, though onset may occasionally be delayed up to a week. The rash begins as an erythematous, maculopapular eruption confined to a single dermatome, and within a short period progresses into clusters of clear vesicles. In other words, 'The rash usually starts as small red spots on the skin in one specific area, and soon turns into groups of tiny, clear blisters'. These vesicles continue to emerge over a three to five-day period, then rupture and gradually dry, forming crusts. The entire process from eruption to crusting typically lasts 7 to 10 days. During this period, the lesions are contagious to individuals who have never had varicella or been vaccinated against it. Pain remains a dominant feature, often worsening with the appearance of new lesions.

3. Healing stage

As the lesions begin to resolve, crusts dry and fall away within two to four weeks. The skin may return to normal, but in some cases, residual pigmentation changes, scarring, or localised sensitivity can persist. The intensity of pain generally diminishes during this stage, though patients may continue to experience local tenderness or itching. For many, this marks the end of the illness; however, the resolution of the rash does not guarantee the cessation of discomfort.

4. Post-herpetic neuralgia (PHN)

A significant number of patients, especially older adults, may experience persistent pain following the disappearance of the rash. This condition, known as post-herpetic neuralgia, can last for weeks, months, or in some cases, years. The pain is neuropathic in nature, often severe, and described as burning, stabbing, or electric-shock-like. It may be constant or triggered by light touch, temperature changes, or even clothing brushing against the skin. PHN is a major cause of long-term morbidity in herpes zoster, significantly impairing quality of life and often requiring multidisciplinary approaches to pain management.

TRANSMISSION

For nurses, it's important to understand the level of transmission, as they work with many patients, and especially in eldery momes and fragile patients.

Transmission of Herpes Zoster

Herpes zoster is not a primary infection but a reactivation of the varicella-zoster virus (VZV), the same virus responsible for chickenpox. After an individual recovers from chickenpox, the virus remains dormant in the sensory nerve ganglia. Years or even decades later, reactivation can occur, typically triggered by age-related immune decline, immunosuppression, stress, or other health conditions. This reactivation produces Herpes Zoster. Importantly, Herpes Zoster itself is not transmitted directly in the same way as influenza or measles, but the virus contained within the lesions can be spread.

Risk of transmission to others

A person with active Herpes Zoster cannot give another person Herpes Zoster. However, if someone who has never had chickenpox or has not been vaccinated against varicella encounters the fluid from Herpes Zoster blisters, they can develop chickenpox. Only after a primary chickenpox infection is the individual at risk of developing Herpes Zoster later in life. This means that while Herpes Zoster is a reactivation, the virus can still act as a primary infection source for others.

Routes of transmission

The virus is spread through direct contact with the fluid contained in the vesicles. Airborne transmission, as seen with chickenpox, is much less common in Herpes Zoster but can occur if there is disseminated herpes zoster (widespread rash affecting multiple dermatomes or in immunocompromised patients). Transmission does not occur before vesicles appear or after lesions have crusted over, as the virus is no longer viable.

Infection control considerations for nurses

Nurses should be aware that patients with Herpes Zoster, particularly those in the acute vesicular stage, may pose a risk to susceptible individuals. Standard precautions should be observed, with particular attention to:

- Covering lesions to reduce the risk of direct contact with vesicle fluid.
- Use of gloves and proper hand hygiene when caring for affected skin areas.
- Avoiding exposure of patients with active Herpes Zoster to pregnant women without immunity, neonates, or immunocompromised individuals, as these groups are at the highest risk for severe primary varicella infection.

Implications for nursing practice

Understanding the transmission pathway is vital for patient education. Nurses play a key role in informing patients that:

- They are not contagious through casual contact such as talking or being in the same room, unless there is widespread or disseminated disease.
- The main risk lies in others touching the lesions directly or being exposed during dressing changes if infection control measures are inadequate.

- Once the rash has crusted, usually within 7–10 days, they are no longer infectious.

For nurses, this knowledge is essential not only for infection prevention in clinical settings but also for **counselling patients and families**, thereby **reducing fear, stigma, and unnecessary isolation**.

DIAGNOSIS, TREATMENT, AND PREVENTION

Diagnosis

Diagnosis is based on patient history and clinical examination, supported by Polymerase Chain Reaction (PCR) testing of fluid from the vesicles to confirm the presence of varicella zoster virus. The rash usually appears on one side of the body only. A rash on both sides of the body is unlikely to be Herpes Zoster, except for immunocompromised patients. The rash develops into itchy blisters that look like chickenpox. The rash may be atypical in certain groups of people, for example, older people and immunocompromised people. Differential diagnoses may include herpes simplex virus infection and contact dermatitis.

Treatment

The risk of severe complications in immunocompromised patients is believed to be reduced by the quick provision of oral antiviral drugs, which also reduces the severity and duration of the illness. For the treatment to be effective. It is recommended that it be initiated within 72 hours of the rash's development or up to one week after the rash's onset for individuals at a high risk of complications. Not all patients who develop the disease may receive antiviral treatment and pose no threat, but prevention and medical intervention are highly recommended. If a person develops herpes zoster and does not receive any treatment, the illness will usually follow its natural course. In many otherwise healthy adults, the rash and acute pain will resolve spontaneously within two to four weeks. However, the absence of treatment can significantly increase the risk of complications and prolong suffering.

The following options are available:

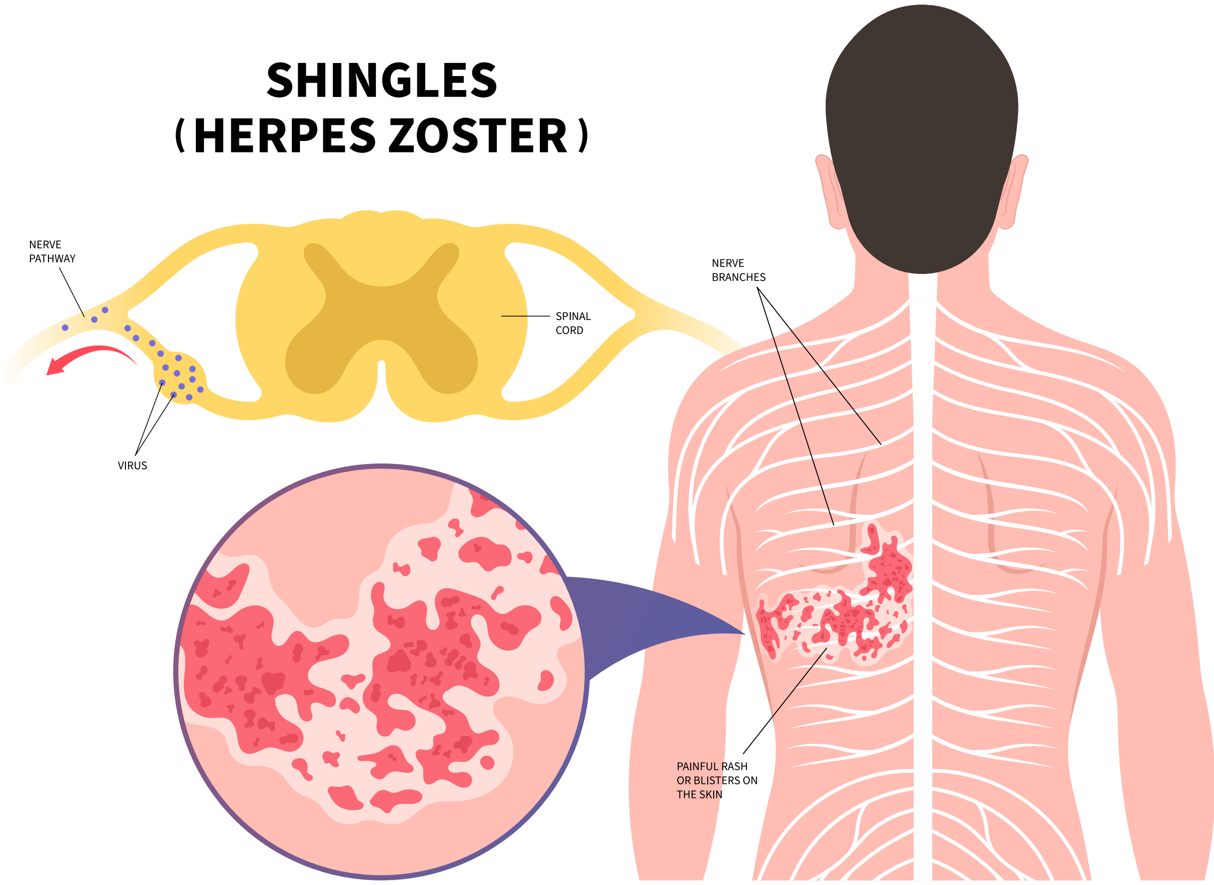
- Aciclovir: 800 mg, administered five times daily for seven days (continue for an additional two days following the crustingLe of the rash in the immunocompromised).
  - Aciclovir is primarily prescribed as an oral tablet for herpes zoster, with IV reserved for severe cases
- Famociclovir: 500 mg, three times daily, for a period of 10 days (continue for an additional two days after the rash has crusted in the immunocompromised).
  - Famciclovir is an oral antiviral alternative to aciclovir, often preferred for its simpler dosing schedule. It is well tolerated, effective against herpes zoster, but more costly and not available in IV form
- Valaciclovir: 1000 mg, three times daily, for seven days (continue for an additional two days after the crusting of the rash begins in the immunocompromised).
  - Aciclovir is the classic, widely available choice; valaciclovir and famciclovir are more convenient alternatives with fewer daily doses but at a higher cost.

Prevention through vaccination

The most effective strategy to prevent herpes zoster and its complications, particularly post-herpetic neuralgia, is **vaccination**. Unlike the childhood varicella vaccine, which protects against chickenpox as a primary infection, the Herpes Zoster vaccine is specifically designed for adults to boost waning immunity against the varicella-zoster virus already dormant in their nervous system. In other words, it is **not a booster** of the childhood varicella vaccine but rather **a targeted immunisation that strengthens the immune system's ability** to keep the virus suppressed and prevent reactivation. There were two types of Herpes Zoster vaccines: the live-attenuated vaccine and a recombinant (non-live) vaccine, however, sice June 2025 the live-attenuated vaccines (Zostavax) is not available in Europe. The recombinant vaccine is preferred in many countries because of its higher efficacy and suitability for older adults, including those with weakened immune systems. Vaccination is generally recommended for people over 50 years of age, or 18+ with increased risk, even if they have previously had Herpes Zoster, as it reduces the risk of recurrence and long-term complications.

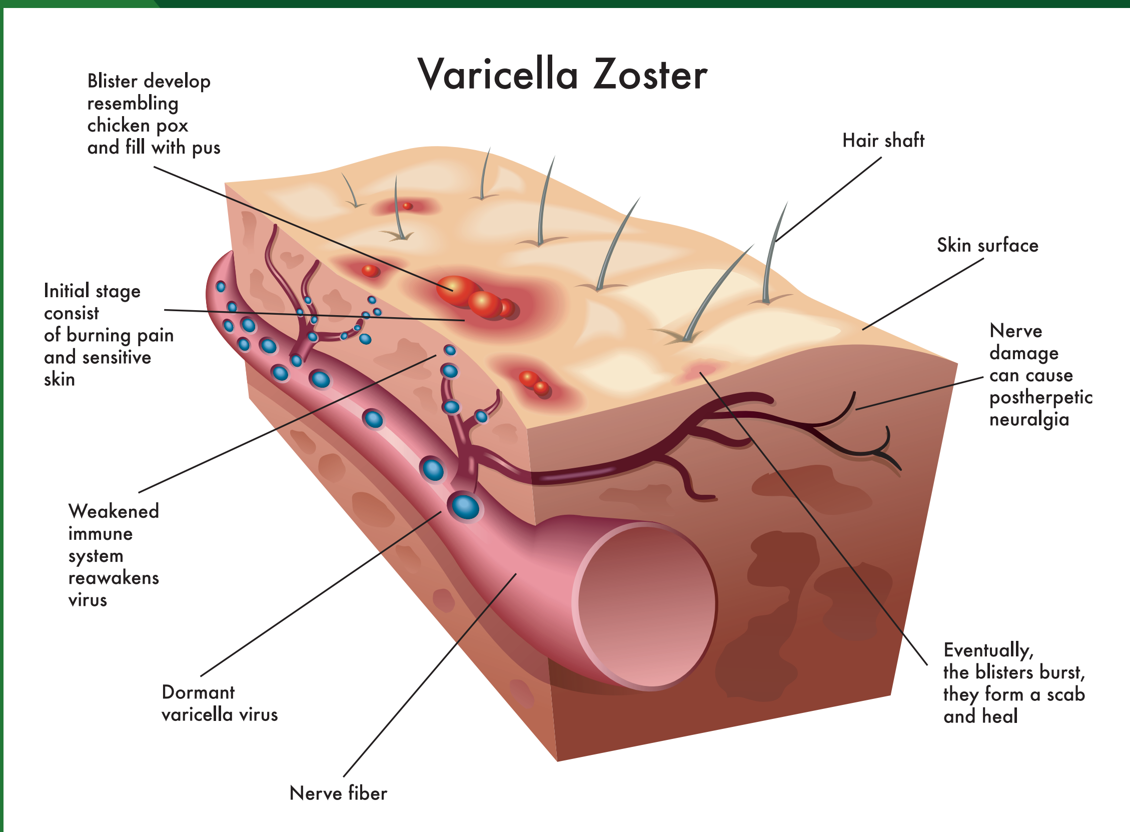
CONCLUDING: IMPACT ON QUALITY OF LIFE

Herpes zoster can deeply affect quality of life through pain, fatigue, and emotional distress, and this burden is even greater when it occurs alongside another chronic disease such as diabetes, cancer, or heart failure, where resilience is already low and vulnerability high. In such cases, Herpes Zoster may tip the balance, leading to loss of independence, social withdrawal, or worsening of the underlying condition. Nurses play a pivotal role here, not only in managing symptoms through pain control, infection prevention, and coordinated care, but also in strengthening health literacy by helping patients and families understand the illness, its complications, and the benefits of timely treatment and vaccination. By combining clinical expertise with education and empathetic support, nurses can reduce suffering, protect long-term wellbeing, and empower patients to actively participate in their recovery.



Chapter 3

THE RELATION BETWEEN HZ AND THE CELLS MECHANISMS



HZ AND THE CELLS MECHANISMS

ey in the human immune system are the T-Cells, which have many functions but are strongly related to the so-called memory cells, who learn to initiate a defense system to hostile agents. The production of specific -Varicella-related- memory T-cells is induced by primary infection with Varicella Zoster Virus (VZV), which prevents the virus from reactivating. But because of getting older, the probability of clinical manifestations of the disease is elevated by factors that reduce cellular immunity, such as aging or conditions/medications that reduce T-cell levels to the point where they are unable to inhibit viral replication. The aging population and the decline in the natural immunity of senior adults are among the factors contributing to the increase in the incidence of HZ.

CAUSES AND RISK FACTORS

The most significant risk factor for the development of HZ appears to be the aging factor, but women and individuals with a family history of zoster disease exhibit a higher incidence.

The overall incidence in adults is 2 to 4 cases per 10.000 population, with an increasing occurrence in elderly adults and an estimated 8 cases per 10.0000 in those aged 70-79 years. HZ is less prevalent in children, and most healthy children will not develop Herpes Zoster until they are well into maturity.

The cause of reactivation of the Varicella Zoster causing HZ is frequently unknown; however, the following factors may increase the probability of this scenario.

Several factors are known to increase this risk:

- **Ageing and natural immune decline:** The most important risk factor is advanced age, particularly over 50 years, when cell-mediated immunity against VZV naturally decreases.
- **Immunosuppression:** Conditions such as cancer, HIV/AIDS, or medical treatments (chemotherapy, radiotherapy, corticosteroids, biologics, or organ transplantation drugs) can reduce immune defences and trigger reactivation.
- **Physical illness or chronic disease:** Diabetes, chronic kidney disease, or cardiovascular problems may weaken overall immunity and resilience.
- **Stress and psychological strain:** Severe emotional or physical stress has been linked to reduced immune surveillance, allowing the virus to reactivate.
- **Fatigue and poor nutrition:** Long-term exhaustion or malnutrition can compromise the immune system’s ability to suppress latent viruses.
- **Local trauma or surgery:** In some cases, nerve injury, surgery, or radiation therapy near a nerve root has been associated with Herpes Zoster appearing in that area.

VACCINATION

Herpes Zoster vaccination has been shown to lower the risk of getting the disease and to make symptoms milder and shorter if it does occur.

- The older vaccine Zostavax provided early protection, however Since june 2025 is no longer available on the EU market.
- but today Shingrix is preferred because it gives stronger and longer-lasting protection, especially for older adults and people with weakened immune systems. Vaccination also reduces the chance of Herpes Zoster coming back in those who have already had it.

There are no European standards on the recommended age group for Herpes Zoster vaccination. In the USA, however, clear guidance exists. Studies show that adults aged **50 years and older** are the main group advised to receive the vaccine. This applies even if they have had Herpes Zoster before. Vaccination is also recommended for adults aged **19 years and older** who are immunocompromised. This includes people with weakened immune systems due to diseases such as cancer or HIV/AIDS, or treatments like chemotherapy, steroids, or transplant medicines. The vaccine most recommended today is Shingrix (a non-live, recombinant vaccine), which is preferred because of its high effectiveness and good protection against postherpetic neuralgia.

Key points:

Vaccination is advised even if the person has already had a Herpes Zoster episode (to prevent recurrence). Vaccination is strongly recommended for people with conditions that weaken the immune system, sometimes starting earlier (from age 19). Two doses are required, usually 2 to 6 months apart.

Why two shots for Herpes Zoster vaccination, and why wait between them?

The Herpes Zoster vaccine (Shingrix) is given in two doses to make sure the body builds strong, long-lasting protection. The first shot starts the immune response, helping the body recognize the varicella-zoster virus. The second shot, given 2 to 6 months later, strengthens and “reminds” the immune system, boosting protection and making it more durable over time. This intertwined two-step process ensures better immunity than just one dose and gives stronger protection against Herpes Zoster and postherpetic neuralgia (long-term nerve pain after Herpes Zoster).

CURRENTLY, THERE IS ONE VACCINES ARE AVAILABLE TO PREVENT HERPES ZOSTER

At present, there are two main types of vaccines that can protect against herpes zoster (Herpes Zoster). Both are designed to strengthen the body’s immune system against the varicella-zoster virus, but they work in different ways and are not interchangeable.

Recombinant zoster vaccine (RZV)

The newer vaccine, also known by its trade name Shingrix, does not contain any live virus. Instead, it uses only one specific part of the virus—glycoprotein E (gE)—which is found on the virus’s surface. This protein cannot cause infection, but it is the main “signal” the immune system recognises when fighting varicella-zoster. To make the immune response stronger, the vaccine includes an adjuvant, a substance that helps stimulate the body’s defences. RZV is given as two doses, usually a few months apart, and is suitable even for people with weakened immune systems. The European Medicines Agency (EMA) has approved RZV because of its high effectiveness in preventing Herpes Zoster and its complications, especially post-herpetic neuralgia.

Nursing perspective

For nurses, it is important to understand and explain that Herpes Zoster vaccines are not “boosters” of the childhood chickenpox vaccine, but specialised vaccines designed for adults to prevent reactivation of the dormant virus. They represent a key preventive tool, especially in older adults and those with chronic illnesses, where Herpes Zoster can have a serious impact on quality of life.

NURSING RELATION

General Considerations for Nursing Care

The nursing care plan for Herpes Zoster is designed to meet the patient's physical, emotional, and psychological needs. Its main goal is to reduce symptoms, support healing, and prevent complications. These complications may include postherpetic neuralgia and secondary bacterial infections. Nurses use targeted interventions such as pain management, infection control, wound care, and psychosocial support. Routine assessments are essential throughout the illness. Patient education is equally important to ensure the patient understands the condition and follows the treatment plan. This helps them manage the illness safely and effectively at home.

The nursing team can offer comprehensive support to enhance the patient's overall quality of life, reduce the risk of the virus disseminating to others, and assist the patient in managing the emotional challenges associated with Herpes Zoster by collaborating care and conducting continuous evaluations. The nursing management of Herpes Zoster is characterized by the primary objectives of ensuring patient welfare and promoting effective healing.the incidence of HZ.

ASSESSMENT

Subjective Data:

- Pain, burning
- Numbness, tingling
- Itching
- Headache
- Sensitivity to light
- Fatigue

Objective Data:

- Rash developing in clusters of vesicles
- Rash follows dermatome (nerve pathway)

Nursing Assessment:

- **History of Present Illness:**
  - Obtain a detailed account of the onset and progression of symptoms, including the appearance of the rash, associated pain, and any factors that may have triggered the outbreak.
- **Pain Assessment:**
  - Assess the severity, location, and character of pain.
  - Use a pain scale (0-10) for accurate measurement.
  - Identify factors that worsen or alleviate the pain.
- **Skin Examination:**
  - Inspect affected areas for the characteristic rash.
  - Document the extent and appearance of the lesions.
  - Neurological Assessment: Assess sensory function in the affected dermatomes. Look for signs of hypoesthesia or hypoesthesia. Assess motor function as applicable.
  - Vital Signs: Monitor vital signs regularly, particularly in older adults or those with underlying health conditions, to identify any signs of systemic involvement or complications.
  - Ocular Assessment: If lesions are present on the face, assess for ocular involvement, such as herpes zoster ophthalmicus.

Psychosocial Assessment:

- Assess the emotional and psychological impact of the illness on the patient, as Herpes Zoster can be distressing, especially if complications like postherpetic neuralgia occur.

Immunization History:

- Inquire about the patient's immunization history, specifically for varicella-zoster virus (chickenpox vaccine). This helps determine the likelihood of recurrent episodes.

NURSING DIAGNOSIS

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PLANNING & IMPLEMENTATION

Recombinant zoster vaccine (RZV)

- **Reporting System:** For nurses, it is crucial to build a personal relationship with the patient and establish consistent contact, ensuring sustainability during the treatment pathway and the recovery process.
- **Clinical:** Patients must experience continuity and clarity in communication. They should always be fully informed about their condition and feel empowered to communicate all aspects, both medical and nursing-related to the healthcare team.
- **Interdisciplinary:** It is essential to establish a sustainable interdisciplinary team that addresses physical, mental, and social support needs, ensuring comprehensive care.
- **Online:** Develop an online tool for reporting and communication, supporting the documentation of agreements, recovery pathways, and shared decision-making. The tool should also allow external clinicians (e.g., wound care specialists from other regions) to be informed, without direct access to patient records, and enable engagement with peers, family, and friends to support the patient's recovery journey.

SPECIFIC ASPECT IN NURSING CARE

Pain Management

Pain associated with Herpes Zoster (Herpes Zoster) is often described as one of the most intense and debilitating experiences a patient can endure. Beyond the acute phase of the viral infection, many patients continue to suffer from lingering nerve pain, known as postherpetic neuralgia, which can last for months or even years. This chronic pain can deeply impact not only physical wellbeing but also emotional and psychological health, sometimes leading to despair, depression, and even suicidal thoughts.

For nurses, understanding the complexities of pain management in Herpes Zoster and Herpes Zoster is not merely a clinical responsibility—it is a fundamental aspect of compassionate and holistic care. Nurses are often the first to recognize the signs of escalating pain, to provide relief through interventions, and to advocate for the patient's broader physical and emotional needs. Their role extends beyond administering medications to ensuring continuous communication, emotional reassurance, personalized pain management strategies, and coordination of interdisciplinary support when needed. Here we highlight the critical role nurses play in assessing, managing, and alleviating pain in patients with Herpes Zoster and Herpes Zoster. It emphasizes the need for early identification, multidisciplinary collaboration, and tailored patient-centered approaches to support recovery and improve quality of life. In doing so, it reaffirms the nurse's position as both a clinical expert and a crucial advocate for the patient's comfort and dignity throughout the recovery journey.

Interventions:

- Administer prescribed analgesics and opioids as needed for severe pain.
- Topical treatments such as antiviral ointments (acyclovir) or analgesics can help with pain relief.
- Use cool compresses or cool moist dressings to provide relief and reduce inflammation.
- Provide a quiet, dimly lit environment to minimize sensitivity to light.

GOAL: The patient will experience a reduction in pain and discomfort, increase of literacy and self-care.

PLANNING & IMPLEMENTATION OF PAIN RELIEF OPTIONS FOR HERPES ZOSTER (HERPES ZOSTER) PATIENTS

1. Antiviral Therapy

- **Medications:** for example, Acyclovir, Valacyclovir, Famciclovir
- **Purpose:** These do not directly relieve pain but reduce viral replication, limit the severity of the outbreak, and shorten the duration of symptoms. Early initiation (within 72 hours of rash onset) can help prevent long-term pain (postherpetic neuralgia).

2. Acute Pain Management (during active infection)

- **Simple analgesics:** Paracetamol (acetaminophen) and NSAIDs (e.g., ibuprofen)
- **Stronger analgesics:** Opioids (e.g., tramadol, morphine) — for moderate to severe pain if needed temporarily
- **Topical treatments:** Lidocaine patches or gels — to numb local nerve endings
- **Neuropathic Pain Management** (especially if pain persists)
- **First-line treatments:** Gabapentin or Pregabalin (antiepileptics used for nerve pain) and Tricyclic antidepressants (e.g., amitriptyline, nortriptyline)
- **Topical options:** Capsaicin cream (low concentration) or capsaicin patches for localized nerve pain (only once lesions have healed)

4. Adjunctive Therapies

- **Corticosteroids:** (short course, e.g., prednisone) — sometimes prescribed to reduce acute inflammation and nerve pain, but controversial and not recommended routinely.
- **Nerve blocks:** Local anesthetic nerve blocks in severe cases (by pain specialists)

5. Non-Pharmacological Support

- **Cool compresses** — to soothe irritated skin during acute phase
- **Oatmeal baths or soothing lotion**s — calms itching and skin discomfort
- **Psychological support:** Chronic pain can impact mental health, so counselling, relaxation techniques, or mindfulness therapy may help in severe cases.
- **Surgical Operation:** In rare and severe cases of Herpes Zoster, when pain persists despite all conventional treatments, a surgical intervention may be considered. This approach focuses on interrupting or blocking the affected nerve pathway to reduce the intense, long-lasting pain caused by the virus. Procedures such as nerve blocks or targeted nerve ablation can temporarily or permanently disrupt the pain signals travelling to the brain. While not a first-line treatment, these interventions can offer

meaningful relief for patients suffering from severe neuralgia that does not respond to medication or other therapies.

6. Prevention

- Vaccination (Shingrix): Highly effective in preventing Herpes Zoster and its complications, especially postherpetic neuralgia.

WOUND CARE AND INFECTION CONTROL

GOAL: The patient will experience primary infection, but often also secondary infections or spread of the virus.

Interventions:

- Implement strict hand hygiene practices and instruct the patient to wash hands before and after touching the lesions.
- Observation and treatment of primary (related to the virus) and secondary infections (streptococcus)
- Keep lesions clean and dry. Apply prescribed topical treatments.
- Isolate the patient and instruct visitors on appropriate PPE (personal protective equipment).
- Limit exposure to high-risk individuals (pregnant women, infants, immunocompromised individuals).
- Teach the patient and peers such a friends and family members, how to properly care for the lesions to prevent bacterial infection.

Planning & Implementation: CARE GOALS:

- Prevent the spread of the virus (primary infection).
- Minimize the risk of secondary bacterial infections.
- Promote healing of lesions.
- Protect vulnerable populations from exposure.
- Empower the patient and their support system to contribute effectively to infection control.

Planned Interventions:

1. **Hand Hygiene and Personal Protective Measures:** Enforce rigorous hand hygiene protocols for both healthcare providers and the patient. Educate patients and visitors about handwashing and appropriate use of PPE.
2. **Wound Observation and Treatment:** Regularly monitor lesions for signs of secondary infection (e.g., increased redness, swelling, pus). Administer antiviral medications and topical treatments as prescribed. Initiate antibiotic treatment promptly if secondary bacterial infection (e.g., streptococcus) is detected.
3. **Environmental and Patient Isolation:** Implement isolation precautions when necessary to reduce transmission risk. Guide visitors and caregivers on protective procedures when interacting with the patient.
4. **Skin Care and Hygiene:** Keep affected areas clean and dry and apply topical agents to lesions as directed to promote healing and prevent complications.
5. **Patient and Peer Education:** Instruct the patient, family, and close contacts on proper wound care and emphasize the importance of hygiene, lesion care, and limiting exposure to high-risk individuals.

Implications for Nursing Practice

- **Infection Prevention Leadership:** Nurses must act as infection control champions by strictly following and modelling hygiene and isolation procedures, thereby preventing nosocomial transmission.

- **Continuous Monitoring:** Nurses are responsible for vigilant monitoring of wounds for early detection of secondary infections, ensuring timely intervention and avoiding complications such as cellulitis or systemic infection.
- **Health Education:** A strong focus on education helps empower patients and families to maintain safe practices at home, reducing readmission rates and improving outcomes.
- **Psychosocial Support:** Isolation and visible lesions may cause anxiety, stigma, or depression in patients. Nurses should incorporate emotional support into care plans, addressing psychological well-being alongside physical health.
- **Risk Mitigation:** Special attention must be given to protecting high-risk groups (pregnant women, immunocompromised individuals, infants), both in hospital settings and in the patient's home environment.
- **Interdisciplinary Collaboration:** Nurses must coordinate with physicians, infection control specialists, and wound care teams to ensure comprehensive care that covers both virologic and bacterial aspects.
- **Support or initiate national patient peer groups:** Initiating peer support groups for patients with Herpes Zoster can be an important part of holistic care. Every patient experiences the illness differently, with unique feelings, fears, and challenges. A peer group offers a safe space to share these experiences, exchange coping strategies, and learn from others who truly understand what they are going through. Many patients find comfort in discovering they are not alone, and such groups often help break the silence around the condition. They can also encourage individuals to explore alternative approaches within their treatment plan, always in consultation with their healthcare team. As a result, peer support can significantly enhance emotional well-being and confidence during recovery.

ASSESSMENT FOR COMPLICATIONS:

GOAL: Early detection and intervention for complications, especially postherpetic neuralgia or ocular involvement.

Interventions:

- Assess vision changes, particularly if the rash involves the forehead, eyes, or nose. Early treatment with antiviral medications is essential.
- Monitor for signs of postherpetic neuralgia (persistent pain after rash resolves). Notify the healthcare provider of additional pain management strategies.
- Assess for signs of systemic involvement or fever.

Planning & Care Implementation: Planning of Care: Early Detection and Intervention for Herpes Zoster Complications

CARE GOALS:

To ensure early recognition and treatment of ocular involvement, prevent or minimize the severity of postherpetic neuralgia (PHN), and identify systemic complications promptly to initiate appropriate management.

Planned Interventions:

1. **Ocular Assessment:** Regularly assess the patient for vision changes, especially if lesions appear on the forehead, around the eyes, or on the nose (the "Hutchinson's sign" can predict eye involvement). Immediately notify the healthcare provider of any visual symptoms (blurred vision, eye pain, redness, sensitivity to light) for ophthalmologic referral. Initiate or reinforce early antiviral therapy to limit viral replication and prevent severe eye complications (e.g., keratitis, uveitis).
2. **Neuropathic Pain Monitoring:** Assess patients frequently for signs of postherpetic neuralgia, such as ongoing burning, stabbing, or shooting pain after rash remission and stabilization. Document pain characteristics and intensity using standardized pain scales. Alert healthcare providers to initiate neuropathic pain management protocols (e.g., gabapentin, pregabalin, tricyclic antidepressants).
3. **Systemic Symptom Surveillance:** Monitor vital signs and systemic symptoms such as fever, fatigue, or widespread rash extension. Recognize early signs of disseminated herpes zoster (especially in immunocompromised patients) and escalate care accordingly.

Implications for Nursing Practice

- **Timely Recognition Saves Vision and Reduces Morbidity:** Prompt identification of ocular symptoms can prevent irreversible damage, including vision loss. Nurses must maintain a high level of vigilance for any lesions involving the face or scalp.
- **Proactive Pain Management:** Nurses play a key role in identifying early signs of PHN and advocating for appropriate pain interventions, minimizing long-term suffering, and improving quality of life.
- **Systematic Monitoring:** Regular assessment protocols ensure early detection of systemic complications, allowing timely medical interventions that can prevent severe disease progression.
- **Patient Education:** Educate patients on the mportance of reporting any changes in vision, persistent pain, or general malaise promptly. Encourage adherence to antiviral medication regimens.
- **Interdisciplinary Collaboration:** Nursing actions must integrate closely with medical, ophthalmological, and pain management teams to provide comprehensive, patient-centered care.
- **Emotional and Psychological Support:** Persistent pain and fear of vision loss or systemic illness can severely impact a patient's mental health. Nurses should provide reassurance, coping strategies, and referrals to psychological support when needed.

PSYCHOSOCIAL SUPPORT

GOAL: The patient will express feelings of emotional well-being and show improved coping mechanisms.

Interventions:

- Provide emotional support, acknowledging the distress that Herpes Zoster can cause.
- Offer reassurance and educate the patient and family about the nature of the disease and the course of treatment.
- Provide information about postherpetic neuralgia, its symptoms, and management strategies to help manage anxiety.
- Refer to counseling or support groups as needed. Planning & Care Implementation:

Planning & Care Implementation:

Expected Outcomes: The patient will verbalize a better understanding of the disease process and its expected course. The patient will express reduced anxiety and fear regarding current symptoms and possible complications (e.g., postherpetic neuralgia) and demonstrate improved coping strategies and actively engage in self-care and treatment adherence. When appropriate, the patient will participate in counselling or support networks for additional emotional reinforcement.

Care Implications for Nursing Practice

- **Holistic Patient Care:** Nurses must recognize that Herpes Zoster is not only a physical illness but also a psychological burden. Pain, appearance of lesions, isolation requirements, and fear of complications can cause anxiety, depression, and social withdrawal. Addressing emotional needs is as important as managing physical symptoms.
- **Communication and Education as Therapeutic Tools:** Honest, clear, and empathetic communication helps reduce fear of the unknown. Providing timely information about the expected healing process, pain management, and available support structures empowers patients and families.
- **Early Identification of Psychological Distress:** Nurses must actively assess for signs of emotional strain, such as hopelessness, persistent worry, or mood changes. Early intervention can prevent escalation into severe depression or anxiety disorders.
- **Facilitation of Support Networks:** Referral to professional counselling, mental health services, or patient support groups can offer patients the tools to manage the psychological impact of their illness more effectively.
- **Family and Peer Engagement:** Educating family members and close friends fosters a more supportive environment around the patient. Family involvement helps mitigate feelings of loneliness and reinforces self-care practices at home.
- **Continuity of Care:** Psychosocial support should not end at hospital discharge. Follow-up contact or referral to community services ensures sustained emotional support through the full recovery period, especially if complications like postherpetic neuralgia develop.

PATIENT EDUCATION

GOAL: The patient will demonstrate understanding of the disease, its course, and the prescribed treatment.

Interventions:

- Educate the patient about the nature of Herpes Zoster and its contagiousness, especially to individuals who have never had chickenpox or the varicella-zoster vaccine.
- Explain the importance of completing the prescribed antiviral medication regimen.
- Instruct the patient on self-care techniques, including how to apply topical treatments, when to change dressings, and when to seek medical help.

Evaluation:

- Pain Assessment
- Healing Progress
- Infection Control
- Patient Education
- Psychosocial Well-being

Psychosocial support is an essential component of care for patients with Herpes Zoster (Herpes Zoster), recognizing that the emotional impact of the disease can be as significant as the physical symptoms. Nurses play a critical role in providing emotional support, acknowledging the distress caused by pain, visible lesions, isolation, and fear of complications such as postherpetic neuralgia. Through clear and empathetic communication, patients and families should be reassured and educated about the nature of the disease, the course of treatment, and the possibilities for managing lingering pain. Early identification of emotional strain—such as anxiety, depression, or feelings of hopelessness—is crucial, allowing for timely intervention. Nurses should offer information about postherpetic neuralgia and available coping strategies to reduce anxiety and improve self-efficacy. Where needed, referral to counseling services or support groups can provide additional layers of emotional resilience. By actively involving family and peers and maintaining continuity of psychosocial care beyond hospitalization, nurses help patients regain emotional well-being, foster better coping mechanisms, and support a more holistic and sustainable recovery.

Planning & Implementation: Approaches to Patient Education for Holistic Care

Providing education to patients with Herpes Zoster (Herpes Zoster) requires a multifaceted approach that supports both clinical management and emotional well-being. Several formats can be utilized to make information accessible, practical, and supportive throughout the recovery journey.

Tutorials and demonstrations form a cornerstone of education, whether delivered in-person or online. Practical sessions can teach patients how to clean and dress Herpes Zoster lesions properly, and how to safely apply topical creams without risking further infection. Virtual tutorials, such as short online videos or webinars like *"5 Steps for Managing Herpes Zoster at Home"* and *"Understanding Postherpetic Neuralgia and How to Manage It,"* provide flexible learning options for patients who prefer to access information from home.

Peer consultation and support groups are another effective method to build confidence and resilience. Organizing small group education sessions allows patients to share experiences about coping with pain and emotional distress. In addition, pairing newly diagnosed patients with peer mentors who have successfully managed the condition can provide personalized advice, practical tips, and vital emotional encouragement.

Flyers and handouts remain essential tools for reinforcing messages. Simple, visual materials—such as *"Hand Hygiene for Herpes Zoster: Protect Yourself and Others," "When to Call Your Doctor: Warning Signs During Recovery,"* and *"Daily Self-Care Checklist for Herpes Zoster Patients"*—offer clear, immediate guidance. Infographics are particularly useful, as they visually highlight important dos and don'ts, such as covering lesions and avoiding scratching to prevent the spread of infection.

Short educational videos can enhance understanding through dynamic, engaging formats. Short animations or explainer videos like "What is Herpes Zoster? *Understanding the Virus"* and *"Managing Herpes Zoster Pain:* Treatment Options Explained" break down complex information into digestible segments. Testimonial videos, featuring real patients sharing their stories of pain, healing, and recovery, can deeply resonate emotionally and help reduce feelings of isolation.

Patient statements and storytelling bring a human perspective to the illness. Written or recorded accounts of real experiences—such as overcoming postherpetic neuralgia or managing the stigma associated with visible symptoms—can powerfully reassure and motivate patients. As one patient put It: *"When I developed Herpes Zoster, I thought I would never feel normal again — but support and care made all the difference."*

To increase visibility in clinical settings, posters and noticeboards can convey key messages in waiting rooms and treatment areas. Messages such as "Think it's just a rash? Know the Signs of Herpes Zoster," and "Pain After the Rash? It Might Be Nerve Pain - Talk to Your Nurse!" can raise awareness and prompt earlier reporting of complications.

Mobile app tips and notifications offer patients daily engagement through technology. Apps can send gentle reminders about medication schedules, symptom self-checks, or hygiene practices, helping patients stay organized and proactive throughout their recovery.

Finally, **nurse-led educational hotlines or helpdesks** provide a personal and responsive link for patients who need immediate guidance or reassurance. By offering telephone or online support, nurses can help manage anxiety, answer questions about symptoms, and prevent unnecessary emergency visits.

By using these various formats in a coordinated way, nurses and healthcare teams can create a rich educational environment—one that empowers patients to participate actively in their care, manage their symptoms effectively, and feel supported every step of the way.

Chapter 4

NURSING MANAGEMENT WITH HZ PATIENTS

MANAGEMENT OF PATIENTS WITH HERPES ZOSTER

Infection control measures for patients with herpes zoster are based on their immune status and the extent of the rash, whether localized or disseminated. Healthcare professionals should assess both factors to determine the appropriate precautions. Standard infection control measures should always be followed, with additional precautions based on the patient's immune status and rash localization, as outlined below:

PATIENT IMMUNE STATUS	LOCALIZED HERPES ZOSTER	DISSEMINATED HERPES ZOSTER
Immunocompetent	Completely cover lesions and follow standard precautions until lesions are dry and scabbed.	Airborne and contact precautions until lesions are dry and scabbed.
Immunocompromised	Airborne and contact precautions until disseminated infection is ruled out. After dissemination is ruled out, cover lesions and follow standard precautions until lesions are dry and scabbed.	Airborne and contact precautions until lesions are dry and scabbed.

MANAGEMENT OF HEALTHCARE PERSONNEL WITH HERPES ZOSTER

Healthcare Personnel with Evidence of Immunity: Healthcare personnel with documented immunity to varicella (e.g., those who have received one or more doses of the varicella vaccine or have serological evidence of immunity) should follow these guidelines:

Localized Herpes Zoster in Immunocompetent Personnel:

- Lesions must be covered, and the healthcare worker should be restricted from providing care to high-risk patients (such as neonates, pregnant women, and immunocompromised individuals) until all lesions are dry and have formed a crust, it's scabbed.
- If lesions cannot be fully covered, the worker must be excluded from duty until lesions are dry and scabbed.

Disseminated Herpes Zoster or Localized Herpes Zoster in Immunocompromised Personnel:

- The worker must be excluded from patient care until all lesions are dry and scabbed.
- If disseminated infection is suspected, the healthcare worker should remain excluded until the infection is ruled out. formed a crust, it's scabbed.

MANAGEMENT OF HEALTHCARE PERSONNEL WITH HERPES ZOSTER

Healthcare Personnel with Evidence of Immunity: Healthcare personnel with documented immunity to varicella (e.g., those who have received one or more doses of the varicella vaccine or have serological evidence of immunity) should follow these guidelines:

No Post-Exposure Prophylaxis Required:

- Healthcare workers with confirmed immunity do not require post-exposure prophylaxis (PEP) or work restrictions
- These workers should ensure they are up to date with two doses of the varicella vaccine.
- If only one dose of vaccine has been received, a second dose should be administered within 3-5 days after exposure, as long as at least 4 weeks have passed since the first dose.

Monitoring for Symptoms:

- Healthcare personnel should self-monitor or have their health status monitored by an infection control nurse from 8 days after exposure to 21 days after the last exposure. It’s helpful, if there is an online alert system, to rais awareness, to avoid being forgotten.
- Any symptoms such as fever, headache, skin lesions, or systemic signs should be immediately reported.
- If symptoms appear, the healthcare worker should be removed from patient care, placed on sick leave or at a non-clinical working domain, and receive antiviral treatment.the infection is ruled out. formed a crust, it’s scabbed.

Healthcare Personnel with No Evidence of Immunity: Healthcare personnel without documented immunity to varicella (those who have not been vaccinated or do not have evidence of immunity) should be treated as susceptible and follow these guidelines:

- Allocate or Temporary Reassignment: These workers should be temporarily reassigned away from patient care duties from the 8th day after exposure through the 21st day after the last exposure.
- Post-Exposure Vaccination: They should receive post-exposure vaccination within 3-5 days of exposure, in accordance with ACIP and CDC guidelines. Vaccination given 6 or more days after exposure is still effective in preventing future infections.

RECOMMENDATIONS FOR HEALTHCARE INSTITUTIONS

To prevent the spread of varicella-zoster virus (VZV) and nosocomial infections, healthcare institutions should:

- Maintain Documentation of Immunity: Ensure that all healthcare personnel have readily accessible documentation of their immunity to varicella. This should be checked and verified regularly.
- Provide Vaccination and Screening: Healthcare institutions should offer varicella vaccination to all personnel who lack evidence of immunity, preferably before they begin employment. Two doses of the varicella vaccine should be administered 4-8 weeks apart for those who are not immune.
- Implement Exposure Protocols: Establish clear protocols for managing healthcare personnel exposed to herpes zoster in the workplace. This includes guidelines for post-exposure vaccination, use of VZIG, and ensuring appropriate work restrictions are in place based on immune status.
- Educate Healthcare Workers: Provide education about the risks associated with exposure to herpes zoster, particularly for those without immunity. Inform staff about the importance of reporting symptoms promptly and adhering to vaccination schedules.
- Manage Exposures Effectively: Develop a system for promptly identifying and managing

healthcare personnel who have been exposed to varicella-zoster virus, ensuring they receive the appropriate medical care and that infection control measures are followed (Riccò, et al., 2024).
- Engage with national and international campaigns during immunisation and infection prevention week, and take initiatives to have professionals engaged. This can also create an interprofessional focus team related to Herpes Zoster, to act as a reference in a health institute. This is also with facilitation to enable them to be active on this and collaborate with relevant international institutes.

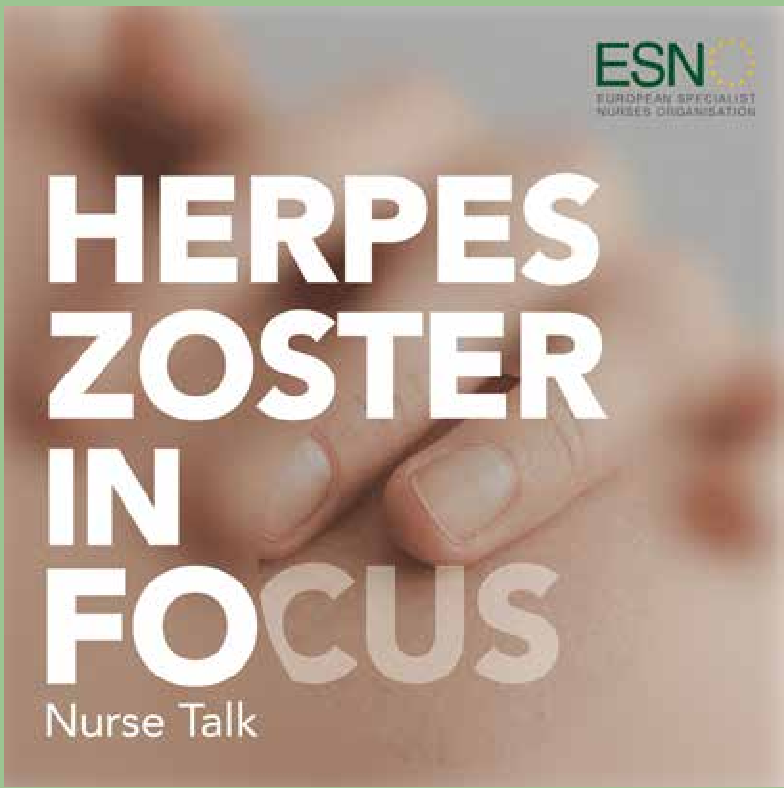
CONTINUING PROFESSIONAL DEVELOPMENT

This highlights the vital role of continuing professional development in Herpes Zoster (Herpes Zoster) care, emphasizing the need for nurses to maintain clinical competence, engage across disciplines, and strengthen health literacy in society. It underscores the responsibilities of both institutions and individuals to invest in education, collaborate with patient organizations, and overcome cultural barriers through diverse learning formats.

- Continuing professional development (CPD) in Herpes Zoster (Herpes Zoster) care is essential for nurses to maintain excellence in clinical practice, patient education,and societal engagement. Herpes Zoster is often perceived narrowly as a medical issue, but its management crosses into nursing care, wound management, mental health support, pain control, and infection prevention. Addressing these dimensions requires not only scientific knowledge but also cultural sensitivity, as pain perception, stigma, and health-seeking behavioursdiffer across societies. Nurses, consistently ranked as the most trusted professionals,are uniquely positioned to bridge these gaps, using education as a tool to enhance both individual patient outcomes and broader health literacy.
- Institutional facilitation is crucial in enabling nurses to meet these expectations. Healthcare organizations must take responsibility by providing structured CPD opportunities, interdisciplinary learning environments, and resources that reflect up-to-date clinical and social practices. Institutions that invest in regular in-person courses.
- At a personal level, each nurse must embrace lifelong learning as a core professional value. Staying connected with peer organizations, both nationally and internationally, supports alignment with evolving standards and strengthens professional identity and advocacy skills.
- Engagement with patient organizations is equally critical. Collaborative education initiatives break down silos between professionals and the public, harmonize messaging, and empower communities. Nurses can lead workshops, co-create educational materials, and participate in joint campaigns that address not only the disease itself but the broader cultural and emotional aspects of living with Herpes Zoster and postherpetic neuralgia.
- Educational methods can vary—from in- person skills training, webinars, and interdisciplinary simulations to patient co- education sessions and online resources. A comprehensive approach ensures that nurses are not only informed but actively shaping a culture of understanding, resilience, and holistic care around Herpes Zoster.

THE PODCASTS

- Open Spotify: https://open.spotify.com/show/1y4Yi2m0wnLfOIBFG2FBbN?si=b2a7d0aeef7742c8
- Apple: https://podcasts.apple.com/us/podcast/herpes-zoster-in-focus/id1849118411



ABOUT THE EDITIONS

We speak about Herpes Zoster from three different perspectives. The patient's perspective, the medical perspective and the Specialist nurse in perspective and practice.

1. In the first episode, we speak with Chantal Tesson, representative of the patient organisation Pain after Herpes Zoster, who shares her personal experience with the disease. She reflects on the importance of giving patients a strong voice in healthcare discussions and policy development.
2. In the second edition, Dr. Mienke Rijsdijk explores the medical perspective of HerpesZoster, delving into its causes, the impact on patients' lives, and the latest treatment options. The conversation highlights the importance of early recognition and comprehensive care strategies.
3. Our third conversation is with Danielle Laurijsen, Nurse Specialist in pain management, who discusses the close relationship between nurses and patients in managing Herpes Zoster. She emphasises the role of health literacy, a holistic care approach, and the growing autonomy of nurses in treatment pathways.

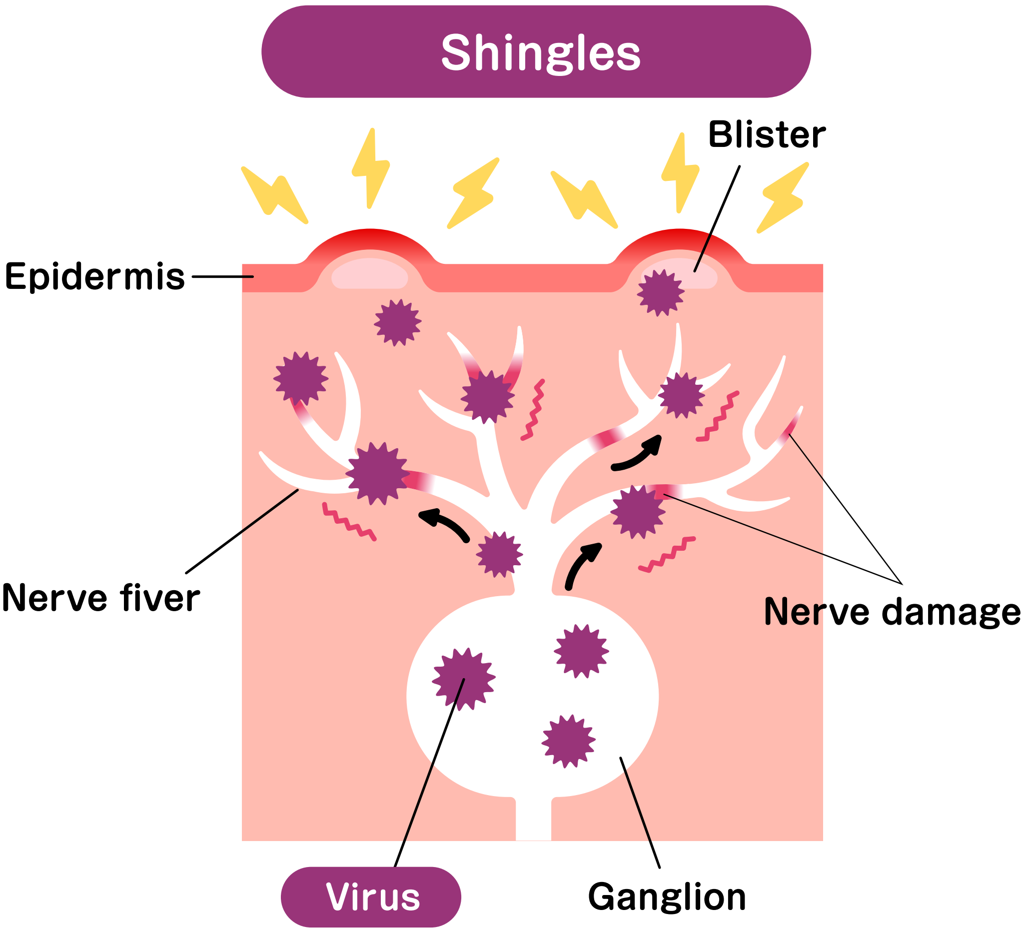
CONTINUING PROFESSIONAL DEVELOPMENT

The nursing profession is a state of immense growth and reflects it's role in clinical care but also in education, training management at all levels, both local, national and international.1 In this context it's also crucial to understand that all nursing contributions need to be mentioned in the contact of the nursing profession, also related to the competence building in relation to microbes, vaccination, anti-microbial resistance and infection prevention. In this context, it needs to be understood that education on this issue is an integrated part of the profession
and need to be context of Nurses Outcome Classification and Interventions Classification.
This also applies to maintaining skills related to infection prevention, vaccination and antimicrobial resistance and the general knowledge about microbes and interventions. A nursing diagnosis is a clinical judgment concerning a human response to health conditions/life processes, or vulnerability for that response, by an individual, family, group, or community. The foundation of nursing diagnosis is clinical reasoning, and it requires the ability to distinguish normal from abnormal data, cluster related data, recognize missing data, identify inconsistencies in data, and make inferences.
Donor suitability assessment involves the collection of subjective and objective information (e.g., vital signs, donor interview, physical exam) and review of historical information in the donor file. Nurses also collect information on strengths (to identify health promotion opportunities) and risks (areas that nurses can prevent or potential problems they can postpone). Nursing diagnoses are used to identify intended outcomes of care and plan nursing-specific interventions sequentially. A nursing outcome refers to a measurable behaviour or perception demonstrated by an individual, family, group, or community that is responsive to nursing interventions.
The Nursing Outcome Classification (NOC) is a system that can be used to select outcome measures related to nursing diagnosis. NOC can also be used to determine staffing needs as nursing is the largest operational cost in health centers, so a small change in a staffing model has a large impact on financial outcomes 4 An intervention is defined as "any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance patient/client outcomes".
The Nursing Interventions Classification (NIC) is a comprehensive, evidence-based taxonomy of interventions that nurses perform across various care settings. Using nursing knowledge, nurses perform both independent and interdisciplinary interventions.

CONCLUSION

Herpes Zoster presents distinctive obstacles in terms of its affective impact on patients and its clinical management. Nurses are in a critical position to offer compassionate support, accurate education, and timely intervention as essential members of the healthcare team throughout the disease. Nursing care is essential for enhancing patient outcomes and quality of life, as it involves the identification of early symptoms, the management of discomfort, the promotion of vaccination, and the remission and stabilization of potential complications.

The fundamental knowledge and skills required to provide care for patients with Herpes Zoster have been delineated in this guide. Nurses can guarantee that individuals afflicted with this condition receive comprehensive, safe, and empathetic care by adhering to current best practices and maintaining a patient-centered approach. Healthcare professionals must maintain a high level of vigilance, advocacy, and ongoing education to alleviate the impact of Herpes Zoster on our communities.



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“This guide is a practical, evidence-based resource written specifically for nurses, designed to strengthen knowledge, confidence, and communication in the care of patients with herpes zoster. It offers clear explanations of the condition, its underlying mechanisms, and the factors that contribute to reactivation, alongside essential guidance on prevention, early recognition, and effective management.
With a strong focus on real-world nursing practice, the book provides hands-on tips, communication strategies, and patient-centred approaches that help nurses navigate the often complex physical and emotional needs of individuals experiencing herpes zoster and its complications. From managing acute pain to addressing fears, misconceptions, and long-term concerns such as postherpetic neuralgia, the content supports nurses in delivering compassionate, evidence-informed care.
By combining clinical insight with practical education tools, this book empowers nurses to improve patient outcomes, strengthen health literacy, and play an active role in reducing the personal and societal burden of herpes zoster. It is an essential companion for all nurses involved in vaccination, infection prevention, community health, and age-related care.” **Tihana Gašpert**

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ABOUT ESNO

The European Specialist Nurses Organisation (ESNO) is a non-profit organisation and the goal is to facilitate and provide an effective framework for communication and co-operation between the European Specialist Nurses Organisations and its constituent members. ESNO represents the mutual interests and benefits of these organisations to the wider European community in the interest of the public health. Members of ESNO consist of individual European specialist nurses organizations.

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