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Post herpetic neuralgia with subsequent symptoms of Ramsay hunt syndrome type 2: A case report

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Abstract

Ramsay hunt syndrome is a serious neurological condition caused by reactivation of the varicella-zoster virus at the geniculate ganglion. It is distinguished by a triad of facial palsy, vesicular eruption in the ear, and otalgia. Ramsay Hunt Syndrome Type II additionally known as herpes zoster oticus. It's a presentation of lower motor nerve fiber lesion of seventh cranial nerve, deafness, vertigo, pain, vesicles on the face, ear and altered taste perception, vesicles on ear could be a typical pathognomonic feature. Immediate treatment is crucial to avoid permanent complications.

Keywords: Ramsay hunt syndrome (RHS), Otolgia, post herpetic neuralgia (PHN), facial palsy, herpes zoster infection (HZI)

Introduction

American neurologist James Ramsay Hunt, 1st delineated Ramsay Hunt syndrome, in 1907. Symptoms including a vesicular rash of the external ear and the unilateral two thirds of the face, tongue and altered taste sensation with associated paralysis of the seventh cranial nerve. It is of 3 types, Ramsay hunt cerebellar syndrome, also known as ramsay hunt syndrome type 1, is characterised by cerebellar degeneration, myoclonic epilepsy, progressive ataxia, tremor, and dementia. Ramsay hunt syndrome type 2 also called herpes zoster oticus. It includes lower motor neuron lesion of facial nerve, deafness, vertigo, pain, vesicles on the face, ear and altered taste sensation, vesicles on the ear is a common appearance of herpes oticus. Ramsay hunt syndrome type 3 also called hunt's disease or artisan's palsy an occupationally induced neuropathy of deep palmer branch of ulnar nerve.

Ramsay Hunt Syndrome Type II is name given to a group of symptoms that include unilateral vesicular rash on the external ear, two-thirds of the tongue, and damage to the seventh cranial nerve. The syndrome also known as herpes zoster oticus and shingles of the geniculate ganglion, is caused by the re-activation of the varicella-zoster virus (VZV) within the geniculate ganglion and associated sensory nerves with frequently affecting other cranial nerves VIII, IX, X, and XI. Ramsay Hunt syndrome may be clinically regarded as a polycranial neuronitis rather than an infection limited to the geniculate ganglion of the seventh cranial nerve. The current case is an example of herpes zoster infection, preceded by postherpetic neuralgia with subsequent symptoms of Ramsay hunt syndrome.

Case report

A 28 year old male patient reported in the department with the complaint of severe pain on left side of face since 3 days. He described having several unilateral vesicles with itching and unilateral lancinating pain on the left side of his face radiating to his temple for three days. On examination, there were painful vesicular eruptions and ulcers, as well as a mediocre to lower border of the mandible in the left side dermatome of face and numerous vesicles and ulcers were seen intraorally in the lower lip. (Fig.1) & (Fig.2) The diagnosis of Herpes zoster infection was made based on clinical results. For seven days, he was given Acyclovir (800 mg) five times a day, paracip (500mg), metrogyl ointment, and lignocaine 2% ointment. After 15 days, the patient was examined and showed healing of all vesicles with scarring, but persistent

aching, itching, and paraesthesia in the dermatome supplied by the affected nerve suggestive of PHN. He was given pregabalin (150 mg) and paracetamol (500mg) for three days and told to keep using the ointment.

After 3 months, the patient returned with the inability to shut his left eye, tinnitus in his left ear, and hypopigmented skin which was suggestive of healing tissue in his left side of face.(Fig.3) Based on patient's history and general evaluation Ramsay Hunt syndrome type 2 was provisionally diagnosed, and the patient was started on pregabalin (120 mg), aceclofenac & paracetamol (500 mg) (sos), saframycin ointment, and neurobion forte for next 15 days following which the symptoms completely subsided during a month. (Fig.4)

Discussion

Ramsay Hunt syndrome is a varicella zoster virus complication that causes unilateral facial palsy as well as vesicular eruptions in the ear, palate, and tongue in a single dermatome. Clinically, facial drooping, palpebral fissure widening, and a diminished smile on the affected side with dull, aching pain. All of these characteristics were present in our patient, with herpes zoster infection, preceded by postherpetic neuralgia with subsequent symptoms of Ramsay hunt syndrome. RHS can be treated with an antiviral regimen to avoid varicella zoster virus replication, eye protection by using continuous lubricants, antiseptics, and in case of extreme pain when there is no acute infection, steroid are used otherwise gabapentin for 15 days and anticonvulsant doses until reaction is sufficient.



Fig 1: Unilateral erythematous clusters of vesicles in the left side dermatome of face extending to left ear. (page no. 2)



Fig 2: Intraoral lesion showing cluster of vesicle in the lower lip. (page no. 2)



Fig 3: Inability to shut his left eye, tinnitus in his left ear, and hypopigmented skin which was suggestive of healing tissue in his left side of face (page no.2)



Fig 4: Four months postoperative pictures showing healing with scarring and ability to close to eyes.(page no.2)

Conclusion

Ramsay Hunt syndrome is a rare condition with enigmatic symptoms. In patients with HZI symptoms, a high index of suspicion and close monitoring are needed. Early treatment with antivirals and corticosteroids has been shown to improve outcomes in these patients.

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