SHINGLES CASE STUDY
COMPETITION

A Diagnostic Dilemma

Mrs MI is a pleasant, active and healthy 52 year old lady with a problem of chronic sinusitis. She is not in any way immunologically compromised. She takes a Thiazide for mild hypertension and Premarin as hormonal replacement following a totally hysterectomy.

On 23/5/94 Mrs MI underwent bilateral endoscopic intranasal ethmoidectomy and antrostomy which was followed by washout of the maxillary sinuses and cautery of the inferior turbinates. She was discharged the following day on a nasal steroid spray and a long acting non-sedating antihistamine.

On 2/6/94 – day 9 post operation – Mrs MI presented with a complaint of severe pain behind the left eye. This had begun as a gritty feeling in the eye and rapidly progressed to severe retro-orbital pain which radiated to the upper left quadrant of the face. At this stage there was periorbital oedema and an angry red inflammation of the conjunctiva; pupillary reaction and vision were normal. Fearing complications of her previous surgery my partner referred her back to her ENT specialist. She was admitted to hospital and started on IV antibiotics. When the otorhinolaryngologist had excluded significant pathology related to her sinuses (by tomography) he called in an ophthalmologist and a physician. Neither specialists was able to further clarify her problem and, since she was feeling a little better, Mrs MI's rather concerned ENT surgeon stopped her antibiotics and allowed her to return home on 4/6/94 with a presumptive diagnosis of "Cluster Headaches".

I was summoned at 07h30 on Sunday 5/6/94 by a worried Mrs MI who had had a terrible night as a result of excruciating pain in her left eye. She described a pain which was stabbing in nature and came in waves of agony without ever fully abating between attacks. The pain centred upon the eye and radiated to the entire left side of the face. I examined her and was struck by her prominent left sided periorbital oedema; there was no proptosis but the conjunctiva was angrily injected and the eyeball was exquisitely tender. She was apyrexial; fundoscopy was normal as was her vision and pupillary response and I could not elicit any tenderness over the frontal, or other sinus. All other systems were normal. Murphy's law applied – the ENT specialist was out of town – and I contacted her ophthalmologist who felt convinced that there was no intraocular pathology. In desperation I started a broad spectrum antibiotic, administered parenteral analgesia and, hoping that time would reveal more, left the patient with oral analgesics.

Later that afternoon I returned, in some trepidation, to Mrs MI. I was fascinated to note diffuse erythema in the left upper quadrant of her face, with a sharp demarcation in the midline and below the eye. There was also one very small vesicle on her upper eyelid. Over the following two hours three more vesicles erupted. It was with a feeling of relief, tempered by concern for the stormy few days ahead, that I made a diagnosis of shingles; and started Zovirax in the recommended dose that evening.

The next day (6/6/94) the patient was still bedridden, in a lot of pain and complaining of nausea. There were many more fine vesicles on the forehead and eyelid. On the advice of the Ophthalmologist I started Maxitrol drops. The ensuing morning (7/6/94) revealed a Mrs MI regaining her hope; the pain was much less and she was pleased to tell me that she had slept the night before. There were now

profuse vesicles extending onto her scalp and the early lesions were beginning to crust. I stopped one of her analgesics and her nausea disappeared.

The pain continued to subside over the next few days as she conscientiously took her Zovirax. By 9/6/94 the erythema began to lessen and I could confidently tell her that I could see no new lesions. By this time she was feeling well enough to sit out of bed. By 12/6/94, when the Zovirax was due to be completed, Mrs MI was feeling much better although still with some crusted lesions and mild pain. She was very relieved when there was no recrudescence of her symptoms after the Zovirax course was completed. The last few lesions dried and fell off and by Friday 17/6/94 the skin was clear, although tender to the touch, and slightly red. Since her pain appeared to be a thing of the past we – prematurely – congratulated the manufacturers of Zovirax. The following morning Mrs MI telephoned me to say that she had had a short episode of severe pain on the left side of her face in the night. Early in the course of her illness I had warned her of the possibility of post-herpetic neuralgia and it appeared as though these warnings might have been prophetic.

Over the next few days Mrs MI had several more of these distressing attacks and by 25/6/94 she had developed a constant, fiery, burning sensation over the upper part of the left side of her face. Carbamazapine rendered this pain initially bearable and then, as I increased the dose to 400mg bd, eventually controlled it completely. It would appear therefore that we had a qualified success with Zovirax which initially controlled an extremely painful and distressing condition but did not, in this case, prevent the unpleasant sequelae.

I conclude with some interesting comments that I heard during the course of this saga. The ophthalmologist: "I promised myself I would never be caught out by shingles again." The physician: "I was sure it wasn't cluster headaches." The otorhinolaryngologist: "I am so pleased it wasn't a complication of my surgery", Mrs MI: "It was the worst pain I have ever experienced; much worse than giving birth."

Dr RG Whittaker
MBChB(UCT), DA(SA), Dip Obst
PO Box 158, Stutterheim, 4930

Application for S A Family Practice Manual Subscription

I ....
(full names and in block letters)
am a registered medical practitioner on the Register on the South African Medical & Dental Council and practice in the field of Family Practice/Primary Care.

Subscription: R40,00

Enclosed my cheque for R40,00
(VAT Included)

For further information contact
Sandra Scott
(011) 463-5252

Signature: ....

Qualifications: ....

Date of Qualifications: ....

Postal Address: ....

.... Tel (H): ....

.... (W): ....

SAMDC Registration Number:..

Please post to:
S A Family Practice
P O Box 3172
Cramerview, 2060

Free to Academy Members