Case Report

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Delayed onset post-herpetic pseudohernia: a case report

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ABSTRACT

Post herpetic pseudo hernia is a rare neurological complication of herpes zoster (HZ). It could lead to diagnostic confusion as abdominal wall herniation presents with similar clinical picture. We present a case of post herpetic pseudo hernia initially misdiagnosed by referring general physician as abdominal wall hernia. A 60-year-old man presented with painless swelling in the right flank for 1 week. The bulge was noticed two weeks after appearance of painful rash of HZ. On clinical examination, fading dried brown rashes were observed in right T10-11 dermatome. No hernial defect was palpable. The bulge became more prominent on standing and coughing. Abdominal sonography report was normal with absence of abdominal mass or hernial defect. The patient was diagnosed as a case of post herpetic pseudo hernia. The bulge resolved spontaneously in 3 months. Physicians should consider the possibility of Post herpetic pseudo hernia if abdominal bulge appears following HZ infection to prevent unnecessary interventions.

Keywords: Abdominal wall, Herpes zoster, Post-herpetic, Pseudohernia

INTRODUCTION

Herpes zoster (HZ) is a clinical syndrome characterized by unilateral skin rash with vesicular eruptions and neuralgia along a specific dermatome. Following a childhood chickenpox infection, varicella zoster virus may remain dormant in the sensory ganglia for years. The virus may get reactivated leading to Herpes zoster. HZ primarily affects the posterior root ganglion leading to sensory symptoms such as characteristic pain in a dermatomal distribution. Segmental paresis due to zoster leading to abdominal bulge is a rare complication of herpes zoster. Thomas et al estimated the prevalence of abdominal muscle paresis due to herpes zoster as 0.2%.1 The pathogenesis of this motor involvement may involve immune-mediated mechanism with aseptic inflammation or direct spread of virus from the dorsal root ganglion to the anterior horn cells, adjacent motor nerve roots or peripheral nerves.^{2,3} The clinical picture of post herpetic pseudo hernia may mimic abdominal wall herniation leading to diagnostic dilemma. Here we present a case of post herpetic pseudo hernia misdiagnosed as abdominal wall herniation and referred to general surgery department.

CASE REPORT

A 60 years old man was referred by a general physician to general surgery outpatient department (OPD) with a provisional diagnosis of abdominal hernia. The patient presented with a progressive bulge in the right flank for 1 week. The bulge was noticed two weeks after appearance of painful vesicular rash of herpes zoster. He complained that the swelling increased with coughing and straining. The patient denied pain, nausea or alterations in bowel movements. He had no complains of abdominal muscle weakness or any other complains at the time of presentation (Figure 1, 2).

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Figure 1: Bulge in the right flank and arrow depicts the fading rashes (right lateral view of abdomen with patient in supine position).



Figure 2: Bulge in the right flank (patient in supine position).

On examination, fading dried rashes were observed in right T10-11 dermatome. There was a bulge in right flank region leading to abdominal asymmetry. The bulge became more prominent on standing and protruded even more when patient was asked to perform valsava's maneuver. On abdominal palpation, there was no tenderness and no hernial defect was palpable. There was no visceromegaly or spinal tenderness. On auscultation, bowel sounds were found to be normal. Abdominal sonography was performed, and report was normal with absence of abdominal mass or hernial defect. The patient was diagnosed as a case of post-herpetic pseudohernia. Patient was advised abdominal binder and asked for follow up. The bulge resolved completely after three months.

DISCUSSION

Segmental HZ abdominal paresis is characterized by abdominal wall weakness that can present with abdominal or flank bulges. The weakness occurs in the muscles innervated by the affected spinal cord segment that corresponds to the cutaneous manifestation. The diagnosis of post-herpetic pseudohernia can be suspected by a close temporal association with rashes of HZ and can be made clinically.

The mean age of the patients presenting with this condition has been reported as 62 years and symptoms of paresis usually appear within 2-6 weeks of the appearance of the rash.^{1,2} The age of our patient was 60 years and the weakness appeared 2 weeks following appearance of rash. He was provisionally diagnosed as a case of hernia by a general physician and referred to the general surgery OPD.

Ultrasonography excluded abdominal wall hernia. We did not perform electromyography to confirm neurological deficit to avoid burden on the patient because of its invasiveness. Awareness of this clinical entity and identification of a recent history of herpes zoster followed by an ipsilateral abdominal bulge can help in diagnosis of post-herpetic pseudohernia by physical examination only. We managed our patient conservatively using abdominal binder. He recovered completely in 3 months. Chernev et al documented that most patients with pseudohernia after herpes zoster eventually recover completely. ⁴

Unlike abdominal hernia which requires diagnostic studies and surgery, post-herpetic pseudohernia is self-limited in nature and has good prognosis hence recognition of this neurological complication of HZ is important to prevent unnecessary interventions.

CONCLUSION

Pseudohernia is a known albeit rare complication of herpes zoster infection. Physicians should consider the possibility of pseudohernia if the abdominal bulge appears following herpes zoster infection to prevent unnecessary referrals to the surgery department.

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