A Rare Presentation of Varicella Zoster: Segmental Paresis
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BACKGROUND

• Segmental zoster paresis (SZP) is a rare complication of herpes zoster
• Presents with a focal weakness along a myotome that corresponds with dermatomal involvement.
• As it may mimic stroke, infection, or autoimmune pathology, the diagnosis of SZP is a formidable one.

CASE PRESENTATION

An 81-year-old male with a past medical history of renal cell carcinoma s/p R nephrectomy 2017 and CKD with recently diagnosed renal-limited microscopic polyangiitis (on chronic prednisone), presented with severe left arm pain and an erythematous and purpuric rash involving the left forearm and palm for approximately 2 weeks. He was empirically treated with a 10-day course of valacyclovir as an outpatient without improvement. His symptoms further progressed to severe burning pain of his left hand, purpuric lesions and left wrist drop.

Notable findings of Physical Exam:
- Musculoskeletal: Sensory deficits and weakness in left arm with 0/5 wrist flexion/extension, 1/5 elbow flexion/extension, and 4/5 shoulder flexion/extension. + Wrist drop of L hand
- Skin: Left hand diffuse swelling without joint swelling or tenderness. Palpable lesions on dorsal aspect of left forearm and flat petechial lesions on left hand (Image 1 and 2).

CLINICAL COURSE

• Although labs and inflammatory markers were unremarkable his presentation was concerning for mononeuritis multiplex secondary to a systemic ANCA-associated vasculitis.
• He was initiated on pulse dose steroids pending further serologic workup.
• CT cervical spine was negative for acute pathology or cervical dislocation.
• Electromyography was suggestive of the involvement of multiple peripheral nerves and concerning for mononeuritis multiplex.
• He underwent a skin biopsy which revealed a necrotic epidermis and acantholytic, multi-nucleated keratinocytes compatible with a varicella zoster (VZV) infection
• Given biopsy findings, it was suspected that the skin lesions and mononeuritis multiplex were all secondary to VZV and not part of a systemic vasculitis, which explained why his skin lesions were localized to the affected extremity rather than a more systemic rash.

DISCUSSION

• Treatment was initiated with additional 10-day course of valacyclovir. Steroids were tapered and azathioprine was held given ongoing VZV infection and his weakness progressively improved.
• Although acute VZV and postherpetic neuralgia are familiar to physicians, segmental paresis affects 3-5% of patients with cutaneous herpes zoster and is an underrecognized syndrome.
• This case illustrates how such presentations are often misdiagnosed and initially mistreated.
• Recognition of this syndrome is crucial to clinical practice to allow for a thorough work-up and initiation of treatment in a timely manner.

REFERENCES