

Bilateral herpes - Zoster of widely separated dermatomes in a non-immuno compromised male

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Abstract: Herpes zoster is a neurocutaneous viral infection caused by varicella zoster virus (VZV). Oral acyclovir is the treatment of choice and lowers the incidence of complications. HZ is usually a unilateral condition. Bilateral herpes zoster of two widely separated dermatomes is a rare condition. Herpes zoster involving simultaneously right and left axillary dermatome in a non-immuno-compromised 60-year-old male is being reported due to its rarity.

Keywords: bilateral, herpes zoster, dermatome, non-immuno compromised.

INTRODUCTION

Herpes zoster is a neurocutaneous viral infection caused by varicella zoster virus (VZV). Herpes zoster (HZ) is a viral infection which afflicts one or more closely grouped, spinal or cranial nerves, resulting in a unilateral radicular pain and vesicular eruption limited to a dermatome innervated by that nerve[1]. It may result in post herpetic neuralgia, scarring and keloid formation. Oral acyclovir is the treatment of choice and lowers the incidence of complications. HZ is usually a unilateral condition. Bilateral herpes zoster of two widely separated dermatomes is a rare condition.

CASE REPORT

A 60-year-old moderately built and well nourished male presented in Apex Hospital, Rampura Phul, with severe burning pain and blisters over left and right axilla and right thigh of three days duration. Examination revealed erythema, oedema and multiple grouped vesicles situated on left and right axilla. Similar vesicular lesions, erythema and oedema were noticed on posterior and medial aspect of right thigh. General physical and systemic examinations were normal. There was no history of any recurrent infections, chronic systemic illness or taking immunosuppressive therapy.

All routine investigations including Hb, TLC, DLC, PBF, ESR, FBS, LFT and RFT were within normal limits. ELISA for HIV - 1 and 2 was negative. Tzanck smear from the base of vesicles showed multinucleated giant cells with typical acidophilic inclusion bodies. Biopsy from lesions at both sites

revealed multilocular vesicles, ballooning and reticular degeneration characteristic of herpes - zoster.

Patient was given acyclovir 800mg 5 times a day for 10 days. Complete recovery occurred with no post herpetic neuralgia or scarring.

DISCUSSION

Herpes zoster is usually a localised unilateral neurocutaneous infection by varicella zoster virus (VZV) that follows the distribution of a sensory nerve and that is thought to occur when VZV latent in the sensory ganglion reactivates. Factors reported to determine the occurrence of zoster include waning specific cell mediated immunity to VZV related to age, immunosuppressive disease or drug therapy, local trauma such as surgery, local therapeutic X-ray irradiation and possibly local musculo-skeletal problem.

Zoster does not occur with equal frequency in all areas of skin. Its frequency in thoracic dermatomes is 50%, cranial nerves 20%, cervical dermatomes 14%, lumbar 14% and sacral only 2%. [2-4].

Herpes zoster is almost invariably unilateral, which is of diagnostic importance. Bilateral involvement is rare, [5] although in some cases there may be few lesions on the opposite side of midline owing to transverse nerve twigs. Zoster involving two widely separated regions simultaneously is very rare. [6]

Kolalapudi [7] reported two cases of herpes-zoster at two different sites in the same individual both of which were immunocompromised viz. one was HIV

- infected and other was receiving immunosuppressive drugs.

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