



Do you know your family health history?

It can help reduce your health risks, but asking relatives can be awkward. These tips can help.

Some people inherit heirlooms—jewelry, furniture, clothing, and other items—from their relatives. But there’s something even more valuable we *all* inherit: our health.

Finding out what medical conditions run in your family is one of the best ways to predict your [risk for certain diseases](#). Relatives often get together around the holidays, so this time of year can be a good opportunity to learn about your [family health history](#).

Our genes are important factors that affect our health. For example, people with [sickle cell disease](#) (a blood disorder) inherited the genetic variant for this illness from both parents.

But just because your family members have a condition doesn’t mean you have it or will in the future. For complex conditions such as diabetes, while family health history is important for determining individual risk, lifestyle and environmental factors also affect disease progression.

Laura Koehly, Ph.D., chief and senior investigator for the Social and Behavioral Research Branch at the National Human Genome Research Institute (NHGRI), explained that when people don’t know their family health history, a doctor can’t use that information to measure their risk and personalize their health care.

What a family health history can do for you

- Give health care providers information to identify disease at earlier stages
- Help providers recommend ways to reduce risk, including preventive care
- Help family members make lifestyle changes to reduce risk
- Inform a pregnant person (or someone considering pregnancy) about gene variants they have and what those variants mean [for the fetus](#)



FAST FACT

In a 2024 survey by the National Center for Health Statistics, **95% of adults** believe knowing their family health history is somewhat or very important. But only about **15% of adults** are actively collecting that information.

SOURCE: [CENTERS FOR DISEASE CONTROL AND PREVENTION](#)

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How to talk to family members about their health history

It's a good idea to talk to as many relatives as you can about your family health history. There could be information gaps or confusion about what people know. Ideally, it's best to know two generations back (i.e., parents, aunts and uncles, and grandparents). Older family members are more likely to know about previous generations' health conditions.

Health is a complicated topic. When talking about it with family, listen carefully, be patient and respectful. If someone does not want to talk about their health around others, ask whether you can talk with them in private. Remind them that knowing your family health history can help you and other relatives live better and longer.

Some good questions to ask family members include:

- Do you have any chronic diseases, such as heart disease or diabetes, or health conditions, such as high blood pressure or high cholesterol?
- How old were you when you developed symptoms or were diagnosed?
- Have you had any other serious diseases, such as stroke or cancer (and what type)?
- Has anyone else in our family had the same diseases or conditions?
- What is our ancestry? (Some diseases are more prevalent within certain ethnic groups.)
- Have you or any of our family members been tested for [genetic mutations](#) (cell changes)?
- How old were our relatives when they died? How did they die?

It helps clinicians to know how old your relative was when they were diagnosed with a disease or condition and whether they died from it, Dr. Koehly said. It helps your doctor determine when to screen *you*.

There are different ways to collect family health information:

- Choose one family member to collect all the health information from various relatives
- Have each relative fill out their own health record
- Create a checklist organized by medical conditions and ask whether anyone in the family has them
- Use a family group chat to ask questions and share information

By having these conversations, families can develop a culture of health and prevention.

"It's also important to empower people and their families to act, to do something, to engage in specific health behaviors, like screening at appropriate times and engaging in a healthier lifestyle," Dr. Koehly said.

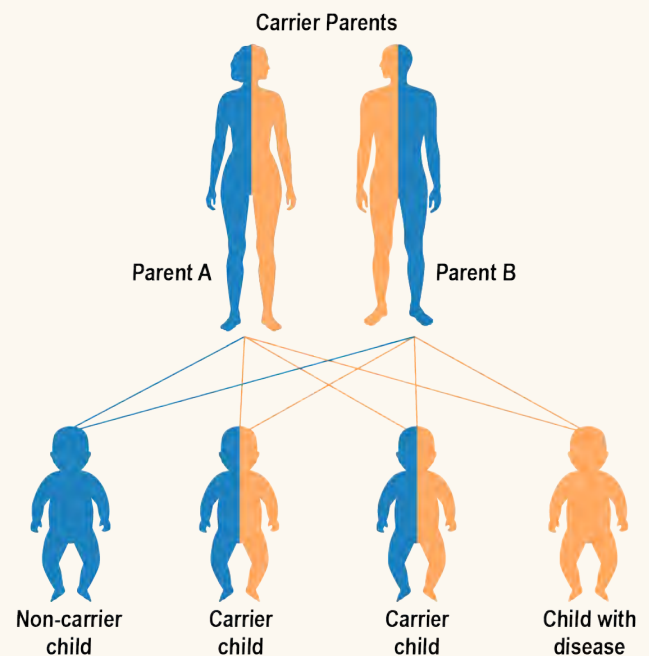
What if you can't ask your relatives?

[Genetic testing](#) can be especially helpful to find out what conditions may run in your biological family. If your relatives can't or don't want to share their health history with you, [direct-to-consumer](#) genomics or ancestry companies are another option. These services may reveal unknown relatives to learn your family health history. If you were adopted or born using sperm/egg donation, adoption or donation agencies may be able to provide health records.

Talk to your health care provider about [health screening guidelines](#) for certain conditions, and tell them if you have any concerns about your risks.

No matter what health conditions you or your family have—and whether you know your family health history—preventive care is important. While you can't change your genes, you can still practice healthy habits such as being active, eating a balanced diet, and [staying smokefree](#).

How conditions get passed from parents to children



A parent can be a carrier for a condition, meaning they don't have the condition themselves but can have children with it. Children get two copies of each gene, one from each parent. If a child has gene copies for a condition from both parents, the child can develop the condition. The child may also become a carrier for the condition themselves, even if they do not have it.

Tools to help you keep track of your family health history

[My Family Health Portrait](#) is a downloadable tool that helps you create a family health history document. It was developed by the Centers for Disease Control and Prevention, NHGRI, and other partners.

NHGRI's [Families Sharing Health Assessment and Risk Evaluation \(SHARE\)](#) initiative also has free online worksheets (available for PDF download) to help you understand your disease risk. These worksheets cover colorectal cancer, breast cancer, prostate cancer, type 2 diabetes, and heart disease. You can also download SHARE workbooks in English, Spanish, Hausa, and Haitian Creole.

Whatever you use, Dr. Koehly said, remember to *share it with your relatives!* Make sure younger generations can access the family health history, add to it, and use it for their own health care decisions. ■

This article was originally published in 2019. It has been updated.

What is palliative care?

We asked a professional

People with serious or terminal illnesses have to make difficult choices. It can be hard to understand all the information they get from their doctors. It can also be an emotional rollercoaster for them and their loved ones. What if there was someone to help them make decisions?

That's where Kristin Nannetti, MSN, RN, CCRN, CHPN, CNL, comes in. As the Palliative Care Coordinator for VHC Health, her job is to guide patients and their families through all the different areas of care for serious illnesses. She talked with NIH MedlinePlus Magazine about palliative care and how it can give people a better quality of life. She also cleared up some misunderstandings about palliative care.

In your own words, what can palliative care look like?

Palliative medicine is for people with serious and complex illnesses. The goal is to reduce symptoms, improve quality of life, and support the patient and their family so they can cope through their treatment. I like to say palliative medicine is the “human side of medicine.” Our goal is to gentle the journey our patients and their loved ones might face.

We support the physical, psychological, social, spiritual, and existential aspects of their condition. That can include symptom management, complex health care navigation, grief counseling, and advance care planning. We also have “goals of care discussions” where we get to know our patients and their loved ones to help them make informed treatment or care decisions. These discussions take an hour or two per visit, and they usually recur over several weeks, months, or even years. We spend as much time as the patient and their family need to understand their condition, treatment options, and plans. We want to make sure they feel supported through it all.

Why did you decide to go into palliative care? What do you find most rewarding about this work?

When I began a career in health care, I did so to help others. Most of my nursing experience before palliative medicine was in critical care, and my initial career goal was to “save lives.” In part, I saw my role as a nurse to fight off death. But while working in the intensive care unit (ICU), I saw a lot of suffering and futile care (care that is unlikely to make a patient better). I experienced moral distress while working in the ICU and felt burned out. I realized that everyone dies, and sometimes the most compassionate thing we can do as clinicians is to aid a peaceful, natural death.



Kristin Nannetti is the Palliative Care Coordinator for VHC Health in Virginia.

At that time, I thought palliative care was a sad specialty to work in, but I kept feeling drawn to it. So I shadowed a palliative care nurse and took a special nursing course. Then I took a leap and transferred from critical care into palliative medicine. Soon after, I realized my home in health care is in palliative medicine.

Now I know palliative medicine isn't actually sad—chronic and terminal illnesses are. What's sad is the suffering people endure with these illnesses and the shortcomings of the health care system. Palliative medicine helps make those sad things better. That's what's most fulfilling about my job.

How is the training for palliative care different from other nursing training? Do you need any special skills for this work?

I've taken specialized classes, studied palliative medicine texts, trained with other palliative care specialists, and gone to conferences. In palliative medicine, we focus on all areas. I learned from physicians, nurses, social workers, counselors, nursing aides, and chaplains. I learned about diagnostics for complex and terminal illnesses, symptom management, end-of-life care, and disease prognostication—when physicians try to predict how a disease will progress or how much time a person has left to live. I learned about advance care planning, compassionate communication, ethical and legal standards of care, grief counselling, and case management. Plus, I learned how to support patients and families spiritually when they're going through a crisis.

Clear, compassionate communication and empathy are important special skills required in palliative medicine. Dealing with serious or complex illnesses can be difficult, and patients often struggle to cope. They may be sad or angry, so I let my patients vent, cry, laugh, whatever they need in that moment. You need to be able to understand where those emotions are coming from. I meet my patients where they are in those moments and help them find the path forward while feeling understood and seen.

How do you determine when palliative care is right for a patient?

Anyone with a serious or complex illness that is impacting their quality of life can discuss palliative care with their providers. It's helpful if patients seek a palliative care consultation as soon as they are diagnosed with a serious illness, especially if their condition requires symptom management or support. But palliative care isn't just for managing severe pain or for people who are dying. The timing is fluid—patients can begin palliative care at any time during their treatment journey, even very early on, up to and through end-of-life care. In order to know if palliative care is right for you, ask your primary care provider or specialist.

Hospice is a type of medical, supportive palliative care for people with six months or less to live.

What is it like to talk with people about their palliative care planning and decision-making? How do you help patients make tough decisions?

My role is to help patients and families understand what they can expect with their illness, treatments, symptoms, and prognosis. I think of myself as a steward who helps guide them on their journey through illness. Knowledge can be empowering. Having these conversations with patients and their loved ones can reduce their anxiety and fear.

When I start a new consultation, typically the first thing I do is learn as much as I can about the patient's medical history and treatment options. I make sure that when we have this conversation, it's comfortable for the patient and whoever is joining us. So we pick a time that's good for them, find a quiet location, and ensure we won't be interrupted.

Then I ask them open-ended questions: What do they understand about their condition and treatment plan, and how much do they want to know? Sometimes the discussions can

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Palliative Care Consultation



- STEP 1:** Learn as much as possible about the patient's medical history and treatment options.
- STEP 2:** Schedule a time to talk that is good for the patient and whoever is supporting them. Make sure you will not be interrupted.
- STEP 3:** Address any symptoms the patient might be experiencing: pain, difficulty breathing or sleeping, etc.
- STEP 4:** Ask open-ended questions to determine what they understand about their condition and treatment plan, as well as how much they want to know.
- STEP 5:** Answer any questions about their care and share information they might not already have.
- STEP 6:** Give the patient time to process the information, sometimes in silence.
- STEP 7:** Find out more about the patient personally to make sure they get the best possible care: What is most important to them? Do they have any religious or spiritual beliefs or any cultural preferences that their care team needs to be aware of? Who is their support system?
- STEP 8:** Make a plan for any treatments or care the patient will need and schedule a follow-up appointment.

be difficult for the patient and their loved ones to hear, so I give them time and space to digest the information. Often, they need emotional support. This is where my grief counseling skills come in handy. I'll ask them to tell me about themselves: What's most important to them? How are they coping with this? Do they have any religious or spiritual beliefs that they lean on during hard times? Do they have any cultural preferences that their care team needs to be aware of? What aspects of their personality should their care team know so that we can give the best possible care? Who is their support system?

By the end of the discussion, we will have a plan for the patient or at least a plan for my follow-up with them. My goal is to ensure they have made an informed decision that reflects their goals and values and that they feel at peace with this decision. I might need to dispel some misconceptions about palliative care and hospice, too. These divisions of medicine are often misunderstood.

What are some common misconceptions around palliative care? How do you address these with patients and their families?

One common misconception is that palliative care is only for people who are dying, but it also maximizes quality of life and reduces suffering. So it's done together with curative treatments. For example, we could help a person with cancer better tolerate their chemotherapy by managing their symptoms. That can make their treatment more successful and help them live longer and better.

Another misconception is that all palliative care is hospice care. Palliative care is for any stage of a serious illness, but hospice is specifically for patients with a more limited prognosis of six months or less.

A lot of people think that all palliative care clinicians do is offer opioids for pain relief. This is common in palliative care, but it's not the only way. We also offer non-opioid medications and [complementary medicine](#). These are things like massage therapy, acupuncture, pet therapy, music and art therapy, Reiki, and so on.

Palliative care patients can still see their other physicians, too. We work with other physicians to offer the best possible care, but we do not replace other providers. I correct these misconceptions head on through kind and compassionate education.

How do you manage a situation where the patient's or family's desire is different from their health care provider's recommendation?

This is a common reason palliative care teams are consulted. If the patient or their family are making these decisions based on a misunderstanding or a misconception, maybe they need more information about their condition or their options. Maybe they're based on religious or cultural reasons. Or maybe they're concerned about futility of care. If what the patient wants is feasible, then I respect their decision.

If there is still disagreement after these conversations, an ethics consultation may help. Most hospitals have [ethicists](#) who speak with both the patient or their surrogate and the medical teams. Their job is to help find a realistic solution for everyone.

What's an especially memorable experience from your work as a palliative care provider?

I have many wonderful and inspiring memories from my work. My best memories are typically about patients who wanted to cross something off their bucket list before they died and the times I could help them do that.

I've participated in a few weddings for patients and for their children. There was a young woman with gastric cancer who wanted to marry her boyfriend—the father of her children—

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before she died. So the staff on the oncology unit, the chaplains, and I organized a wedding party with cake, balloons, and flowers. She got dressed up, and we got them married in her hospital room. She died later that night, so it was sad, but we were able to provide her and her husband with that final moment of joy. That meant a lot to them.

There are many tragic memories that I have from my career, but I look for good in everything I do and see. I remember a 36-year-old mother with breast cancer whose treatment gave her a few months longer than she would have had otherwise. She was able to spend more time with her family and friends. Witnessing the love she and her husband had was inspiring, and I am grateful that I was able to learn from their example. I believe that even in dire circumstances, we can try to make the situation better for people.

Have you or your loved ones ever received palliative care? If so, what was that experience like for you?

Three of my grandparents died while in hospice care. Each of them had beautiful departures from the physical world. I'm not going to lie—it was challenging. Health insurance doesn't cover a lot of the day-to-day care that people need at home when they're sick. So my family and I took turns taking care of them until they passed away. It was a beautiful gift that my grandparents got to die in the comfort of their own homes, without pain or suffering, surrounded by loved ones. And they had peace of mind before they passed away.

And my father-in-law had a palliative care consultation before he died at the end of May. It helped my in-laws and my husband better understand what my father-in-law was going through and what they should expect. Now that we're grieving his loss, I can see that my husband is better able to cope because he was mentally prepared for what was to come.

What advice would you give to patients and families who are considering palliative care?

I would ask, "Why would you not seek palliative care?" People get sick and die every day with or without palliative care involvement. The difference is that those who have palliative care live better and often longer, and they have that extra layer of support through that difficult journey. ■

Osteoporosis: What you need to know

Spot the signs and get advice for living with this ‘silent’ bone disease

Did you know that our bones are [living tissue](#)? To keep them strong, our bodies break down old bone and replace them with new bone. When we are young, we build more bone than we break down. But as we get older, bone can break down more often than it gets replaced. This can lead to [osteoporosis](#).

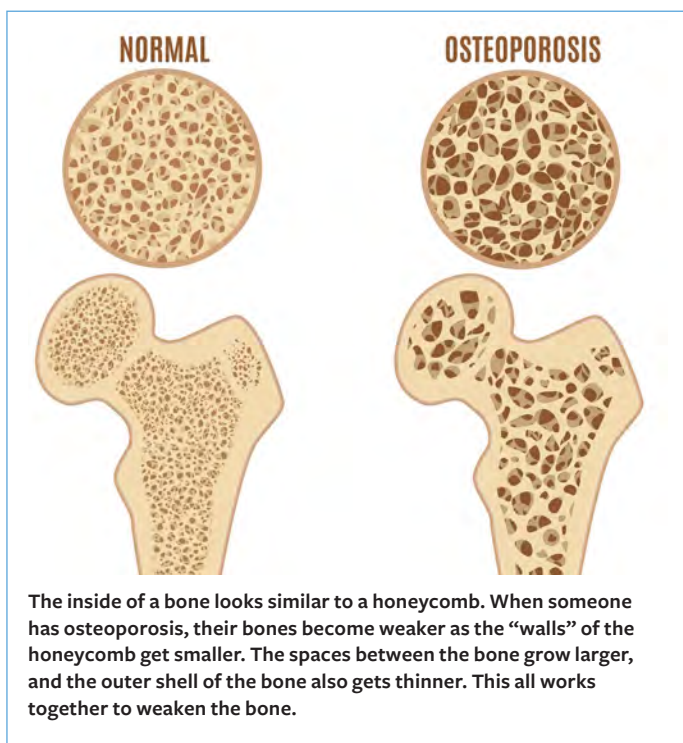
Osteoporosis can develop if your bone mass decreases or the structure of your bones changes. Osteoporosis makes your bones weak and more likely to fracture (break).

Osteoporosis is called a “silent” disease because it doesn’t show any obvious symptoms. Many people do not know they have it until they break a bone after a minor injury or movement. Something as simple as falling from standing height, bending, lifting, or even intense coughing may cause a fracture. Osteoporosis can develop in any bone, but it’s most common in the bones of your hips, wrists, and vertebrae in the spine.

Who is at risk for osteoporosis?

While anyone can develop osteoporosis, the risk increases as you get older. Osteoporosis is more common in people with any of these risk factors:

- **Sex.** Women are more likely to have osteoporosis [than men](#), especially after menopause. White and Asian women are at the highest risk. African American and Hispanic women are at a slightly lower risk. While men are less likely to have osteoporosis, White men are at a higher risk than other groups of their sex.
- **Age.** As you age, you lose more bone than you build. Women over age 65 are [recommended](#) to get screened for osteoporosis by their health provider. There are no official screening recommendations for men, but their risk increases after age 70.*
- **Family history.** Having a parent with osteoporosis or hip fracture increases risk.
- **Body type.** Being slim or thin-boned increases risk because there is less bone to lose.
- **Hormones.** Hormone levels can affect risk for both men and women. Low estrogen levels in women due to menopause, hormone disorders, or extreme physical activity can weaken bones. Low levels of testosterone in men also raises their risk for osteoporosis.
- **Nutrition.** A diet low in calcium, vitamin D, or protein can raise risk.
- **Lifestyle factors.** These include heavy alcohol use, smoking, not being physically active, or being on bedrest for extended periods of time can all raise risk.
- **Medications.** Long-term use of some medications may increase risk. These include corticosteroids, [proton pump inhibitors](#), and medicines to treat epilepsy. Some cancer medications and [glucocorticoid steroids](#) can also increase risk.
- **Medical conditions.** Some medical conditions increase risk, including:
 - [Endocrine diseases](#)
 - Certain digestive diseases, such as [IBS](#)
 - [Rheumatoid arthritis](#)
 - Certain types of cancer
 - [HIV](#)
 - [Anorexia nervosa](#)



How is osteoporosis diagnosed?

A health care provider can [usually diagnose](#) osteoporosis with a routine screening. They may ask you about your medical and family history and whether you have ever broken a bone. They may also want to know if you have lost height or weight or if you are losing muscle strength. Talk to your doctor if your posture, balance, and gait (how you walk) have changed.

The most common test for osteoporosis is a [bone mineral density test](#), which measures how strong your bones are and predicts your risk of bone fractures.

How is osteoporosis treated?

If you have the disease, your doctor will likely recommend treatment designed to slow or stop bone loss and help prevent fractures. They may recommend eating a balanced diet with enough calcium, vitamin D, and protein. They may also recommend other lifestyle changes or prescribe medicine to slow bone loss or rebuild bone. Medications can cause side effects, so talk to your doctor or pharmacist if you have questions about what you’re taking.



Many people do not know they have osteoporosis until they break a bone after a minor injury or movement.

Regular physical activity is important if you have osteoporosis, but certain activities may put a strain on high-risk parts of the body. Avoid high-impact exercise and movements that twist your spine (like swinging a golf club) or heavily bend the waist (like sit-ups and toe touches). A physical therapist, rehabilitation medicine specialist, or physiologist can help you make a safe exercise program. Caregivers can also [help someone with osteoporosis exercise](#) in a safe way.

Can it be prevented?

Keeping bones strong throughout your life can help lower your risk for osteoporosis, so eat a healthy diet rich in calcium and vitamin D, get regular physical activity, limit alcohol intake, and don't smoke. It's also important to have regular checkups and tell your doctor if you've had a fall or [broken a bone](#).



Osteoporosis can develop if your bone mass decreases or the structure of your bones changes, making the bones weaker and more likely to break.



FAST FACT

As of 2018, **by age 50**, more than **12% of U.S. adults** have osteoporosis at the femur neck, in the lumbar spine, or in both. The rate was **higher among women (19.6%) than men (4.4%)**.

SOURCE: [CENTERS FOR DISEASE CONTROL AND PREVENTION](#)

Living with osteoporosis

Whether you have osteoporosis or are trying to prevent it, proper nutrition and certain exercises are good for bone health. Strong muscles help you balance and reduce your risk of falling or breaking bones. People tend to lose muscle as they age, but a combination of weight-bearing exercises, resistance training, and balance training can help. Talk to your health care provider about what's best for you before starting any exercise program.

The National Institute of Arthritis and Musculoskeletal and Skin Diseases also has information on [exercising for bone health](#). If you have osteoporosis, talk with others who have it and reach out to family and friends for support. Learning about the disease can equip you to participate in decisions about your care and help preserve your mobility and independence! ■

**Editor's note: As of this publication, the U.S. Preventive Services Task Force's osteoporosis screening recommendations are under review. Learn more about the review process and updates [here](#).*

My mammogram was ‘abnormal’— what do I do next?



Women between ages 50 and 69 who get mammograms have a lower chance of dying from breast cancer than women who do not get them.



First, thank yourself for getting a mammogram!

Breast cancer is the [second most common](#) type of cancer in women in the United States, and a mammogram, which is an x-ray of the breast, is one of the best ways to detect it. Getting mammograms at recommended times, even if you don't have symptoms, is key to finding breast cancer early.

Detecting it early means more effective treatment options and better outcomes. Women between ages 50 and 69 who get mammograms have a [lower chance of dying](#) from breast cancer than women who do not get them.



FAST FACT

Fewer than 10% of women called back for more tests after a mammogram are found to have breast cancer.

SOURCE: NATIONAL CANCER INSTITUTE



Second, get follow-up tests as recommended by your doctor

“[Abnormal](#)” is how doctors describe a mammogram that shows something has changed in your breast.

To find out what's causing the changes, your provider may recommend [diagnostic tests](#). These would be additional imaging tests such as an [ultrasound](#) or a [magnetic resonance imaging](#) (MRI) scan.

Your doctor may order a [breast biopsy](#) as well. A biopsy is a procedure where a small sample of cells, fluids, or tissue is taken and examined under a microscope. The test happens in a doctor's office, clinic, or hospital (but you can go home the same day).



Third, don't panic

Fewer than 10% of women called back for more tests after a mammogram are found to have breast cancer. But if your mammogram is abnormal, it's important to determine what's going on inside your body.

There are several reasons for changes in a breast, including lumps, nipple discharge, and its skin (such as itching, redness, or dimples). These variations can happen throughout your life for reasons other than cancer:

- **Before or during your period (if you have one)**, your breasts may feel painful, swollen, or tender. You may feel lumps before your period because of extra fluid in your breasts.
- **During pregnancy**, you may feel breast lumps because the glands that produce milk are increasing in number and getting larger.
- **As you approach [menopause](#) (during the time called perimenopause)**, your hormone levels change, which can make your breasts feel tender or lumpy.
- **If you are taking hormones (such as hormone replacement therapy, birth control pills, or injections)**, your breasts may become denser. This can make a mammogram harder to interpret.
- **After menopause**, your hormone levels drop and you may stop having lumps, pain, or nipple discharge.

Even if you're not due for a mammogram, talk to your doctor about breast changes as they occur.



Fourth, know that other things can show up on a mammogram

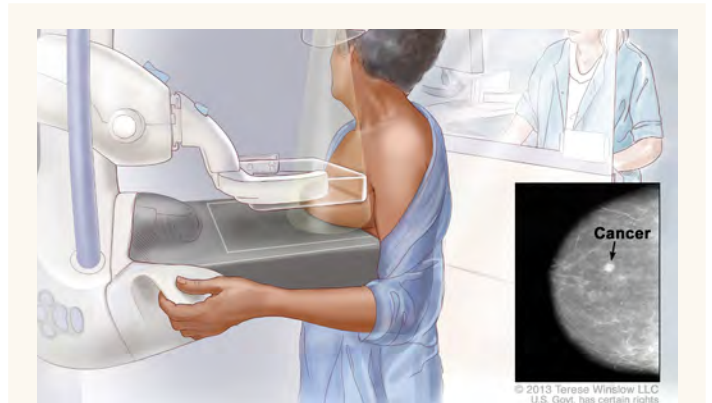
There are several benign (noncancerous) breast conditions that may be visible on a mammogram.

Here are [a few](#):

- **Adenosis.** This is a lump caused by enlarged breast lobules (glands that make breast milk).
- **Cysts.** These are pockets of tissue filled with fluid that may become painful before your period.
- **Blocked breast ducts.** If a blocked duct becomes infected, you may feel a lump under the nipple.
- **Hematoma.** This is when blood clots under the skin. It may cause a lump, fever, and breast inflammation.
- **Lipoma.** This is a benign tumor made of fat cells and is usually a painless, soft lump.

There are also some benign breast conditions that are not cancer but may increase your risk for cancer:

- **Complex fibroadenomas.** This is a benign tumor that usually forms in the breast and is made up of fibrous and glandular tissue.



During a mammogram, the breast is pressed between two plates. X-rays are used to take pictures of breast tissue.

How mammograms work

A [mammogram](#) is a breast cancer screening test that takes an X-ray of the breasts. During a mammogram, a patient undresses from the waist up and places one breast at a time on a flat surface that has an x-ray plate. Then a machine called a compressor presses against the breast to make it flatter. The machine does this again from different angles so that the radiologist can see the inside of the breast more clearly. This can feel uncomfortable if the compressor feels cold or presses the breast firmly.

- **Multiple intraductal breast papillomas (also called intraductal papillomas).** This causes wartlike growths in the breast duct.
- **Radial scars (also called complex sclerosing lesions).** This is benign tissue that looks like a scar when viewed under a microscope.
- **Sclerosing adenosis.** This condition can cause scar-like fibrous tissue to form in the breast lobules.

You can find more information about breast changes and conditions in [this guide from the National Cancer Institute](#), available online and as a PDF download.

If you get follow-up tests after an abnormal mammogram, talk to your doctor about the results. Even if you don't have breast cancer, your doctor may recommend you get your next mammogram at a more specific time than the [general guideline](#), which is every other year for women ages 40 to 74. Staying on top of preventive care is important for living a longer and healthier life. ■

Who should get screened

In general, women ages 40 to 74 are [recommended](#) to get a mammogram every two years. But talk to your health care provider about your individual risk of breast cancer and whether a screening test is right for you. Some patients with higher risk of breast cancer may get an [MRI scan](#) in addition to a mammogram. [Men can also get breast cancer](#), although it's much rarer. This is more common in men between ages 60 and 70. There are no specific screening recommendations for male breast cancer, but men should talk to their doctor if they notice anything unusual.

What's the most effective way to prevent shingles? Getting vaccinated

It's no secret that having shingles can be pretty miserable, but getting vaccinated is an easy way to protect yourself



Shingles is a painful rash on the skin that comes from the same virus that causes chickenpox.

Shingles, also known as herpes zoster, is a painful, often debilitating rash that affects roughly 1 million people each year.

Fortunately, the [current shingles vaccine](#), known by the brand name Shingrix, is highly effective at preventing shingles and its side effects.

What is shingles?

[Shingles](#) is a painful rash or blisters on the skin. It is caused by the same virus—herpes varicella zoster—that causes [chickenpox](#), which is highly contagious. Chickenpox usually affects kids under age 15 and creates an itchy, uncomfortable rash that turns into blisters. While shingles itself is not contagious, you *can* also catch chickenpox from someone who has shingles if you have direct contact with fluid from their rash.



FAST FACT

About half of all shingles cases are in adults ages 60 or older. The chance of developing shingles becomes much greater by age 70.

SOURCE: [NATIONAL INSTITUTE ON AGING](#)

After a person recovers from chickenpox, the virus stays dormant in certain nerve cells in the body and can reactivate later in life. This second eruption of the chickenpox virus is called shingles.

What are the symptoms?

Shingles typically appears as a painful rash or blisters. It often develops in a small area on one side of the body. It can also cause burning, itching, tingling, and even numbness in the affected area. Some people may also experience a fever, headache, chills, and an upset stomach.

Who is at risk for shingles?

Anyone who has had chickenpox is at risk for shingles, especially as they get older. You can't develop shingles unless you've been exposed to the chickenpox virus. However, [more than 99% of Americans born in or before 1980 have had chickenpox](#), even if they don't remember having it.

About 1 in 3 people in the United States will develop shingles in their lifetime, usually after age 50. Although shingles can affect younger adults and even children, it is most common in older adults. People with weakened immune systems are also at greater risk.

What are the possible complications?

While shingles itself can be very painful and uncomfortable, it can also lead to serious complications. The most common complication is [postherpetic neuralgia](#) (PHN), a condition that causes severe nerve pain in the areas affected by the shingles rash. PHN pain can last for weeks or even months after the rash clears up. For some people, the pain is so severe that it hurts to put on clothing. Fortunately, it usually gets better over time.

Other potential complications include vision loss or hearing problems if it develops near the eyes or ears. Very rarely, shingles can also lead to pneumonia, brain inflammation, or even death.

How is shingles treated?

Treating shingles quickly with antiviral drugs can shorten the duration and reduce the severity of its symptoms. These medications include acyclovir, valacyclovir, or famciclovir.

For most healthy people who get treatment quickly, shingles usually goes away within three to five weeks, and the blisters often leave no scars. However, some people may experience lingering pain from PHN.

Tips for coping

If you do develop shingles, there are ways to manage the condition. Here are a few tips:

- Apply cool, wet compresses to the rash to relieve pain and itching. An oatmeal bath or anti-itch cream such as calamine lotion can also help soothe your skin.
- Wear loose-fitting clothing made of natural fibers to reduce skin irritation.
- Keep the rash clean and covered to prevent spreading the virus to others.
- Follow your health care provider's instructions for antiviral medications and pain management.
- Support your immune system by doing what you can to reduce stress (which can worsen symptoms) and getting plenty of rest.

Remember, if you think you might have shingles, treating it early is important, so contact your health care provider as soon as possible to discuss treatment options.

For more detailed information on coping with shingles and managing its symptoms, check out [MedlinePlus](#) and the [National Institute on Aging](#).

Can shingles be prevented?

The most effective way to prevent shingles is to get vaccinated. The Centers for Disease Control and Prevention (CDC) recommends Shingrix for all healthy adults 50 years and older, regardless of whether they've had shingles before. Shingrix was first approved by the Food and Drug Administration in 2017. [According to the CDC](#), two doses of Shingrix are more than 90% effective at preventing shingles and its potential complications.

Shingrix is given as two doses typically two to six months apart. It is available at most pharmacies and doctors' offices. Even if you've already had shingles or received Zostavax, which is the older shingles vaccine and is no longer available in the United States, getting vaccinated with Shingrix can help protect you from future outbreaks.

If you're over age 50, talk to your health care provider about the Shingrix vaccine. Your doctor may also recommend the vaccine if you have a weakened immune system due to a medical condition or medication and are over 19 years old. Check if your insurance or Medicare can cover the cost of the vaccine. ■

Age 50 and older? Get the shingles vaccine!

Shingles is a painful skin rash caused by the same virus as chickenpox. Here are three things to know:



Your risk increases with age. 1 in 3 adults will develop shingles. If you had chickenpox earlier in life, you are at risk for developing shingles.



Shingles can be serious. For many people, shingles symptoms are mild, but others may develop more severe symptoms like intense or long-lasting pain.



It's preventable! The shingles vaccine is more than 90% effective at preventing the disease, and it's recommended for most adults age 50 and older.

Talk with a doctor and learn more at www.nia.nih.gov/shingles.

SOURCE: NATIONAL INSTITUTE ON AGING

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