HERPES ZOSTER CASE PRESENTING WITH PAIN AND A BURNING SENSATION AT THE LEFT HIP

Tuba Tülay KOCA*, MD; Tolga Bağlan*, MD; Gülbahar Saraç*, MD;

1State Hospital, Physical Medicine and Rehabilitation, Malatya, TURKEY.
2Numune Training and Research Hospital, Cytopathology Clinic, Ankara, TURKEY.
3State Hospital, Dermatology Clinic, Malatya, TURKEY.

*Author for Correspondence: Dr. Tuba Tülay KOCA
State Hospital, Physical Medicine and Rehabilitation, Malatya, TURKEY.

ABSTRACT
Varicella zoster virus (VZV) is a member of herpes virus family; it generally presents with a generalized, vesicular rash. HZ develops through reactivation of dormant VZ virus in the spinal and cranial ganglions. A 38-year-old male patient was admitted to our clinic with symptoms of pain at the left inguinal and hip areas and a burning sensation radiating to his thigh. In the follow-up appointment a week later, the patient stated that he had obtained no relief from the medical treatment and painful, mildly itchy blisters appeared in his left inguinal area. In the physical examination, clusters of millimetric vesicles were observed at the left inguinal area, in the lumbosacral junctional area of his back, and the left lower anterior side of abdomen. When atraumatic joint symptoms appearing during adulthood, presence of HZ infection should be considered a possible cause, and the patient should be questioned about skin lesions. The disease rarely becomes lifethreatening. The current approach to the HZ comprises antiviral agents and analgesics, and the desired results are frequently achieved in young patients with mild infection.

KEYWORDS: herpes zoster, hip pain, sciatica.

A 38-year-old male patient was admitted to our clinic with symptoms of pain at the left inguinal and hip areas and a burning sensation radiating to his thigh. The patient indicated that he had been playing football once a week, and that he might have injured his hip joint because he had pain at the ipsilateral knee. The patient had no known history of disease except seborrheic dermatitis. In the physical examination, the movements of left hip and knee were painfree and complete. No lesion was observed on the skin during the initial examination. A nonsteroidal anti-inflammatory drug of 2x1 (twice a day) daily was started in response to the prediagnosis of a sports injury. In the follow-up appointment a week later, the patient stated that he had obtained no relief from the medical treatment and painful, mildly itchy blisters appeared in his left inguinal area. In the physical examination, clusters of millimetric vesicles were observed at the left inguinal area, in the lumbosacral junctional area of his back, and the left lower anterior side of abdomen (Figure 1a, b, c). The patient was diagnosed with herpes zoster (HZ) (commonly called shingles) after evaluation by the Dermatology Clinics. Valacyclovir oral tablets 300 mg/day, a cetirizine oral tablet 10 mg/day, and afucicid acid 20 mg local treatment 2x1 were recommended. At the follow-up appointment a week later, the lesions had spread from left inguinal area to the lower medial side of the thigh, and the other lesions were crusted.

Varicella zoster virus (VZV) is a member of herpes virus family; it generally presents with a generalized, vesicular rash. HZ develops through reactivation of dormant VZ virus in the spinal and cranial ganglions. In developed countries, 95% of the adult population is seropositive for VZV: therefore, they have a risk for VZ viral infection. Reactivation may occur at any age, but it generally occurs at advanced ages through a decline in cell-mediated immunity. Half of the individuals (50%) who develop VZ viral infection are aged 80 years or older.

When the patient was admitted with left inguinal pain and a burning sensation radiating to anteromedial side of thigh, prediagnosis of muscle strains due to sports injury, synovitis of left hip joint, pathology of obturator nerve, meralgia paraesthesia nerve entrapment, and sciatica were initially considered. Having no relief from the nonsteroidal anti-inflammatory drugs and the appearance of the lesions after pain began were considered to result from the dermatomal sensorial ganglion involvement of HZ. The lesions were spread dominantly along the L1 dermatomes; however, they were also observed at the S1 and L2 dermatomes.

It is rare for HZ infection to present with unilateral hip pain as an initial symptom. Radiation of the pain and burning sensation from left inguinal area to lower areas accompanied with knee pain may lead to a consideration of sciatica. In the case reported by H. Boluk et al, no
A pathological finding was found through imaging methods performed on the patient who was admitted with sciatica symptoms; soon after that, HZ lesions appeared. In the presentation of that case, it was emphasized that the lesions exhibited a difference by following the trace of the sciatic nerve. The sciatic nerve is a peripheral nerve that is formed by the fibers coming from L4, L5, S1, S2, and S3 nerve roots of the lumbosacral plexus. The current case was considered to be HZ infection because the infection involved more than one sensorial dermatome rather than a peripheral nerve. When atraumatic joint symptoms appeared during adulthood, presence of HZ infection should be considered a possible cause, and the patient should be questioned about skin lesions. The disease rarely becomes lifethreatening. The current approach to the HZ comprises antiviral agents and analgesics, and the desired results are frequently achieved in young patients with mild infection. Our patient was young, and he responded very well to the antiviral treatment.

Figure 1a: A cluster of millimetric vesicular lesions 3 cm in size were observed along the left lower inguinal alignment of the abdomen.

Figure 1b: Two clusters of millimetric lesions 2 cm in size were observed at the midline of the lumbosacral junction.
Figure 1c: Two clusters of millimetric vesicular lesions 1 cm in size at the left inguinal area and the anteromedial side of the thigh.

REFERENCES