**Materials and Methods**

*Study Population*

This study was conducted retrospectively in patients who experienced PHN and visited our outpatient pain or dermatology clinic in the Third Affiliated Hospital of Sun Yat-Sen University, Guangzhou, from March 2017 to March 2019. We conducted this study in accordance with the Helsinki Declaration after obtaining approval from the ethics committee of the Third Affiliated Hospital of Sun Yat-sen University (ID, [2019]02-482-01). Moreover, all participants were informed about the voluntary nature of enrollment, anonymity, and the fact that the study results would be used only for scientific purposes.

PHN was defined as the pain persisting no less than 90 days after a diagnosis of HZ infection [1]. Patients less than 18 years old, those with severe concomitant organic or neurological diseases, epilepsy, alcoholism, drug abuse, and cognitive impairment before treatment were excluded from the current study. Patients with incomplete clinic records were also excluded.

*Variables*

The patients’ sociodemographic and clinical variables were retrospectively identified from our outpatient clinic information system, which included the data that were completed by the clinicians at the time when patients attended the outpatient clinic. The sociodemographic variables included age, sex and body mass index. Clinical variables included pain intensity, time from onset of rash, extent of spread of rashes, time since PHN diagnosis, affected dermatome site and proportion of patients receiving medical treatment.

The magnitude of pain intensity was assessed by the numerical rating scale. When patients visited the clinic, they were asked to rate the magnitude of their pain intensity from “0” (no pain) to “10” (most intense pain imaginable), accompanied by the following instruction, “Please rate your pain by indicating the number that best describes your pain on average in the last 24 h” [7]. The extent of spread of rash was scored by the scale described by Coen et al. [8]. Using this scale, the dermatome that developed the herpetic rash was evaluated and was graded on a scale of 1–5 to measure the extent of spread of rash.

*Assessment of Anxiety and Depression*

The Chinese version of the Hospital Anxiety and Depression Scale (HADS) was used to assess anxiety and depression [9, 10]. This self-report questionnaire is widely used specifically to detect and classify the severity of anxiety and depression in hospital and medical outpatient clinical settings [10]. The HADS questionnaire has two 7-item subscales—anxiety (HADS-A) and depression (HADS-D). Each item is rated on a 4-point scale (0–3 points), with a maximum score of 21 for anxiety or depression assessment. According to a previous study, on each subscale, a total score of less than 8 usually indicates normal mental state, 8–10 is borderline or suggestive of possible anxiety or depression state, and more than 10 is indicative of mood disorder [11].

*Statistical Analyses*

In this study, the collected variables were compared between two groups of patients — those without anxiety/depression (HADS-A/HADS-D score <8) and those who had possible or were indicative of anxiety/depression (HADS-A/HADS-D score ≥8). Statistical analyses were performed using the IBM SPSS Statistics software (version 20.0, IBM, Armonk, NY, USA). Quantitative variables are expressed as mean and standard deviation; categorical data are expressed as numbers (percentage). Univariate logistic analysis identified the risk factors associated with anxiety/depression among patients with PHN. Each variable with a *p* value of less than 0.2 in univariate logistic analysis was included in the subsequent multivariate logistic regression for identifying the significant variables. Spearman’s correlation analysis was used to identify independence of variables. A *p* value of less than 0.05 was considered statistically significant for multivariate logistic regression and correlation analysis.