

Occipital neuralgia following thoracic herpes zoster: case report

Torasik herpes zoster sonrası gelişen oksipital neuralji: Olgu sunumu

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Summary

Paroxysmal shooting or stabbing pain in the dermatomes of the nervus occipitalis major or nervus occipitalis minor is defined as occipital neuralgia. The initial cause of the neuralgia appears to be from inflammation, damage or irritation of these nerves. In this article, we present a patient with occipital neuralgia followed by thoracic herpes lesion.

Key words: Occipital neuralgia; zoster sine herpette.

Özet

Oksipital neuralji büyük oksipital sinir ve küçük oksipital sinirin dermatomlarında paroksizmal batıcı ve çakıcı tarzda şiddetli ağrı olarak tarif edilmiştir. Neuralji bu sinirlerin inflamasyonundan, hasarından veya irritasyonundan kaynaklanmaktadır. Bu yazıda torasik herpes lezyonunu takiben ortaya çıkan oksipital neuraljili bir hastayı sunuyoruz.

Anahtar sözcükler: Oksipital neuralji; zoster sine herpette.

Introduction

In most instances, zoster produces cutaneous pain at the time of the infection. Pain from the accompanying neuritis follows the same dermatomal distribution of the vesicles, and may precede the skin lesions by several days. Sometimes zoster involves an adjacent dermatome, or a part of an adjacent dermatome.^[1,2] Pain in the involved dermatome develops in over three fourths of patients. Although some patients (usually with a mild shingles rash) do not complain of pain, a few patients develop dermatomal pain without rash (zoster sine herpette).^[3] The International Headache Society (IHS) defines occipital neuralgia as paroxysmal shooting or stabbing

pain in the dermatomes of the nervus occipitalis major or nervus occipitalis minor.^[4] The pain originates in the suboccipital region and radiates over the vertex. Here we report a patient with occipital neuralgia followed by thoracic herpes lesion.

Case Report

A 63-year-old man was seen in our clinic for a sudden-onset shock like-pains in the right occipital region. The pain could be reproduced by palpation of the distribution area of the greater occipital nerve. There were no evident mechanical triggers. No trigemino-autonomous symptoms were reported. On examination, he was found to have a grouped

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vesicular eruption over the distribution of the fifth thoracic nerve on the right side. When he was asked for these lesions he said that they were not painful and they were not disturbing him. Two days after vesicular rash, painful shocks have begun in the right occipital region. He said his main complaint was severe pain on the right side of posterior scalp. Dermatologist diagnosed herpes zoster for the cutaneous lesions on the right side of chest wall. An enhanced magnetic resonance imaging (MRI) test was performed to rule out a lesion in the brain or the neck. No abnormality was found. He was diagnosed as occipital neuralgia according to ICHD-II criteria. A nonsteroidal anti-inflammatory drug was administered every 6 h, but pain did not result in significant relief. By the end of two days carbamazepine was used as 200 mg at the beginning and increased to 600 mg three times daily. Two days later it was possible to touch his scalp without causing pain; at first merely touching the hair had been very painful. He was given acyclovir 800 mg 5 times daily for 7 days. He was advised to report back after every week for follow up. His lesions healed in about ten days time with minimal scarring. We followed him for two months. No herpetic lesions and pain occurred on the scalp.

Discussion

Often, damage or irritation of the nervus occipitalis major and minor is the cause of the neuralgia. Potential causes of irritation may be vascular, neurogenic, muscular, and osteogenic.^[5] A few case of occipital neuralgia which induced by Herpes zoster with or without rash reported.^[6,7] In these cases anatomic continuity of cranial nerves and C1 to C3 spinal nerves has been considered as the cause of neuralgia in other sites. A case of combined development of zoster sine herpette, paresis and myelopathy was thought to be associated with reactivation of VZV.^[8]

Diagnosis of zoster-sine-herpette is not easy, mainly because of the absence of dermatological manifesta-

tions. In this patient it was not difficult to determine the etiology of occipital neuralgia because of occurring nearly simultaneously thoracic rash. It is also interesting to note that, when thoracic distribution zoster occurs, pain is most likely to appear in the same infected dermatome or in an adjacent dermatome, but in our patient pain appeared in another area distant from the dermatome with rash. Lewis described some patients who experienced “zoster type” pain without rash in a dermatomal distribution distant from a dermatome with rash.^[9]

However, these cases have not been showed so distant affectivity as reported in our case. The possible occurrence of pain temporally remote from the zoster rash relates to another suggested clinical entity, zoster pain without rash-zoster sine herpette.^[3] There have been no well-documented cases of occipital neuralgia caused by herpes zoster without or with rash distant from occipital area. Zoster sine herpette should be considered as a probable cause of occipital neuralgia when no skin lesions and other potential causes of irritation are established.

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