A Bilateral Lumbar Multidermatomal Herpes Zoster in an Elderly Woman with Chronic Kidney Disease

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ABSTRACT

Herpes zoster (HZ) is a painful rash caused by the reactivation of the varicella-zoster virus (VZV) permanently latent within the cranial or dorsal root ganglia. Usually the rash presents in only one side of the body, in a single dermatome or restricted to a part of it. In immunocompromised patients, more than one contiguous unilateral dermatome, called multidermatomal HZ, has been described, usually in cervical dermatomes. Bilateral rash is rare. Besides immunosuppression, the major risk factors for virus reactivation are older age and female gender. This is a case of a bilateral lumbar multidermatomal HZ in an elderly woman with chronic renal failure.

Keywords: Bilateral; Herpes zoster; Kidney disease; Lumbar; Multidermatomal

Key Summary Points

Herpes zoster (HZ) is a painful rash caused by the reactivation of the varicella-zoster virus (VZV).

Older age, female gender, and immunosuppression are the major risk factors for virus reactivation.

Usually the rash is unilateral and is restricted to a single dermatome or to a part of it.

Bilateral rash is rare and multidermatomal HZ is more frequent in cervical dermatomes.

This is a case of a bilateral lumbar multidermatomal HZ in an elderly woman with chronic renal failure.

CASE

Herpes zoster (HZ) is a painful rash caused by the reactivation of the varicella-zoster virus (VZV) permanently latent within the cranial or dorsal root ganglia after a primary childhood
infection. Also known as shingles, it presents as a vesicular rash that usually affects only one side of the body, distributed in a single dermatome or restricted to a part of it [1]. In immunocompromised patients, more than one contiguous unilateral dermatome, called multidermatomal HZ, has been described, usually in cervical dermatomes [2]. Although it is unclear if VZV spreads across adjacent ganglia or to neighboring peripheral nerves, two hypothesis have been proposed to justify multidermatomal HZ propensity for cervical region: the rich innervation of cervical dermatomes covering the head and neck [3] and the shorter length of the sensory nerves of cranial and cervical dermatomes compared to thoracic or lumbar ones [2]. Bilateral non-contiguous herpes zoster, also termed herpes zoster duplex, has been reported in immunocompromised patients [4], and in a patient with end-stage renal failure [5]. Finally, one case of thoracic HZ duplex, bilateralis, and symmetricus in an immunocompetent subject has been published [6].

Besides immunosuppression, the major risk factors for virus reactivation are older age and female gender [7]. Prodromal itching, numbness, or burning sensations precede the maculopapular rash, which quickly becomes very painful. The eruption evolves to pustulation followed by ulceration and crusting [8]. Early antiviral therapy is the primary treatment of HZ, but pain management is always needed during the progression of disease until healing, usually within a month. Post-herpetic neuralgia (PHN) is the main complication of HZ occurring in 8–33% of affected patients. Once again, PHN frequency and severity increase with age [9] and may last for months or even years. Due to its poor response to analgesics, PHN can cause sleeping problems, anorexia, weight loss, and depression, compromising self-care and social life [10]. In order to avoid HZ and PHN, prophylactic vaccination has been strongly recommended in older adults [11].

This is the case of a bilateral lumbar multidermatomal HZ eruption in a 91-year-old woman with chronic kidney disease. The rash simultaneously involved bilateral dermatomes from L2 to L5 (Fig. 1). The patient complained of severe back pain, weakness in the lower limbs, and walking impairment so that her quality of life and functional status were very compromised. The patient was admitted to the hospital. Antiviral therapy was started and a pain medicine consultation was requested. Antidepressants and anticonvulsants were
prescribed at low doses according to renal function, with gradual and progressive improvement of symptoms. The patient was discharged home 2 weeks later. Other than older age and kidney disease, no other risk factors were revealed.

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Compliance with Ethics Guidelines. Informed consent for publication was obtained from the patient.

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REFERENCES

1. Cohen JI. Clinical practice: herpes zoster. N Engl J Med. 2013;369(3):255–63.
2. Beuerlein KG, Strowd LC. Multidermatomal herpes zoster: a pain in the neck? Dermatol Online J. 2019;25(11):1–4.
3. Besnè I, Descombes C, Breton L. Effect of age and anatomical site on density of sensory innervation in human epidermis. Arch Dermatol. 2002;138:1445–1450.
4. Peretz A, Nowatzky J, Steiner I. Herpes zoster duplex bilateralis. BMJ Case Rep. 2009. https://doi.org/10.1136/bcr.2006.114116.
5. Akimoto T, Muto S, Nagata D. Bilateral herpes zoster in a patient with end-stage kidney disease. Int Med Case Rep J. 2017;19(10):209–12.
6. Agrawal S, Aara N, Bumb R. Herpes zoster duplex bilateralis symmetricus in an immunocompetent subject. Int J Dermatol. 2014;53(4):e281–e282.
7. Opstelten W, Van Essen GA, Schellevis F, Verheij TJM, Moons KGM. Gender as an independent risk factor for herpes zoster: a population-based prospective study. Ann Epidemiol. 2006;16(9):692–5.
8. Gnann JW Jr, Whitley RJ. Clinical practice. Herpes zoster. N Engl J Med. 2002;1(5):340–6.
9. Curran D, Oostvogels L, Heineman T, et al. Quality of life impact of an adjuvanted recombinant zoster vaccine in adults aged 50 years and older. J Gerontol A Biol Sci Med Sci. 2019;74(8):1231–8.
10. Schmader KE, Sloane R, Pieper C, Coplan PM, Nikas A, Saddier P, Chan IS, Choo P, Levin MJ, Johnson G, et al. The impact of acute herpes zoster pain and discomfort on functional status and quality of life in older adults. Clin J Pain. 2007;23:490–6.
11. Szucs TD, Pfeil AM. A systematic review of the cost effectiveness of herpes zoster vaccination. Pharmacoeconomics. 2013;31:123–36.