

Ramsay Hunt Syndrome - Revisited

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Fig. 1 : multiple vesicles and bullae seen on left side of face



Fig. 2 : mmultiple vesicles on left side of anterior 2/3 of tongue



Fig. 3 : Asymmetry of mouth is seen, patient is not able to shut left eye completely

60 years old male farmer, presented with left sided earache, painful fluid filled lesions on left side of face, forehead, scalp, left ear and left side of tongue, associated with burning pain since 15 days. Patient has no history of hypertension, diabetes mellitus or any major medical or surgical history. Patient had no history of fever, myalgia, difficulty in opening mouth, slurred speech, taste alteration. On examination, there were multiple vesicles and bullae on an erythematous base, few were eroded with crusting on left side of forehead, cheek, chin, frontal scalp, external auditory canal, pre & post auricular area (**Fig. 1**) and lateral border of anterior 2/3 of tongue (**Fig. 2**). Left sided lower motor neuron facial paralysis was evident, patient had difficulty in puffing of mouth, asymmetry in smile, inability to shut the eye completely with upward and outward rolling of eyeball while attempting closure, blunting of nasolabial groove. (**Fig. 3**). ELISA HIV 1 and 2 was done which was non reactive. Tzanck smear was done revealing multinucleated giant cells other routine investigations were within normal limit.

Based on these clinical and lab findings, we put forth a diagnosis of Ramsay Hunt Syndrome. Patient was started on acyclovir 800 mg 5 times a day for 7 days and prednisolone 40 mg once a day and was tapered. On 7 day of follow up, patient showed improvement in the symptoms of facial palsy & lesions healed up.

Ramsay hunt syndrome (RHS) also called herpes zoster oticus is a rare presentation of herpes zoster characterized by triad of ipsilateral peripheral facial paralysis (PFP), erythematous vesicles in auditory canal and otalgia¹. VZV reactivation occurs in geniculate ganglion² by various immunosuppressive factors stress, fever, radiotherapy.

Closest differential diagnosis which should be considered are Bell's palsy, lyme disease, trauma, metabolic diseases and tumors³. RHS has worse prognosis than Bell's palsy with total recovery in about only 30% cases^{3,4}. Incidence increases with age,¹. Sometimes vesicular lesions may appear on tongue especially on anterior 2/3. In some cases PFP can precede vesicular lesions. Some do not consider vesicular eruptions as a necessary criteria for diagnosis of RHS as in RHS sine herpette.^{1,3} In such cases, various presentations are seen with PFP as a constant finding. Apart from these classical triad, other symptoms are nausea, vomiting, vertigo, Sensorineural hearing loss, nystagmus, tinnitus.^{1,2,5} These symptoms are related to the involvement of other cranial nerves-trigeminal, glossopharyngeal, vagus, hypoglossal. Diagnosis is mainly clinical. In

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atypical cases like sine herpete, virological and serological tests are indicated², Early diagnosis is essential to minimize the sequelae. Combination of antiviral and corticosteroid agent is better therapy option in RHS especially within 72 hrs. of symptoms. It results in better prognosis and sequelae rate with total healing in about 75% cases.^{2,3} Acyclovir is used in dose of 800 mg 5 times a day for 7-10 days.³ In case of immunocompromised, children, serious complication, dose of 10 mg/kg/day IV is advocated every 8 hrly for 7-10 days. Corticosteroid is helpful in management of facial nerve paralysis in RHS^{3,4} But caution is needed especially in periocular lesions fearing dissemination of VZV infection⁴In case of persistent neuralgia, surgical decompression is also an option. Despite appropriate treatment, complication / sequelae rate is about 24-90%. These include Post herpetic neuralgia, synkinesis, ophthalmopathies, segmental myelitis, encephalitis.¹

Most common and important sequelae is facial nerve paralysis which is maximal at first week.

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