

## Herpes Zoster and Ogilvie's Syndrome

K.		Alpay
M.		Yandi

Departments of Dermatology and General Surgery, Faculty of Medicine, Karadeniz Technical University, Trabzon, Turkey

Doç. Dr. Köksal Alpay, Department of Dermatology, Faculty of Medicine, Karadeniz Technical University, 61080 Trabzon (Turkey)

Ogilvie's syndrome is characterized by dilatation of the colon without organic obstruction. Most of the causes of the syndrome are extra-abdominal: of these herpes zoster has been reported only twice.

An 83-year-old woman had abdominal pain, distension and blocking of passing flatus and stool for 2 days. On physical examination we found abdominal distention and tenderness. Bowel sounds were hypoactive, and rectal examination did not reveal any intra-luminal lesion.

White blood cell count showed 12,000/mm<sup>3</sup>, a hemoglobin level of 13.0 g/dl and a sedimentation rate of 26 mm/h. All serum electrolytes, blood urea nitrogen, glucose and amylase were within normal limits. Radiographs of the abdomen revealed multiple air-fluid levels and colonic dilatation with an air cutoff just distal to the splenic flexura.

The patient was hospitalized with a pre-diagnosis of acute abdomen (intestinal obstruction?) and was treated by nasogastric decompression and intravenous administration of fluids. Three days later a vesicular zosteriform rash appeared in the right T10 dermatome. The patient was examined by a dermatologist. Multiple clustering vesicles were noted from the umbilicus to the flank overlying the right T10 dermatome. Smears taken from the blisters revealed Tzanck cells. Repeated abdominal radiographs revealed diminished air-fluid levels and dilatation of the cecum, which measured 10 cm at its greatest diameter. On the fourth day the patient began to pass flatus and stool. Her abdomen became flat, and she began to feed orally. The

patient was treated with acyclovir 4 g/day p.o., paracetamol 1,500 mg/day, prednisolone 60 mg/day and topical acyclovir ointment, and was discharged on the seventh day of hospitalization.

The first symptom of herpes zoster is usually pain and paresthesia in the involved dermatome.

This pain may last for 1-7 days and varies from superficial itching, tingling or burning to severe, deep or lancinating pain. It may simulate myocardial infarction, pleural effusion, prolapsed intervertebral disk, duodenal ulcer or cholecystitis, biliary or renal colic or appendicitis [1].

Acute pseudo-obstruction of the colon was first described by Ogilvie in 1948. Ogilvie's syndrome is characterized by acute massive dilatation of the cecum and right colon without organic obstruction. Several conditions have been associated with Ogilvie's syndrome. Analysis of 400 cases by Vanek and Salti [2] showed that they were postsurgical in 49% of the patients, medical in 45% and not identified in 6%. Although the pathophysiology is unknown, it is suggested that interruption of afferent stimulation of lumbar nerves from spinal segments could impair efferent parasympathetic nerves, thus leaving the distal colon atonic and causing a functional obstruction similar to Hirschsprung's disease in children [3,4].

Herpes zoster may cause paralytic ileus, dysfunction of the urinary bladder, detrusor muscles or perianal sphincters and paralysis of limbs in thoracolumbar (T7-L<sub>5</sub>) and sacral dermatomal distribution. Motor paralysis occurs in 5% of patients, especially when the virus involves the cranial nerves. Mild motor deficits are often missed in thoracolumbar zoster. Ogilvie's syndrome related to herpes zoster was first reported by Caccese et al. [5] in 1987, a second case by Pai et al. [6] in 1990. To our knowledge our case illustrates a third example of this association. We agree with Caccese et al. [5] and Pai et al. [6] that herpes zoster infection should be added to the list of conditions with Ogilvie's syndrome

#### References

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