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Herpes zoster presenting as facial cellulitis

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Introduction: Herpes zoster is a clinical manifestation of the reactivation of latent varicella zoster virus infection. It is a cause of considerable morbidity, especially in elderly patients, and can be fatal in immunosuppressed or critically ill patients. The pain associated with herpes zoster can be debilitating, with a serious impact on quality of life, and the economic costs of managing the disease represent an important burden on both health services and society.[1] We are presenting case of 56 years old non-diabetic female with herpes zoster masquerading as facial cellulitis.

Case report: the patient had fever and swelling over right side of face including lower lip associated with intense pain for last ten days. She had received course of antibiotics with minimal relief. On clinical examination she had edema involving left side of face with hemorrhagic crust over lower lip and chin and erosion over upper lip. Oral mucosa was normal on examination. She also had fever, which was documented upto 102^0 F. There was painful sub-mental lymphadenopathy. Systemic examination was within normal limits.

Routine hematological and biochemical examination revealed leukocytosis (TLC 12900). Pus culture and blood culture were sterile. Serology for HIV was negative. Patient was started on acyclovir along with deflazacort and NSAIDs for symptomatic relief. On fifth day patient was reviewed again and showed significant improvement. The edema had subsided and only crusting was present. Erosions over lips had recovered completely and fever was subsided.

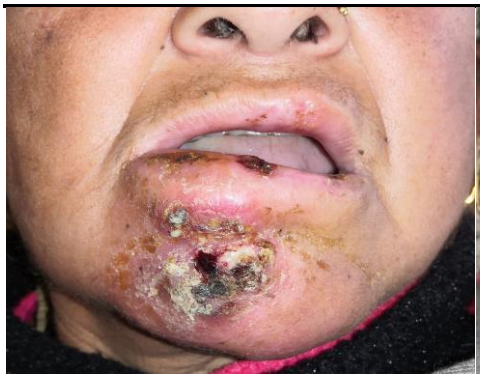

Figure1-Erythema and edema with haemorrhagic crust over chin and lips

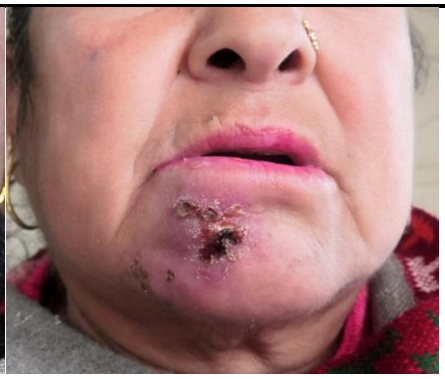

Figure 2- After five days of therapy erythema and edema has subsided significantly

Discussion: herpes zoster is caused by reactivation of varicella zoster virus and commonly the initial presentation is pain followed by skin eruption, which is unilateral not crossing midline. Eruption includes grouped papules that become vesicular and pustuler over the time. Treatment includes oral acyclovir 800 mg five times a day for 7-10 days or famciclovir 250 mg three times a day for seven days or valacyclovir1 gm three times day for seven days. The addition of oral prednisolone to aciclovir treatment has been shown to reduce pain, speed healing of lesions, and enable a more rapid return to daily activities.[2]

The common complications include post herpetic neuralgia and motor involvement. Other complications include erythema multiforme[3], granuloma annulare[4]. It may also be complicated by secondary bacterial infections.[5]

Declaration of patient consent

The authors certify that they have obtained all appropriate patient consent forms. In the form the patient(s) has/have given his/her/their consent for his/her/their images and other clinical information to be reported in the journal. The patients understand that their names and initials will not be published and due efforts will be made to conceal their identity, but anonymity cannot be guaranteed.

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Nil.

Conflicts of interest:

There are no conflicts of interest.

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