



## Sacral Herpes Zoster: A Treatable Cause for Faecal Incontinence

Dave S, Singh-Ranger D\*, Garbos M, Thangiah R and Vivekanadan S

Department of Colorectal Surgery, Princess Alexandra Hospital, UK

### Abstract

Faecal incontinence is difficult to treat. Usually the cause is secondary to sphincter disruption caused by birth trauma. Complete resolution of incontinence is rare.

This case report describes an infective cause for faecal incontinence that was completely reversible. The importance of this case is the effect of Sacral nerve Herpes Zoster on bowel and bladder function. It is our aim to make the colorectal fraternity aware of Herpes Zoster faecal incontinence. It is a rare condition but ultimately treatable with complete resolution.

### Introduction

Shingles, also known as Herpes Zoster infection, is due to the Varicella Zoster virus. It is only present in individuals who have previously suffered Varicella infection. It is not contagious.

The most common site for Varicella Zoster virus to lay dormant is the dorsal root ganglia of the thoracic sensory nerves. Activation produces painful vesicles along the dermatome of the involved nerve. It may be described as “a belt of roses from hell” [1]. Less frequently, Herpes zoster may occur on the face along the distribution of the ophthalmic division of The Trigeminal nerve or, rarely, facial nerve palsy together with a rash on the Tympanic membrane and external auditory canal (Ramsay Hunt syndrome). A severe neuralgia can occur once the rash disappears.

Shingles may present with symptoms more distressing than the characteristic neuralgia and rash. These may be of concern to the clinician who is unfamiliar with a presentation not described in standard medical textbooks. One such infection is that which involves the dorsal root ganglia of sacral nerves S1, S2 and S3. This can result in bowel and bladder symptoms that, although distressing for the patient, can be ultimately treated with complete return to normality.

We herein report a case of Herpes Zoster infection that involved the dorsal root ganglia of S2 and resulted in an unusual presentation of acute urinary retention (with overflow incontinence) and faecal incontinence.

The aim of this report is to make the general surgeon aware of this presentation of Shingles as it is easily treatable.

### Case Presentation

A 76-year-old man presented to the emergency department with a one week history of worsening anal pain, fresh rectal bleeding and sudden onset of acute urinary retention and faecal incontinence. It was the distress of the latter two symptoms that brought the gentleman to the Accident & Emergency department.

Symptoms indicating a possible neoplasm, altered bowel habit, weight loss and poor appetite, were not present. Furthermore, he did not have malena or a family history of colorectal, stomach, uterine or ovarian cancers.

On examination, he had maculopapular, vesicopustular lesions on the left buttock (Figure 1) and anal margin. He also had signs suggestive of a palpable bladder. The rash was characteristic of Shingles and the symptoms of urinary retention and faecal incontinence were regarded to be a sequela of the infection.

The patient was treated with a urethral catheter; 1,500 ml of urine was drained. An intravenous course of Acyclovir was commenced and this resulted in complete resolution of faecal incontinence. A trial without catheter was successful and the patient discharged seven days later.

### OPEN ACCESS

#### \*Correspondence:

Singh-Ranger D, Department of Colorectal Surgery, Princess Alexandra Hospital, Hamstel Road, Harlow, CM20 1QX, UK, Fax: +44-01279-827602; E-mail: d.singhranger@yahoo.co.uk

Received Date: 29 May 2022

Accepted Date: 08 Jul 2022

Published Date: 18 Jul 2022

#### Citation:

Dave S, Singh-Ranger D, Garbos M, Thangiah R, Vivekanadan S. Sacral Herpes Zoster: A Treatable Cause for Faecal Incontinence. *Clin Surg*. 2022; 7: 3553.

Copyright © 2022 Singh-Ranger D. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.



**Figure 1:** Maculopapular, vesiculopustular lesions on the left buttock and anal margin.

## Discussion

The pre-eruptive phase of Herpes Zoster is characterized by non-specific symptoms of headache, fever, malaise and myalgia. Burning, itching and hypersensitivity follow in the involved dermatome. Unusual skin sensations occur such as stinging, aching, numbness, throbbing, tingling, or stabbing pains. It often reaches peak intensity in the nerve distribution below the affected dermatome.

Following the eruptive phase an erythematous maculopapular rash occurs. This quickly becomes vesicular and pustular with some erupting to leak serous fluid. Ruptured vesicles ulcerate, crust over and then become dry in seven to ten days. The result may be scarred and discolored skin.

Within several weeks to a month, symptoms and lesions usually resolve without treatment. A chronic phase of postherpetic neuralgia may result. In relation to the anorectum this may well present with anal pain.

Perianal Herpes Zoster is rare. Presentation is not the same as described in this report. For example, the rash may only be present

around the anal margin [2]. In other cases, sacral shingles may cause flaccid paralysis of the detrusor or anal sphincteric muscles. Resolution is, however, complete [3,4]. The combination of urinary retention and faecal incontinence is extremely rare [4]. Anorectal herpes zoster may be a marker for immunosuppressive disorders such as Acquired Immunodeficiency Syndrome (AIDS) [5] and Wegener's Granulomatosis [6]. Population-based studies have suggested that Herpes Zoster is not a marker for occult malignancy [7,8] and such patients do not require special screening.

## References

1. Timbury MC. Herpesvirus diseases. Medical virology. Edinburgh London Melbourne New York: Churchill Livingstone. 1991:100-3.
2. Hamilton CI Jr, Perkins EK. Anal herpes with generalized varicelliform eruption. Report of a case. Calif Med. 1951;74(1):41-2.
3. Jellinek EH, Tulloch WS. Herpes zoster with dysfunction of bladder and anus. Lancet 1976;308(7997):1219-22.
4. Yamanishi T, Yasuda K, Sakakibara R, Hattori T, Uchiyama T, Minamide M, et al. Urinary retention due to herpes virus infections. NeuroUrol Urodyn. 1998;17(6):613-9.
5. Thune P, Andersson T, Skjorten F. Acquired Immune Deficiency Syndrome (AIDS) manifesting as anogenital herpes zoster eruption: Demonstration of virus-like particles in lymphocytes. Acta Derm Venereol. 1983;63(6):540-3.
6. Roupe G. Letter: Anogenital herpes zoster in two cases of Wegener's granulomatosis. Br J Dermatol. 1974;90(6):718.
7. Ragozzino MW, Melton LJ, III, Kurland LT, Chu CP, Perry HO. Risk of cancer after herpes zoster: A population-based study. N Engl J Med. 1982;307(7):393-7.
8. Fueyo MA, Lookingbill DP. Herpes zoster and occult malignancy. J Am Acad Dermatol. 1984;11(3):480-2.