CLINICAL GUIDELINE

Herpes Zoster Ophthalmicus Assessment, Acute Referral Centre

A guideline is intended to assist healthcare professionals in the choice of disease-specific treatments.

Clinical judgement should be exercised on the applicability of any guideline, influenced by individual patient characteristics. Clinicians should be mindful of the potential for harmful polypharmacy and increased susceptibility to adverse drug reactions in patients with multiple morbidities or frailty.

If, after discussion with the patient or carer, there are good reasons for not following a guideline, it is good practice to record these and communicate them to others involved in the care of the patient.

Version Number:	4
Does this version include changes to clinical advice:	No
Date Approved:	7th June 2022
Date of Next Review:	30th June 2025
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Important Note:

The Intranet version of this document is the only version that is maintained.
Any printed copies should therefore be viewed as 'Uncontrolled' and as such, may not necessarily contain the latest updates and amendments.

Assessment of Herpes Zoster Ophthalmicus in Acute Referral Centre (ARC)

History

- Previous episodes / ocular involvement
- Past ophthalmic History
- Immunosuppression
  - Suspect if <40 years
  - African ethnicity

Symptoms

- Dermatological
  - Pain / paraesthesia / rash
  - Distribution
  - Extension over scalp
  - Duration
- Headache, Fever, Lethargy

- Ocular
  - Blurred vision
  - Eye pain / photophobia
  - Red eye
  - Discharge

Examinations to be Performed in Casualty

- **Relevant dermatological**
- **Visual acuity**
- **Pupil assessment**
- **Intraocular pressure**
- ***Corneal sensation***
- **Ocular adnexa**
- **Slit lamp anterior segment**
- **Dilated fundal examination**

Dermatological
- Vesicular skin rash
- Typically cranial nerve V1 distribution
- Can occur V2 or V3
- Unilateral, obeys midline
- Hutchison sign – rash on tip of nose

Eyelids
- Cicatricial changes in previous cases and lid malposition
- Lid oedema causing ptosis
- Lagophthalmos – beware of corneal exposure
- Trichiasis

Conjunctiva
- Mucopurulent discharge
- Hyperaemia
- Petechial Haemorrhage
- Papillae or follicular conjunctivitis
- Pseudomembrane

Cornea
- Exposure keratopathy
- Punctate erosions
- Dendritic type lesions (tapering ends compared to bulbs seen in HSV keratitis)
- Disciform keratitis. Can occur after rash.
- Neurotrophic keratitis
- Peripheral corneal ulceration
- Secondary infective keratitis
- Epithelialitis and keratitic precipitates associated with uveitis

Uveitis
- Usually presents 1 week after onset of rash
- Anterior chamber activity
- Keratitic precipitates and epithelialitis

Episcleritis / Scleritis
- Injection of superficial or deep scleral vessels
- Associated nodular lesion

Dilated Fundal Examination
- Vitritis
- Retinitis / Choroiditis

Optic neuropathy
- Reduced visual acuity
- Swollen, hyperaemic optic disc

Ocular motility palsy
- Palsy of cranial nerve III, IV & VI can occur
- Assess pupil responses and orbicularis function if IIIrd palsy suspected

Management of Herpes Zoster Ophthalmicus in Acute Referral Centre (ARC)

Dermatological Rash

Warm bathing of crusting lesion

Duration

Less than 5 days duration or deemed severe – **Acyclovir 800mg** 5 times daily. 1 week course

More than 5 days duration – Acyclovir unlikely to alter disease course

Acyclovir is as effective as other oral antiviral agents and is the oral agent of choice

Blepharitis Present

Eyelid hygiene advice and **Fusidic acid 1% ointment** BD to lids. 1 week course

Follow-up: *With GP if no ocular involvement*

HZO related **scleritis**, **vitritis**, **retinitis**, **optic neuropathy** and **neurological manifestations** may need systemic antiviral therapy and steroids. Please consult with senior or uveitis team.

Consider discussing with the **Brownlee Unit** any patient known to have or suspected of having an immunocompromising condition or is known to be on iummunosuppressive therapy.

Anterior Segment Disease – Commence all patients on Acyclovir 800mg 5 times daily. 1 week course. Pack available in ARC

Conjunctivitis – Acyclovir 800mg 5 times daily. 1 week course.

No Corneal Involvement

Eyelid hygiene advice

Fusidic acid 1% ointment BD. 1 week course

Follow-up

Primary care / cornea clinic 1 week

Corneal Disease – Acyclovir 800mg 5 times daily. 1 week course.

Epithelial Disease

Infiltrate present	See separate bacterial keratitis protocol
No infiltrate	**Artificial tears (Carbomer)** 2 hourly **Liquid paraffin (Lacrilube) BD** Follow-up: *Primary care / cornea clinic 1 week*
Dendritic disease	Add **Fluorometholone 0.1%** TDS to above

Stromal Disease

Epithelial defect	Treat as epithelial disease above
No epithelial defect	**Prednisolone acetate 1%** QDS Follow-up: *Primary care / cornea clinic 1 week*

Neurotrophic Keratitis

Treat as epithelial disease as above

Consult with senior or seek Corneal team review

Anterior Uveitis – Acyclovir 800mg 5 times daily. 1 week course.

Epithelial Defect

Cyclopentolate 1% TDS

Treat defect first - refer to epithelial disease guideline above

Epithelium Intact

Prednisolone acetate 1% hourly

Cyclopentolate 1% TDS

Refer to AAU protocol for frequencies and duration of treatment

Follow Up

If IOP Normal	*Primary care clinic review 2 weeks*
If IOP ↑ but ≤35mmHg	**Timolol maleatel 0.5%** BD *Primary care clinic review 2 weeks*
If IOP >35mmHg	**Brinzolamide-Timolol (Azarga)** BD **Acetazolamide SR 250mg** BD Recheck IOP *within 4 days*. Timing dependent on individual concern.

Analgesia

Initial episode: Simple analgesia as appropriate (Paracetamol / Co-codamol)

Neuropathic pain: Refer to GP to consider alternative analgesia

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