



Your Questions Answered

SHINGLES

Q I just heard about a new vaccine that protects against shingles. How do I know if it would be right for me?



DR. DONALD GILDEN ADVISES:

A If you are over age 60 and had chicken pox as a child, you should get the new shingles vaccine. Shingles, which produces rash and searing nerve pain in hundreds of thousands of older adults each year, occurs when the same virus that causes chicken pox is reactivated.

Even if you don't remember having chicken pox, getting vaccinated still might make sense. That's because people can be exposed, produce antibodies, and not know they've had chicken pox. You can have your blood drawn at a lab and tested to see if you have antibodies against the virus. Anyone who tests positive for the antibodies should get the vaccine.

While the vaccine doesn't guarantee that you won't get shingles, it does cut the rate by about 50 percent. Therefore, it's certainly worth taking a shot at reducing the likelihood that you'll develop this condition.

That's because shingles can be quite painful and the effects can be long-lasting. Many people have pain for four to six weeks and some for as long as months or even years.

About five years ago, I had shingles. I was lucky: The pain and rash went away in a couple of days. But the first day, I was miserable. I had no appetite. I felt terrible pain in my arm.

That experience really made me realize what my patients with postherpetic neuralgia—a chronic nerve pain that can follow an episode of shingles—were going through. They don't call it the "belt of roses from hell" for nothing.

If you've had shingles in the past 10 years, skip the vaccine since the shingles will have boosted your immunity to the virus.

Donald H. Gilden, M.D., is professor and chairman of neurology at the University of Colorado Health Sciences Center in Denver.

DO YOU HAVE A QUESTION TO ASK THE EXPERTS?

Send it to neurologynow@lwwny.com

INSOMNIA

Q A friend takes melatonin when she can't sleep. Does it really work?



DR. CLIFFORD SAPER ADVISES:

A Melatonin is a natural hormone that acts on the brain to promote circadian rhythms, including sleep rhythms. Clinical trials show very tiny improvements in sleep—falling asleep four minutes sooner and 2 percent improvement in sleep time—in healthy people, and no improvement in people with other disorders such as depression.

The problem with natural melatonin is that it can't be patented, so no one has taken the expense of getting it approved by the Food and Drug Administration and producing it under FDA-controlled conditions, where the exact amount and purity is guaranteed. It's marketed instead as a "natural substance," which means it can be sold by anyone, with virtually no controls over quality, purity, or the amount contained in a tablet. Therefore, when you get melatonin from a health-food store, there's no way to know that the pill actually contains what is claimed on the label. Studies have found an enormous range of doses in individual pills—and often not the dose that is claimed on the bottle.

Moreover, most people aren't aware of some of the side effects that can occur with melatonin. Higher doses taken for a long period of time, for example, cause testicular atrophy in men.

The bottom line: I would never take over-the-counter melatonin, because the entire supplement industry is unregulated.

An alternative, prescription ramelteon (Rozerem), activates melatonin receptors in the brain, so it works like a synthetic melatonin. Approved by the FDA last year, ramelteon has the advantage that you know exactly what you're getting. The best evidence is that, like melatonin, ramelteon decreases the time it takes to fall asleep by only a small amount. It doesn't have any effect on frequency of nighttime awakenings or total sleep time—both important for high-quality, restorative sleep.

Clifford B. Saper, M.D., Ph.D., is professor at Harvard Medical School and chairman of neurology at Beth Israel Deaconess Medical Center in Boston.

CLUSTER HEADACHES

Q I've been experiencing cluster headaches for years. Is there anything I could do to prevent them?



DR. RICHARD LIPTON ADVISES:

A Cluster headaches derive their name from the fact that the headaches come in clusters. Attacks may occur several times a day for weeks or months, followed by long headache-free periods.

The duration of individual headaches tends to be short: 30 to 90 minutes. But they are agonizing. People have described them as feeling like a hot poker in the eye.

Severe one-sided pain is often associated with other features. These can include drooping of an eyelid, eye redness and tearing, and nasal stuffiness—all on the same side as the head pain.

Cluster headaches are almost always benign. But there are some serious conditions that can cause a similar pattern of headaches. Therefore, people with a new onset of cluster headaches should have an MRI.

As with migraines, treatment can be abortive or preventive. Because cluster headaches are relatively short-lived but intense, abortive therapies need to work quickly. One very effective acute treatment is oxygen, administered at home by face mask; it typically works within 10 minutes.

Another very effective therapy is injectable sumatriptan (Imitrex), which is also used for migraines. That works in about 5-10 minutes. There is also a nasal spray, which is not as fast as oxygen or sumatriptan injections.

The mainstay of treatment, though, is prevention.

Prednisone and other steroids work very quickly to turn off a cluster attack. But these are powerful drugs that shouldn't be taken on a long-term basis.

For the long term, a calcium channel blocker known as verapamil works very well—but it takes a couple of weeks to kick in. So, a new patient will be started on prednisone and verapamil simultaneously; then the prednisone can be tapered off.

Patients with cluster headaches should probably be managed by a neurologist, since most primary care physicians will see only one or two patients with this problem in their whole career.

Richard B. Lipton, M.D., professor and vice chair of neurology at the Albert Einstein College of Medicine in the Bronx, N.Y., is director of the Montefiore Headache Center.

SCIATICA

Q I have pain shooting from my lower back down my leg. Is there anything I could do about this?



DR. MIROSLAV BACKONJA ADVISES:

A A lot of people assume that any time you have pain going down your leg, it's due to sciatica. But there are other possibilities. First, it's entirely possible that the pain is transitory. Frequently this type of pain results from overused muscles. This can happen, for example, when a "couch potato" plays golf over the weekend or chops logs on vacation. The pain will resolve in a couple of days with some stretching and some anti-inflammatory medications, such as ibuprofen or naproxen sodium.

If the pain is more long-lasting, you should see a physician.

As it turns out, the vast majority of patients who show up in their doctor's office with pain radiating down the leg have myofascial pain syndrome. In fact, this was one of the causes of John F. Kennedy's lower-back pain.

The syndrome isn't well understood, but can be easily diagnosed because patients will have specific "trigger points," which are spots on the body that are especially tender to the touch. Physical therapy can help with this syndrome. Your doctor may also want to find ways to improve your sleep since poor sleep is thought to contribute to the problem.

It's very important to seek medical advice if you have back pain plus some other medical symptoms, such as fever, chills, or blood in the stool or urine. This could be the sign of a serious medical problem.

If the back and leg pain comes with certain other symptoms—such as loss of coordination or numbness in your legs or feet—then you might well be experiencing sciatica.

That condition results when the root of the sciatic nerve is compressed. This generally happens as a result of a combination of arthritic changes in the vertebrae coupled with a disc protruding into the spinal canal through which the nerves pass.

If you have sciatica, your neurologist will be able to determine what's the best course of therapy. This could include pain management or even surgery.

Miroslav Backonja, M.D., professor of neurology at the University of Wisconsin–Madison, is director of research and education at the university's Pain Treatment and Research Center.