SHINGLES CASE STUDY

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Natal

Teenage independence remains an enigmatic phenomenon. As soon as school years are completed there is often an unseemly haste to leave the parental nest in order to prove the young adult's ability to manage on his/her own in the big wide world.

There is also nothing like an illness to shatter this can-handle-everything-on-my-own attitude and send Mr Independent scurrying back to the comfort and succour of Mother's tender care.

W N is a 19 year old who had recently started his studies at a college in Durban. Three days prior to my seeing him, he had developed diarrhoea and 1 day after that he had developed a headache and started vomiting.

He had taken Imodium and Panado but his headaches were becoming progressively worse and he was starting to feel weak and giddy. It was at this stage that the homefires had started to beckon and thus it was that an ill and sorry looking young man accompanied by a concerned mother presented in the rooms.

The only additional fact of note was that he had noticed a rash on his torso and at the time of presentation it had been present for 2 days.

Clinically he looked unwell with borderline dehydration and a temperature of 38,5. He had a significant degree of neck stiffness and a macular rash in the T9 dermatome on the left side of his chest. (1st Photograph)

A diagnosis of Shingles complicated by Meningoencephalitis was made.

W N was not very keen on the suggestion of hospitalization, a drip and a lumbar puncture. In view of the presence of his herpetic rash and the fact that his headache had been present for 2 days it was unlikely that the clinical meningoencephalitis was bacterial in origin. Hence we rather reluctantly agreed to his request for treatment at home after discussing the possibilities and obtaining the assurance of prompt return at the first signs of deterioration.

He was started on the Zovirax Shingles Pack regimen of 800 mg five times daily for seven days. In addition anti nausea agents and analgesics were prescribed.

W N vomited once on the following day but reported that the very severe headache had appreciably diminished in intensity.

When seen 5 days after the initial consultation he looked well on the road to recovery. He had not experienced any more vomiting and had not had a headache for 3 days. He was champing at the bit to once more shake off the parental shackles and head for Durban where the prospects of his girlfriend and the bright lights seemed much more appealing than recuperative leave in Sleepy Hollow.

His meningitic signs were no longer in evidence and his rash had not really developed as seen in photograph 2.

Although encephalitis is mentioned as a complication of Shingles in standard medical textbooks (Current diagnosis and Treatment - Krupp and Chatton; The Principles and Practice of Medicine - Davidson and Macleod), I have not encountered this condition in any of the Shingles patients I have previously treated. Hence I was immensely relieved the morning after the initial consult to hear that W N had improved. In fact I was greatly relieved to hear that he was actually alive, as that evening my vivid imagination had me contemplating the consequences of missing a Meningococcal meningitis!

What of the patient? I know his mother was as impressed as I was in the speedy trans-formation of a pretty ill, quiet, withdrawn soul to a fit confident young man again. W N himself had already forgotten his morbidity and was downright peeved that he had to go through all this follow up business by the doctor and mollycoddling by his mother.

Directly following the consult he was off to Durbs and I have no doubt that all my admonitions to take it easy fell on deaf ears. Ah, the impatience of youth!