Vulvar Manifestations of Sacral Herpes Zoster

SAKRAL HERPES ZOSTER'DE VULVA TUTULUMU

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SUMMARY

Objective: To present a case of sacral herpes zoster involving the vulva and review the related literature.

Institution: Turkish Health and Therapy Foundation Medical Center Hospital.

Materials and Methods: A case of sacral herpes zoster involving the vulva in a young woman is presented. In the light of this case the various manifestations of herpes zoster are discussed.

Results: Review of the related literature proved similar cases without additional symptoms such as dysfunction of bladder and anus to be rare.

Conclusion: When a vesicular lesion is encountered in vulva one must take sacral herpes zoster into consideration and must perform a detailed examination to avoid useless and expensive laboratory tests and an inadvertent diagnosis such as sexually transmitted disease.

Key Words: Herpes zoster, Sacral zoster

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ÖZET

Amaç: Vulvayı tutan bir sakral herpes zoster infeksiyonu vakasını sunmak ve ilgili literatürü tartışmak.

Çalışmanın yapıldığı yer: Türkiye Sağlık ve Tedavi Vakfı Tıp Merkezi Hastanesi.

Materyal ve Metod: Genç bir kadında vulvayı tutan, şiddetli ağrı ve yanma gibi yakınmalara sebep olan ve ilk anda cinsel yolla geçen hastalıkları düşündüren bir genital herpes zoster vakası sunulmuş ve literatür taranmıştır.

Bulgular: Sadece vulvayı tutan ve örneğin mesane ve anal disfonksiyonu gibi başka semptomu olmayan sacral herpes zoster vakası nadirdir.

Sonuç: Vulvada veziküler bir lezyon ile karşılaşıldığı zaman lüzumsuz ve pahalı tetkiklerden ve aynı zamanda hastada çeşitli olumsuzluklara sebep olabilecek uygunsuz teşhislerden kaçınmak için sakral herpes zoster tanısı akılda tutulmalıdır.

Anahtar Kelimeler: Herpes zoster, Sakral zoster

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Herpes zoster is an infection caused by the varicella-zoster virus in a partly Immune host and 70% of patients give a previous history of chickenpox. The virus proliferates in the dorsal root ganglion causing an inflammatory reaction characterised by nerve cell necrosis, haemorrhage and a mononuclear cell infiltration. The fibers of the related nerve root and nerve show similar changes (1).

The usal manifestation of primary varicella-zoster virus infection is a pruritic, generalized vesicular eruption with centripedal distribution. In the normal host, new lesion formation usually ceases by day 4 and most crusting occurs by day 6.During varicella infection, a life long infection of posterior root ganglia is established. Dermatomic zoster results from reactivation of latent virus (2). However reports of small epidemics of zoster suggests that zoster could also be exogenousiy acquired (7,8). Herpes zoster is characterized by a segmental papulovesicular eruption on an inflamatory base arranged in a continuous or interrupted band along the dermatomes of the skin supplied by the affected sensory nerves or extramedullar/ cranial nerves usually with a degree of hyperesthesia, pain and tenderness. Of all dermatozomal zoster eruptions, only 5% is sacral and furthermore, vulvar involvement might be even rarer (9). Here we presented a case of vulvar herpes zoster and we reviewed the literature.

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CASE

A 27-year-old woman developed a moderately painful group of few vesicles on left labium majus the day before her admission. Their base was edematous. In physical examination a 3x3 cm tender left inguinal

lymphaderiopathy was also delected. She did not complain of any other symptom such as disturbance of micturation or defecation. Her medical and family histories were unremarkable. Until the laboratory test results were available the treatment with acyclovir 5x200 mg was initiated with the diagnosis of genital herpes simplex infection. Two days after the first admission the patient was readmitted with severe pain and soreness of the left side of vulva and left buttock. Examination revealed vesicles and pustules, making several grops on an erythematous base on the left sacral area and the left buttock as well as left labium majus. Lesions did not pass midline and they were unilaterally situated, involving a neurotome. Again she had no micturation or defecation problems. The HSV type II Ig M (EIA) was negative (cutoff<1.0) and Ig G (IFAT) was positive (cutoff<1/TO). The treatment of zoster was instructed with oral acyclovir 5x800 mg an antiinflammatory agent; naproxen sodium 2x550 mg and corticosteroid (triamcinolone acetonide) single dose; intramuscular (1 mg/kg) for the relief of neurologia. One week later the patient called and let us know that she did well but her 5-year-old daughter was ill because of chickenpox. Photograph is not available because of patient's reluctance.

DISCUSSION

Zoster occurs during the lifetime of 10% to 20% of all persons. Although people of all ages may be afflicted, there is a direct correlation between increasing age and the incidence of zoster (3). The exanthem of zoster consists of grouped vesicles on an erythematous base. The vesicles become pustular or occasionally hemorrhagic by day 3 to 4, and then ultimately collapse to form crusts by day 7 to 10 (2). The dermatomes most frequently affected are thoracic (55%), cranial (20%), lumbar (15%) and sacral (5%) (10). Izumi (10) reported in 1973 that neurogenic bladder is commonly present in patients with sacral zoster. Richmond (1) reported three cases of zoster affecting different segments of the spinal cord and resulting in urinary retention. Also Jellinek and Tulloch (4) reported seven cases of zona zoster with dysfunction of bladder and anus. In these cases sacral or lumbar shingles existed.

The review of the literature revealed vulvar herpes zoster to be rare. We could not interprete if this was because of the rarity of the condition or of the perception of it as a sexually transmitted disease such as genital herpes or lymphogranuloma venereum. Indeed vulvar zona must be differentiated especially from these two conditions. Although each infection has characteristic clinical picture, even a venereologist's clinical impression may be erroneous in up to 40% of genital ulcers. Herpes simplex virus may also produce segmentally focal lesions that resemble zoster (6). Although the clinical diagnosis of dermatomic zoster is straightforward, an important distinction is that of zosteriform herpes simplex infection. But this should be considered in patients with maxillary or sacral nerve root involvement or with histories of previous vesicular eruptions in the same distribution (2). Another potentially confusing factor is the simultaneous occurence of two pathogens in the same ulcer (5). We suggest that when a vesicular lesion is encountered in vulva one must take sacral herpes zoster into consideration and must perform a detailed examination, especially with inspection of the sacral area and the buttocks. By this way he or she can avoid useless and expensive laboratory tests and an inadvertent diagnoss that can cause psychosocial problems. Also the management of zoster is somewhat different and especially the reassurence of it is not being a sexually transmitted disease and the treatment of the patient complaining of severe pain are important.

REFERENCES

1. Richmond W. The Genito-urinary Manifestations of Herpes Zoster Three case reports and a review of the literature. Br J Urol 1974; 46:193-200.
2. Straus GE, Ostrove JM, Inchauspe G, Felser JM. Freifeld A, Croen KD, Sawyer MH. Varicella-Zoster Virus Infections Biology, Natural History, Treatment and Prevention. Ann Int Med 1988; 108:221-37.
3. Ragozzino MW, Melton U III, Kurland LT, Chu CP, Perry HO. Population-based study of herpes zoster and its sequelae. Baltimore: Medicine, 1982; 61:310-6.
4. Jellinek EH, Tulloch WS. Herpes zoster with dysfunction of bladder and anus. Lancet 1976,12:1219-22.
5. Kraus SJ. Genital ulcer adenopathy syndrome. In: Holmes KK, Mardh P, Sparling PF, Wiesner PJ, eds. Sexually Transmitted Diseases. 1th ed. Mc Graw-Hill Book Company, 1984:706-14.
6. Weller TH. Varicella and Herpes zoster changing concepts of the natural history, control, and importance of a not-so-benign virus. N Eng J Med 1983; 309:1434-40.
7. Schimpft S, Serpick A, Stoler B, et al. Varicella-zoster infection in patients with cancer. Ann Intern Med 1972; 76:241-54.
8. Palmer SR, Caul EO, Donald DE, Kwantes W, Tillet H. An outbreak of shingles? Lancet 1985; 2:1108-11.
9. Viral Diseases. In: Arnold HL, Odom RB, James WD, eds. Andrew's Diseases of Skin, Clinical Dermatology. 8th ed. Philadelphia: W8 Saunders Company, 1990:436-85.
10. Izumi AK. Herpes zoster and neurogenic bladder dysfunction. JAMA 1973; 224:1748.