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Herpes zoster infection at the palate of a young male: An infrequent finding

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Painful vesicular sores involving one side of the skin and mucous membrane in herpes zoster (HZ) infection are due to the reactivation of varicella-zoster virus (human herpes virus type 3), a double-stranded DNA virus.[1,2] Herpes zoster infection most often involves thoracic, lumber, cervical, and sacral regions.[2,3] Involvement of oral mucosa is an infrequent finding.[2] At this juncture, we presented a case of herpes zoster infection at the palate of a young male patient.

A 28-year-old male patient reported to the outpatient department of a dental college with a chief complaint of multiple painful ulcers on the right side of the palate since 4 days ago. The patient gave a history of fever, and myalgia also. On oral examination, multiple crops of ulcers were noted extending from the incisive papilla to the soft palate involving the anterior faucial pillar region. However, the ulcers did not cross the midline. Cracking of lips was also noted (Fig. 1A) The prodromal symptoms, the multiple painful ulcerative lesions not crossing the midline, made it a straightforward diagnosis of a HZ infection. The patient was treated with oral acyclovir 800 mg 5 times a day for 5 days, followed by acetaminophen 500 mg thrice daily, with vitamin B12 1500 mcg once daily for 15 days and folic acid 5 mg twice daily for 15 days. The patient was advised to use petroleum jelly for the chapped lips.

The patient returned 10 days following the treatment with almost complete resolution of the ulcers (Fig. 1 B). However, mild pain was felt by the patient during chewing of hard foods. The patient was advised to continue the vitamins for one more week and acetaminophen 500 mg if needed. The patient gave telephonic feedback after 15 days and reported that he was completely asymptomatic. After 45 days when the patient came back, the oral cavity was completely clean and the lips were smooth with no history of post-herpetic neuralgia (Fig. 1C).

HZ, more familiar as 'shingles' takes its origin from the Latin word 'cingulum', which means 'girdle', because it manifests as a unilateral rash that encases the abdomen like a girdle. Likewise, zoster also took its origin from the Greeks, referring to a band worn by combatants to safeguard armour.[4] HZ infection is 15 times more prevalent in HIV-infected patients, whereas 25% of the patients with Hodgkin's lymphoma patients develop HZ infection during the course of the disease.[3] Age of incidence of HZ infection is highly debatable although it is relatively rare in younger populations.[1,3] The diagnosis of HZ is straightforward, based on its unilateral presentation along the dermatomes.[1,3] Other diagnostic modalities include viral culture, cytologic smear with fluorescent monoclonal antibodies, and polymerase chain reaction.[1,2] The differential diagnosis of HZ infection is the primary and recurrent form of herpes simplex virus infection and herpetiform aphthous stomatitis.[1] Apart from antiviral medication, prednisolone, and tricyclic antidepressants have been used to reduce the pain in HZ infection.[3] The unexceptional yet agonizing complication of HZ infection is post-herpetic neuralgia, brought about probably due to the fibrosis around the peripheral nerves.[3,5] Uncommon complications include encephalitis, hemiparesis,

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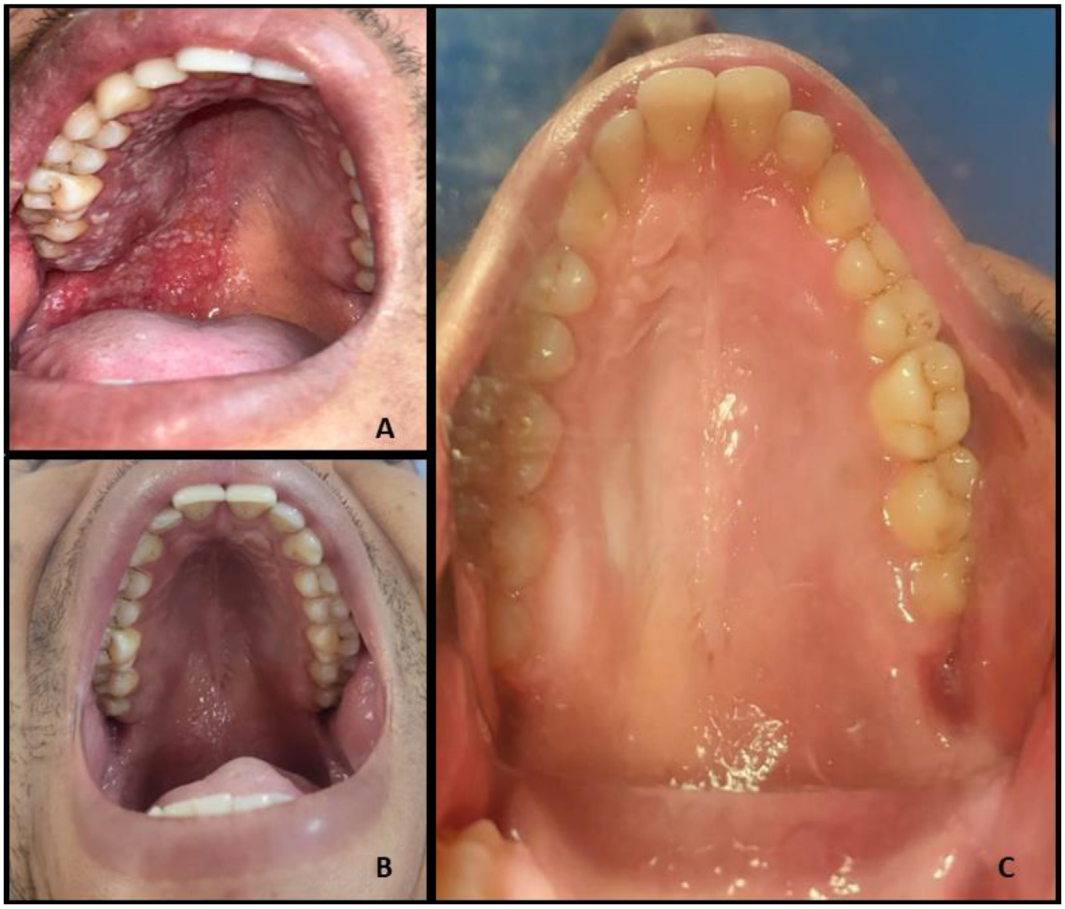

Figure 1 Clinical oral photographs of the patient with herpes zoster at the right palate. (A) Multiple crops of ulcers were noted extending from the incisive papilla to the soft palate involving the anterior faucial pillar region. Cracking of lips was also noted. (B) Almost complete resolution of the ulcers, 10 days following the treatment. (C) The oral cavity was completely clean and the lips were smooth 45 days following the drug treatment.

and retinitis noted mostly in immunocompromised individuals. Vaccination is the most effective medium to prevent the development of post-herpetic neuralgia.[3]

Declaration of competing interest

The authors have no conflict of interest relevant to this article.

References

1. Tsai YC, Lee YP, Hwang MJ, Chiang CP. Oral herpes zoster—Case report. *J Dent Sci* 2021;16:563–4.
2. Güder H, Hamidi AA, Cinar N, Hamidi A. Isolated oral mucosal zoster with facial palsy: a case report. *Cureus* 2023;15:e33472.
3. Dosi TR, Chawla AK, Barkalle G, Phulambrikar T. Herpes zoster of orofacial region. *J Oral Maxillofac Pathol* 2021;25:557.
4. Roxas M. Herpes zoster and postherpetic neuralgia: diagnosis and therapeutic considerations. *Alternative Med Rev* 2006;1:102–13.
5. Zhou H, Wang Z, Jin H, Chen X, Lei L. A systematic review and meta-analysis of independent risk factors for postherpetic neuralgia. *Ann Palliat Med* 2021;10:121812189.

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