

PAIN - LESION PARAMEDIAN DISSOCIATION IN A CASE OF ABDOMINAL HERPES ZOSTER. CASE REPORT

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Abstract

An unusual clinical case of a dissociative herpes zoster is presented. A right hip-thigh pain preceded the occurrence of a group of herpes zoster lesions at the level of left inguinal fossa.

Keywords: herpes Zoster, analgesia

As a former clinical anaesthetist, the author of this presentation had the experience of an interesting algescic situation.

Without any premonitory sign, a severe bursting pain dispersed into the right hemipelvis, irradiating along the two flanks of the thigh in the next days.

The routine biological investigations showed nothing particular whilst, in its turn, a computerized tomography failed to evidence anything dangerous.

Any hip movement was extremely painful and, intriguingly, any resting bed positions proved to enhance the pain, making necessary the appeal to a large variety of painkillers. At the patient's age of 75, the attendant colleagues even embraced the idea of a hidden osseous metastasis of a prostate cancer and even resorted to opiate analgesics.

After about a fortnight, no fewer than seven distinct typical herpes blisters made an in corpore appearance, distributed on the entire left inguinal fossa, observing, as the attached image shows (Figure 1), the median penile line [1].

The opiate analgesia was of course discontinued, the acyclovir being immediately added [2] to common analgesics. It took another two weeks for the crusted lesions to fade their florid picture. In their turn, the pains progressively subsided, first to alleviate being those exacerbated by the bed rest.

Authoritative handbooks [ie.3] do mention the occurrence of skin lesions not only strictly localized but also along the different branches of the same nervous

structure; nothing is, however, mentioned about a 'geographical' paramedian dissociation between the painful and lesion areas.



Figure 1

Basic knowledge [4,5]

The herpes zoster virus is known to affect dorsal root ganglia, dorsal roots and peripheral nerves. The subsequent structural changes and functional abnormalities result in a true neuropathy. Neurons become unusually sensitive, developing spontaneous chaotic pathological activity, abnormal excitability, a sort of peripheral sensitization.

Backed by changes in the Na and Ca channels, ectopic impulses and sympathetic activation, this neuropathy

adds, with rare exceptions, to the herpes eruptive details, a peripheral pain component – a pain occurring without any nociceptive stimulation. The patient described throbbing and burning pain along the nerves, always referred to the body region innervated by the damaged nerves.

Both the skin changes and the pain follow a dermatomal distribution of the virus infection, the symptoms being usually limited to the area of skin where the viral outbreak first happened; only occasionally do the two components cross the middle line.

The neuropathic pain caused by herpes zoster may:

- precede, sometimes by weeks, the cutaneous lesions,
- almost invariably, accompany the local dermatological picture,
- it may continue or reoccur after various periods of time after eruption healing, this being the well known *post-herpetic pain*.

While it is very rare for herpes zoster neuropathy to

be entirely painless, there are enough cases of pain without cutaneous lesions, the so called *zoster sine herpette*.

The treatment consists of combined potent analgesics (tramadol, oxycodon), anti-convulsivants (gabapentine and pregabalin), antidepressants (tricyclic and mainly amitriptyline), lidocaine patches, steroids, transcutaneous electrical stimulation, spinal cord and peripheral nerve stimulation.

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