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Zoster gone wild

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This article aims to present the case of a 64-year-old patient with a clinical presentation of herpes zoster ophthalmicus (HZO) with associated keratouveitis, which, despite local and oral antiviral treatment, led to the development of left-sided oculomotor paresis, headache, and dizziness after two days. The infectiologists also observed an associated herpetiform rash on the trunk. PCR testing of cerebrospinal fluid (CSF) confirmed the presence of varicella-zoster virus (VZV), establishing the diagnosis of serous meningitis associated with a disseminated form of herpes zoster. A 14-day parenteral therapy with acyclovir and a 5-day oral course with methylprednisolone was initiated, followed by maintenance oral virostatic therapy. Head CT excluded an abscess, while brain MRI revealed acute thrombosis of the left transverse and sigmoid sinuses. Thrombophilia tests were negative, and anticoagulant therapy was initiated for one year. After three months of treatment, there was a complete improvement in ocular motility. By nine months, with continued appropriate local ocular therapy, there were no signs of active keratouveitis.
Varicella-zoster virus (VZV), a member of the herpesvirus family, is the etiological agent of chickenpox (varicella) as a primary infection in children. The virus can remain dormant in the nervous system and reactivate later in life, resulting in shingles (herpes zoster) in adults. Herpes zoster typically manifests as a vesicular rash accompanied by pain and itching localized to a dermatome. When the rash involves the first branch of the trigeminal nerve, it is classified as HZO. Although VZV infections are generally not life-threatening, complications such as disseminated infection or meningitis can occur, especially in immunocompromised individuals. Clinical manifestations of meningitis or meningoencephalitis often include fever, headache, cranial nerve involvement, meningeal irritation, nausea, vomiting, and Ramsay-Hunt syndrome. Ophthalmologists frequently encounter isolated HZO in clinical practice, making it crucial to recognize potential complications in the case of an atypical course and to treat them appropriately and promptly.

Pobesneli Zoster

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Namen tega prispevka je opisati primer 64-letnega bolnika s klinično sliko herpes zoster ophthalmicusa (HZO) s pridruženim keratouveitisom, ki je kljub lokalni in peroralni virostatični terapiji po dveh dneh vodil do nastanka levostranske okulomotorne pareze, glavobola in vrtoglavice. Infektologi so na koži trupa opažali pridružen herpetiformni izpuščaj. PCR testiranje likvorja je bilo pozitivno na varicella- zoster virus (VZV), kar je potrdilo serozni meningitis ob diseminirani obliki zostra. Uvedena je bila 14-dnevna parenteralna terapija z aciklovirjem ter 5-dnevna peroralna terapija z metilprednizolonom, sledila je vzdrževalna peroralna virostatična terapija. CT glave je izključil absces. MR glave je prikazala akutno trombozo levega transverzalnega in sigmoidnega sinusa. Testi trombofilije so bili negativni, uvedena je bila antikoagulantna terapija za eno leto. Po treh mesecih zdravljenja je prišlo do popolnega izboljšanja očesne gibljivosti. Po devetih mesecih, ob ustrezni lokalni očesni terapiji, ni bilo več videti znakov aktivnega keratouveitisa.
VZV, član družine herpesvirusov, je etiološki povzročitelj noric (varicella) kot primarne okužbe pri otrocih. Virus lahko ostane latenten v živčnem sistemu in se ponovno aktivira, kar povzroči pasovec (herpes zoster) pri odraslih. Herpes zoster se običajno kaže kot vezikularni izpuščaj, ki ga spremljata bolečina in srbenje v predelu lokaliziranega dermatoma. Kadar izpuščaj zajema 1. vejo trigeminalnega živca, se imenuje HZO. Čeprav okužbe z VZV običajno niso smrtno nevarne, lahko pride do zapletov, kot so diseminirana okužba ali meningitis, zlasti pri imunokompromitiranih posameznikih. Klinične manifestacije meningitisa ali meningoencefalitisa običajno vključujejo vročino, glavobol, prizadetost možganskih živcev, draženje mening, slabost, bruhanje in Ramsay-Huntov sindrom. Oftalmologi se v klinični praksi pogosto srečujemo z izoliranim HZO, zato je ključnega pomena, da v primeru atipičnega poteka prepoznamo možne zaplete ter jih ustrezno in pravočasno zdravimo.