

Rumsay Hunt Syndrome in Pregnancy

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SUMMARY

Pregnancy though considered a physiological phenomenon is still an immunocompromised state. Therefore it frequently unmasks underlying pathology. Herpes zoster despite being dormant may unveil during pregnancy with unusual presentation. Thirty one year old lady gravida 3 presented at 24 weeks with a day's history of altered voice and dysphagia more for liquids diagnosed as Ramsay Hunt Syndrome. High index of suspicion helps identifying rare conditions. Pregnancy is a low immunity state and presents with symptoms confusing the whole picture. Ramsay Hunt Syndrome completely recovers provided timely diagnosis is made.

Keywords: Ramsay hunt syndrome, herpes zoster, pregnancy

CASE PRESENTATION

A lady 31 year of age in her third ongoing pregnancy presented in antenatal clinic at PAF Hospital Mianwali at 24 weeks of gestation with altered voice, a prominent nasal twang, dysphagia more for liquids as compared to solids and nasal regurgitation of liquids for one day. There was no history of associated symptoms like dyspnea, syncope, palpitations, vomiting, vertigo or epigastric pain. She had normal fetal movements and was due to have her anomaly scan in the following week being a late booker. ENT specialist examined her and labeled her left recurrent nerve palsy involving soft palate and vocal cord. In addition vesicular lesions of left hemilarynx, left vocal fold and pooling of secretions of left pyriform fossa were demonstrated. A clinical diagnosis of Ramsay Hunt Syndrome i.e., Herpes zoster of larynx was made. Her base line investigations including ECG was normal which excluded asymptomatic Mitral Stenosis leading to Ortner's Syndrome. Varicella antibodies IgG and IgM with PCR for viral genome were requested and patient was referred to MH Rawalpindi which is a tertiary care center. There she received symptomatic treatment and oral prednisolone which resulted in full recovery in two weeks. She went into spontaneous labour at 39 weeks and delivered vaginally a 3.1kg baby girl.

DISCUSSION

Varicella-zoster virus, which causes chicken pox and shingles also causes herpes zoster oticus^{1,2}. Reactivation of a latent infection by the varicella zoster virus results in shingles. Although cause of the

reactivation is unclear but it is common in post traumatic patients those with neoplasm, AIDS and other immunocompromised states³. Delayed expression of the virus^{1,3} has been blamed. It is probably a cranial polyneuropathy⁴ and is said to be the second most common cause of atraumatic peripheral facial paralysis⁵. Older people (most commonly over 60 years old) are common sufferers¹, but no age group is exempted, including children. Even a case of varicella infection in utero and presentation in infancy with this syndrome has also been reported¹².

Herpetic involvement of the facial (geniculate), vestibulocochlear or trigeminal ganglia results in Herpes zoster oticus (Ramsay-Hunt Syndrome)⁶. Vesicles may appear only in the pharynx or hard palate sometimes^{3,6,8}. In 20–30% of the patients there is persistent vertigo, hearing loss and tinnitus. Facial palsy (not considered to be Bell's) can also occur and prompt initiation of oral steroids and acyclovir should begin when this happens. It improves recovery of facial nerve function and vertigo. Hearing loss is not improved by this treatment though⁶.

Simple presentation as pain in the ear makes diagnosis very difficult. Whereas vesicles in the auditory canal or on the palate make it easier to diagnose. Fever, ear pain, nausea, vomiting, vertigo, tinnitus, nystagmus, hearing loss and facial paralysis can also be associated symptoms^{8,9}. Other symptoms may be loss of taste in the tongue and dry mouth and eyes⁸. Virological studies are available but as the diagnosis is clinical those are usually not required. To determine the extent of damage to the facial nerve and potential for recovery audiometry and nerve conduction studies may be performed.

Treatment is same for pregnant and non-pregnant individuals¹⁰ and is essentially the supportive. Oral acyclovir and famcyclovir may reduce severity and shorten course in uncomplicated cases. Early treatment of all patients with 7 – 10 day

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course of famciclovir (500mg tds) or acyclovir (800mg five times daily), with oral prednisolone 60mg daily for 3–5 days helps recovery.

In a nutshell, there is a paucity of data regarding the role of steroids and efficacy of specific antivirals in Ramsay Hunt syndrome despite the fact that early institution of treatment (within 72 hours) has shown to be beneficial to the patients.

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