

Case Report

Phantom Hernia Due to Abdominal Herpes Zoster

Dr Shivani Ranjan¹, Dr Reeta Gupta Sood²

¹Senior Resident, ²Assoc. Proff.,
Deptt. of Dermatology, Venereology, Leprology, ASCOMS & Hospital, Sidhra, Jammu, J&K, India, 180001

Corresponding Author: Dr Shivani Ranjan

ABSTRACT

Most of the complications of herpes zoster are sensory. Segmental motor weakness is an unusual complication. We present a case of 50 years old male who presented with phantom hernia 3 weeks after the appearance of herpes zoster rash. Our emphasis lies on recognition of this benign self limiting entity to avoid unnecessary studies and procedures.

Keywords: Herpes zoster, Phantom hernia, pseudohernia, segmental motor weakness.

INTRODUCTION

Herpes zoster is a self limiting dermatomal vesicular rash caused by reactivation of varicella zoster virus. Complications of herpes zoster can be cutaneous, ocular, neurological and visceral. Neurological complications include post herpetic neuralgia, segmental zoster paresis, encephalitis, myelitis, meningitis, cerebrovascular manifestations.^[1] Segmental motor weakness is an uncommon complication that occurs in 3 to 5 percent of patients with herpes zoster and is associated with a good prognosis for recovery.^[2] Phantom hernia or pseudohernia is one of the neurological complications of herpes zoster.

Phantom hernia is a term used to describe unilateral bulging on either side of the abdomen due to weakness or paralysis of abdominal wall muscles.^[3] The word "Phantom" is derived from the word "Phantasm" which means the mental imagery produced by fantasy.^[4]

CASE PRESENTATION

50 year-old male was referred from Surgery department to our OPD for a second opinion for a painless mass in the left flank of abdomen. Patient gave history of unilateral painful erythematous grouped vesicular rash at the same site 3 weeks ago. Dermatological examination revealed multiple healed scars of varying sizes and shapes on the left flank, over the T10-T11 dermatome extending from the back to the midline anteriorly below the umbilicus (figure 1). A painless reducible bulge measuring 15 cm x 10 cm was present on the affected side (figure 2). The bulge became more prominent on straining. Abdominal examination showed no protrusion of bowel into hernia sac. Neurological examination was also normal except for localized abdominal wall paralysis. Ultrasound of the swelling and abdomen was normal. We diagnosed a phantom hernia due to herpes zoster. The bulge resolved spontaneously 3 months after the onset without any sequelae.



Figure 1: Herpes Zoster involving T10-T11 dermatome



Figure 2: Phantom Hernia due to Herpes Zoster

DISCUSSION

Herpes zoster is a self limiting condition. Although majority of neurological complications of herpes zoster are sensory but motor complications also occur. Segmental zoster paresis is focal, asymmetric neurogenic weakness that affects the myotome corresponding to the dermatomal distribution of herpes zoster. It typically occurs 2 to 3 weeks after the herpetic rash. The exact pathogenesis is uncertain, but it has been postulated that the involvement of motor nerves is due to viral spread from the dorsal root ganglion to anterior horn cells or anterior spinal nerve roots, which results in inflammation. [5] Because of the abdominal pressure and segmental muscle paresis, there is relaxation

of abdominal wall resulting in pseudohernia formation. [6]

Postherpetic pseudohernia or phantom hernia due to herpes zoster should be suspected when a patient presents with abdominal wall protrusion that coincide with or follow herpes zoster. Most of the previous studies observed that it has a benign evolution, with complete resolution in three months to one year. [7,8] Since it is a potentially reversible disease with good prognosis, so it is recommend that dermatologists, physicians and surgeons should recognize this entity to avoid unnecessary investigations and surgical interventions.

REFERENCES

1. Gilden DH, Kleinschmidt BK, LaGuardia JJ, et al. Neurologic complications of reactivation of varicella-zoster virus. *New England Journal of Medicine*, 2000;342: 635-645.
2. Tagg NT, and Tsao JW. Abdominal Pseudohernia Due to Herpes Zoster. *New England Journal of Medicine* 2006; 355:e1.
3. Raghu MB, Balasubramanian S, KG Menon, et al. Phantom Hernia- An unusual manifestation of hypokalemia; *Indian Paediatrics* Volume 31- January 1994.
4. Hensyl WR. *Stedman's Medical Dictionary*, 25th edn. Baltimore, Williams and Wilkins, 1990, p 1177.
5. Yoleri O, Ölmez N, Öztura I, et al. Segmental Zoster Paresis of the Upper Extremity: A Case Report. *Archives of Physical Medicine and Rehabilitation*. July 2005; 86(7):1492-1494
6. Bashir U, Anwar MI, Tahir M. Postherpetic pseudohernia of abdominal wall: A case report. *J of Pakistan Association of Dermatologists* 2014;24(4): 355-357.
7. Vincent KD, Davis LS. Unilateral Abdominal Distention Follow Herpes Zoster Outbreak. *Archives of Dermatology* 134:1168-1169, 1998
8. Zuckerman R, Siegel T. Abdominal-wall pseudohernia secondary to herpes zoster. *Hernia* 5: 99-100, 2001

How to cite this article: Ranjan S, Sood RG. Phantom hernia due to abdominal herpes zoster. *Int J Health Sci Res.* 2017; 7(9):338-339.
