Persistent hiccups: A rare prodromal manifestation of herpes zoster

Sir,

Herpes zoster (HZ) is a common viral infection that occurs due to the reactivation of dormant varicella zoster virus (VZV) from the dorsal root ganglia. The usual prodromal symptoms of HZ include hyperesthesia, tingling, itching, burning or intense pain in the involved dermatome. However, various other local and systemic symptoms may precede the vesicular eruption. Systemic involvement in the form of fever, lassitude and anorexia can also occur. Motor symptoms such as hiccups occur very rarely in the prodrome of HZ. To date, only three such cases have been reported in literature.[1-3]

An otherwise healthy 29-year-old male patient presented with a three-day history of unilateral, grouped vesicles over the left side of neck and upper chest. Two days prior to the skin eruption, he developed persistent hiccups which occurred relentlessly (4-6 cycles/minute). The patient complained of pain and paresthesia at the site, but no constitutional symptoms. He denied history of acid reflux or peptic ulcer disease, abdominal trauma, bowel disturbance or recent intake of any drug. The cutaneous eruption prompted him to consult a dermatologist. Physical examination showed clusters of vesicles, pustules and erosions on an erythematous base that were distributed along the C3, C4 and C5 dermatomes [Figure 1]. Systemic examination was unremarkable. The complete blood count, liver and renal function tests and serum electrolyte estimations were normal. ELISA for HIV was non-reactive. Tzanck preparations from vesicular lesions revealed characteristic cytopathic changes. The skin biopsy showed an intraepidermal vesicle with multinucleated giant cells containing intranuclear inclusion bodies [Figure 1]. Treatment with acyclovir (800 mg five times a day for 7 days) was initiated. The course was uncomplicated with healing of the cutaneous lesions and resolution of hiccups.

Hiccup is an abrupt, transient involuntary contraction of the inspiratory muscles leading to sudden inspiration that is terminated abruptly by closure of the glottis. The name itself is onomatopoeic and is derived from the characteristic “hic” sound. In 1833, Shortt first recognized the association between hiccups and phrenic nerve irritation.[4] Later, the neural pathways (reflex arc) mediating hiccups were delineated. The afferents travel along with the vagus and phrenic nerve fibres, the pharyngeal plexus (C2-C4) and the sympathetic chain (T6-T12). The phrenic nerve (C3-C5) serves as the efferent pathway. The main centre for hiccups in the central nervous system still remains obscure. Any irritation or stimulation along this reflex pathway can result in hiccups.

The latency period between hiccups and the eruption is variable. Brooks described a case, where HZ, varicella and hiccups occurred in the same patient with the latter preceding the cutaneous lesions by 9 days.[1] The case reported by Efrati developed hiccups 6 days prior to appearance of HZ in the left third to fifth thoracic dermatomes.[2] Recently, Berlin et al.[3] reported the case of a patient with HZ suffering from persistent hiccups since 14 days prior to the onset of skin lesions as compared to 2 days in our patient. The symptoms of the patient improved with valacyclovir. Our patient denied previous episodes of persistent hiccups and did not have any prior gastrointestinal illness. Both the skin lesions and hiccups responded promptly to acyclovir therapy further strengthening this correlation.

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An adult with a cord round the neck: Benign transient lymphangiectasis of the penis

Sir,

A 36-year-old married Indian male presented with a linear, cord-like lesion near the coronal sulcus of 2 days duration. The lesion had started about 30 hours after the prolonged and vigorous sex twice with his wife. Although it was not painful, the site and cord-like appearance of the lesion had alarmed him and his wife. He had been married for the last 12 years and denied the occurrence of a similar episode earlier. There was no history of any systemic illness or use of any medicine or sexual stimulants. He and his spouse had no history of genital ulcers or urethral discharge.

Examination showed a healthy young man who had a skin colored, translucent, firm, nontender, approximately 2 mm wide, cord-like lesion above the coronal sulcus encircling it partly [Figure 1]. The overlying skin was normal and freely mobile. The local temperature was not raised. There was no ulceration, urethral discharge, lymphadenopathy or other skin lesions. The routine hematological investigations, urine examination and blood test for VDRL and sickling were negative. The patient was explained about the self limiting nature of this benign condition, but he was quite anxious. Hence, he was started on tablet roxithromycin 150 mg. twice daily for 7 days, which helped in the regression of the lesion within 2 weeks.

Sclerosing lymphangitis of the penis is an uncommonly reported condition, which usually manifests after hectic sexual intercourse or masturbation.[1-3] It is observed usually in the second or third decade, although it may occur between 18 and 66 years of age.[1] The condition is mostly asymptomatic; however, it can result in embarrassment due to its genital location, alarming appearance and its relation to hectic sex. Fortunately, it resolves spontaneously within 4-6 weeks without any complications.

The exact cause is still not very clear. While the lymphatic pathology has been blamed by some, others have reported findings suggesting a venous origin.[4-5] According to Aragona et al.[4], clinical, anatomical and histological findings indicate a primary involvement of the penile lymphatics, possibly after a prolonged period of sexual excitement. According to a more recent Indian report of this condition, the positive staining of vascular endothelial cells using CD31 and CD34 monoclonal antibodies suggested a venous pathology. Here, the authors did not find any evidence of lymphatic pathology.[4] The importance of trauma and an infectious agent as precipitating factors in the presence of an anatomical aberration in the venous arcade has been suggested in a recent report.[6] Eighteen out of the 1296 STI cases were found to have this condition in a centre in North India.[4] According to Rosen and Hwong, [7] out of the 105 patients reported till 2003, approximately one-fourth had a close temporal relation to uncomplicated gonorrhea, nonspecific urethritis or a positive serologic test for syphilis. Two of their three patients had an underlying infectious disease and responded to oral/injectable antibiotics. In 1996, a similar response was reported from our department after using erythromycin tablets.[8] Most patients are quite disturbed and therefore reassurance regarding its benign nature is important. Abstinence and rest to the affected organ often helps. A recent report of Mondor’s disease occurring a day subsequent to a 15-h flight in a person is interesting. Earlier, after a long flight, the patient had a history of developing superficial thrombophlebitis in the varicose veins of his left lower limb.[9]

REFERENCES