CRANIAL NERVE ZOSTER WITH SPINAL SEGMENT SKIN LESIONS

Herpes zoster is a neuro-ectodermal viral infection which afflicts one or more, closely grouped, spinal or cranial nerves and the overlying skin or mucous membrane. Ramsay-Hunt syndrome is herpes zoster affecting the geniculate ganglion. An atypical presentation of this condition seen by us is described here.

A 9-year-old girl was admitted for fever and severe pain in the right occipital region of 3 days duration. Examination revealed multiple, grouped vesicles and pustules situated in the right occipital region and the right side of neck. Several discrete vesicles were also present on the chest and back. On the fourth day of her stay, she developed right sided, complete lower motor neurone type of facial palsy. There were no symptoms or signs pertaining to the ear or oral cavity. A diagnosis of atypical Ramsay-Hunt syndrome showing concurrent involvement of the second and third cervical segments with dissemination was made. Investigations did not reveal any immunological deficit.

Ramsay-Hunt syndrome, now called herpes zoster cephalicus or oticus, classically presents as facial nerve paralysis with herpetic eruptions involving the external ear. Facial nerve has communicating branches with the second and third cervical nerves and cranial nerves like the trigeminal, glossopharyngeal and vagus. Vesication in herpes zoster oticus can remain confined to the distribution of the second and third cervical nerves with sparing of the usual location on the ear[1] as was seen in our patient. Less commonly, the vesicles may appear only in the trigeminal nerve area (face, mouth or palate) or in the distribution of the glossopharyngeal and vagus nerves.

Vesication and the onset of facial palsy may be separated by a week or more, and either may precede the other. Herpes zoster oticus accounts for 2 to 7% of all facial palsies.[2] Approximately 50% of patients with facial palsy due to herpes zoster have some degree of permanent motor disability. In severe cases sensori-neural deafness and vertigo due to eighth nerve involvement can occur.

Our patient was treated symptomatically, and within 2 weeks pain and skin lesions subsided. Residual facial paresis, however, persisted.

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