CASE 6

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Ref. No. NP-1113

This patient, a 76-year-old white female, was initially seen by her private physician February 23, 1965 for a painful eruption of the right upper face of approximately four days duration. Examination revealed it to be herpes zoster involving the supraorbital branch of the trigeminal nerve. She was placed on ACTH and protamine; however, her symptoms progressed with increasing pain and spread of the eruption to involve the middle portion of the right face and the right eye.

She was hospitalized for a short time and then followed as an out-patient, but, because of continued episodes of pain and the fact that she lived alone, she was readmitted. Examination was as before, revealing a crusting lesion over the right forehead (sharply demarcated at the midline) down to the level of the nose. The right periorbital region was swollen and the right eye closed.

She rested comfortably until the morning of March 24 when she developed sudden respiratory distress and cyanosis. She became hypotensive and expired later that day, about 5 weeks after onset of herpes zoster ophthalmicus.

At autopsy massive pulmonary thrombo-embolism was discovered as the immediate cause of death.

Microscopically the lesion involving the Gasserian ganglion and adjacent nerve was quite characteristic of herpes zoster. Of interest was the continuation of the inflammatory response to involve the trigeminal nerve as it entered the pons and to involve the spinal nucleus of the 5th nerve throughout the medulla and upper cervical cord. The lesion is necrotizing with microglial proliferation, focal demyelination, loss of neurons, as well as perivascular cuffing. A mild leptomeningitis was present throughout the brainstem and slight perivascular cuffing was also seen in the hippocampus and hypothalamus.

The stain is Luxol fast blue, periodic acid Schiff, and hematoxylin. Points for consideration are the frequency with which central lesions occur in herpes zoster and whether they may contribute to the pain.