

RAMSAY - HUNT SYNDROME (A Case Report)

R. P. MEHTA * V. D. TIWARI † AND L. C. ANAND ‡

Summary

A case of Ramsay Hunt Syndrome in a young soldier is described. Importance of early institution of systemic corticosteroids in such cases is stressed on the basis of treatment results obtained in this case.

Ramsay Hunt Syndrome is the symptom complex resulting from herpes zoster of geniculate ganglion. It is one of the common causes of facial palsy. The appearance of herpetic lesions on adjacent parts of pinna and external auditory meatus followed by facial paralysis presents no diagnostic difficulty. Recovery of paralysis may be complete, partial or in few cases permanent. Development of herpetic neuralgia may be aborted by early induction of systemic corticosteroids.¹ By reducing inflammatory oedema corticosteroids may also hasten recovery from facial palsy. The present case highlights importance of early corticosteroid therapy in Ramsay Hunt Syndrome.

Case Report

Male patient aged 21 years, a paratrooper reported with headache, hyperesthesia and pain on right side of neck of 3 days' duration. Two days later he experienced severe pain in right ear and developed fever (Temperature 102°F). At this stage examination revealed few

erythematous macules on right pinna and on neck just behind it. After about eight hours typical grouped erythematous vesicles could be seen on these erythematous areas. Ears were found normal except for the presence of herpetic lesions on right pinna and in the external auditory meatus. On fifth day of illness the patient developed right sided facial paralysis (Fig.1) and loss of taste sensations on tip of tongue. No herpetic lesions were seen on oral mucosa. General and systemic examination revealed no other abnormality.

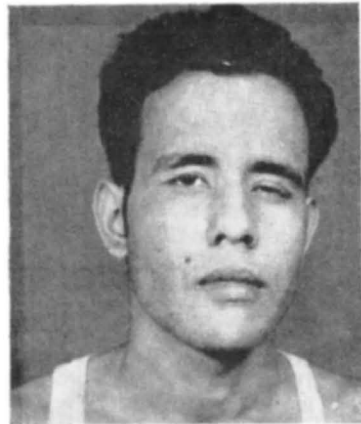


Fig. 1 Right sided facial palsy in Ramsay Hunt Syndrome. (Tenth day of illness).

* Dept. of Dermatology
Military Hospital
Agra Cantt.

† Adviser in Dermatology
Command Hospital, SC, Pune.

Received for publication on 13-11-1978

Patient was put on corticosteroids, initially at a dose of 40 mg per day of prednisolone and also penicillin on fourth day of illness even before facial paralysis developed. Penicillin was given to prevent any superadded bacterial infection of the lesions. Facial palsy started improving from sixth day of starting corticosteroid therapy and recovery was complete after 3 weeks.

Comments

Prolonged convalescence is often seen in cases of herpes zoster if herpetic lesions erupt over a week or so² but recovery is quicker when vesiculation follows the pain for one or two days only³. Among the cranial nerves the most frequently affected by herpes zoster are fifth and seventh³. Involvement of different ganglia by varicella-zoster virus produces different specific syndromes. Ramsay Hunt Syndrome is a zoster of the geniculate ganglion. In lesions of or proximal to geniculate ganglion, in addition to loss of taste there is also loss of lachrymal and salivary secretions. Common conditions producing this effect are head injury, infections of middle ear and mastoid, surgical operations on the ear and herpes zoster of the geniculate ganglion. Facial palsy has been treated in different ways which have included salicylates, iodides, corticosteroids, splinting of paralysed muscles, electrical stimulation and surgical decompression. Gelfand⁴ reported dramatic relief of pain within twenty four to thirty six hours in 4 of 5 patients treated with cortisone orally. Elliot⁵ obtained excellent results treating severely painful zoster with high doses of prednisone. Risk of generalisation of eruption of herpes zoster could

not be confirmed nor did oral corticosteroids make patient's condition worse in the studies of Eaglestein et al¹.

Strikingly rapid recovery of facial palsy in two cases of geniculate herpes was obtained with corticosteroid therapy by Elliot⁵. Elliot is also of the view that in untreated cases of geniculate herpes facial paralysis often lasts for several months and may be permanent⁵. The benefit obtained by corticosteroids appears to be due to reduction of inflammatory oedema early thus preventing pressure and fibrosis of nerve fibres. In our case early treatment with systemic corticosteroids produced excellent results and recovery was complete within three weeks.

Acknowledgement

Lt Col D Bardoloi, Commanding Military Hospital Agra for permission to use the case record for publication.

References

1. Eaglestein WH, Katz R and Brown JA: The effects of early corticosteroid therapy on the skin eruption and pain of herpes zoster, JAMA 211: 1681, 1970.
2. Burgoon CF and Burgoon JS: The natural history of herpes zoster, JAMA. 164: 255, 1957.
3. Burnett JW and Crutcher WA: Viral and rickettsial infections. Dermatology, Ed. Moschella SL, Pillsbury IM and Hurley HJ, WB, Saunders Company, Philadelphia, 1975, P. 570-574.
4. Gelfand ML: Treatment of herpes zoster with cortisone, JAMA, 154: 911-912, 1954.
5. Elliot FA: Treatment of Herpes Zoster with high doses of prednisolone. Lancet, 2: 610-611, 1964.