▪ Headache Medicine 2022, Supplement ▪ p-ISSN 2178-7468, e-ISSN 2763-6178

Headache Medicine

▪ DOI: 10.48208/HeadacheMed.2022.Supplement.40

Ramsay-Hunt syndrome in HIV patient

Maria Eduarda Oliveira Onuki[1], Mariana Leme Braga[1], Flávia Rodrigues de Oliveira[1], Edgar de Bortholi Santos[2]

[1]School of Medicine, Universidade Metropolitana de Santos, Santos, Sao Paulo, Brazil.
[2]Instituto de Infectologia Emílio Ribas, Sao Paulo, Sao Paulo, Brazil.

Introduction
Ramsay-Hunt syndrome (RHS) type II is defined by the combination of herpes zoster oticus to acute peripheral facial nerve paralysis, described in 1907 by James Ramsay Hunt. Reactivation of latent varicella-zoster virus in the geniculate ganglion of the facial nerve will cause RHS, resulting in inflammation, edema, and compression of the VII cranial nerve. However, nerve involvement, and in turn the development of RHS, manifests in less than 1% of infected patients. It is the second most common cause of atraumatic peripheral facial palsy (PFP) and has an incidence of 5 cases/100,000 people, with no sex predilection. Currently, RHS is classically described as a triad of otalgia, ipsilateral facial paralysis, and vesicles near the ear and ear canal; however, motor, sensory, and autonomic impairment when combined result in diverse neurological damage and may cause different symptoms, its diagnosis is mainly clinical.

Goal
To report the case of an HIV patient associated with HRS, seen by IIER between May and June/2022.

Case Report
Male, 49 years old, sought care on 05/20/22 in a hospital with complaints of vertigo and intense headache, associated with nausea and vomiting with onset of symptoms one day ago. His personal history was HIV+, diagnosed in 2013 and under regular treatment. On 5/25/22 resurfaced with the same symptoms of vertigo in conjunction with the appearance of an erythematous and painful vesicle in the right auricular region with edema and flushing of the region in association with PFP symptoms. On 05/30/22 he returned to the clinic with the same symptoms as before, and a magnetic resonance imaging of the temporal bones was done, showing an inflammatory process through the contrast at the bottom of the internal auditory canal suggestive of Bell's palsy. On 06/03/22 he sought care in the IIER ER due to lesions in the left auditory pavilion and paralysis in the right hemiface, without the ability to close the right eye, he was diagnosed with SRH. He took acyclovir 900 mg IV associated with prednisone 25 mg VO for 10 days, with improvement and was discharged.

Discussion
RHS is a rare otologic complication, and may present in several clinical forms, due to the different cranial nerves involved. The patient presented the classic triad, facilitating the diagnosis. Besides the common symptoms, other manifestations such as nausea accompanied by vomiting and vertigo are seen in this case, due to lesions in the vestibular nerve. There are risk factors reported in the literature that can cause reactivation of the virus, such as aging, emotional stress, and immunosuppression. While the incidence of herpes zoster is 15 times higher in HIV-infected patients, SRH in HIV patients is uncertain due to few published reports. In this case, the patient has HIV, which may be one of the triggers for the development of the syndrome. Bell's palsy is more common and has a better prognosis than RHS. It is more common for the appearance of vesicles in the pinna to precede or appear together with the PFP, but their development may be late, making the condition indistinguishable from Bell's palsy, even with suggestive radiological findings such as lesions in the external ear, which started together with the PFP, so the diagnosis was easier. For antiviral treatment of RHS, acyclovir associated with corticosteroid is used early. The follow-up treatment of the case was according to the current recommendation and led to clinical improvement of the patient.

Keywords: Ramsay-Hunt, Herpes zoster, Peripheral facial palsy.