



# The GeriJournal

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## **Gabapentin for Shingles**

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Herpes zoster, aka shingles, is a nasty, usually painful, rash that runs along nerve tracks near the surface of the skin. There is often a prodromal phase where a sufferer experiences tingling, itching or other sensations. Vesicles, scabbing and healing can be followed by days, weeks, months or even years of pain. This condition is called postherpetic neuralgia or PHN.

Common treatment involves starting one of three oral antiviral drugs, Famvir®, Valtrex® or acyclovir, when symptoms first appear. If started within 72 hours of viral eruption, the rash and associated pain are usually milder and shorter in duration.

The response to antiviral drugs is often incomplete, however. Narcotics, antidepressants and anticonvulsants may be required for pain control well after the rash has healed. A study published in the April 11<sup>th</sup> edition of *Archives of Dermatology*, showed that administering gabapentin (Neurontin®) at the outset of antiviral therapy shortened,

reduced or eliminated PHN. Gabapentin was started at a dose of 300 mg daily and was titrated up to a maximum of 3600 mg daily, if tolerated. In residents with compromised kidneys, doses will be lower.

The drug was discontinued after four weeks if patients reported mild or no pain. It was tapered after eight weeks and discontinued one week later for those with moderate or severe pain. Pain intensity in subsequent weeks continued to diminish and was much lower than expected. It was concluded that gabapentin be considered as adjunct therapy at the onset of a shingles rash.

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## **β-Blockers in COPD**

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Giving a β-blocker (atenolol, propranolol, metoprolol, etc.) to a COPD patient seems like lunacy. For years we have been trained to avoid these drugs in any resident with breathing concerns for fear of inducing bronchospasm and respiratory crisis.

Evidence now suggests that β-blockers may actually be beneficial in COPD, much as they are in heart failure. The improvement may be related to better exercise tolerance and increased cardiac capacity or perhaps an increase in lung tissue receptor sensitivity. In any event, exacerbations appear to be reduced and survival increased with the addition of cardio-selective β-

blockers such as metoprolol, and atenolol (*Arch Intern Med* 2010;170:849,880). The initial dose should be low, as respiratory function may decline at the onset of therapy. Residents with both heart failure and COPD should be targeted for β-blocker treatment due to its dual benefit in these conditions.

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## **Who Will Fall**

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Multiple medications, physical impairment, advanced age, neurological conditions, poor home layout and lighting, pets, etc., are all associated with falls. While we are well aware of these risk factors, we rarely perform a simple test that is one of the best indicators of an impending fall; an assessment of BP for the presence of orthostatic hypotension.

A study of over seven hundred community dwelling elderly (> 70 years) conducted in Boston did just that. They defined systolic orthostatic hypotension (SOH) as a drop of at least 20 mmHg in systolic BP one minute after rising from a sitting to a standing position. Those with SOH were 2.5 times more likely to fall than those without SOH. Subjects whose hypertension was poorly controlled (BP > 140/90) were more likely to have SOH. Let's do this one minute test more often, so we can identify potential fallers and make the necessary changes to keep them upright.