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Case Report

A case of Ramsay Hunt syndrome diagnosed after kidney transplantation



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ABSTRACT

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We report the first case of Ramsay Hunt syndrome (RHS) diagnosed after kidney transplantation in Korea. RHS is a disease caused by latent varicella-zoster characterized to involve geniculate ganglion of the seventh cranial nerve. Patients who have undergone kidney transplantation can be easily affected by viral infections because of their immune-compromised status. A 35-year-old man with hypertensive end-stage renal disease underwent kidney transplantation. Two months after surgery, the recipient was diagnosed with RHS and treated with antivirals and steroids. However, after using the antiviral agents for the recommended duration, facial paralysis occurred as a new presentation and he required further treatment. Otagia and periauricular vesicles improved, but the facial palsy remained.

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Introduction

Latent infection of varicella-zoster virus (VZV) is an issue in managing kidney transplant recipients. Because these patients are using various combinations of immunosuppressive agents, incidence of severe forms of viral infection is reported relatively high compared with that of normal immune status. Ramsay Hunt syndrome (RHS), also known as herpes oticus, is a rare manifestation of latent VZV infection and was first described by Ramsey Hunt [1]. This syndrome is caused by the reactivation of latent VZV in geniculate ganglion of the seventh cranial nerve and is characterized by otalgia, vesicle, and facial palsy of the affected side. RHS occurs more commonly in immunosuppressed individuals, such as kidney transplant recipients [2,3],

but it has not been reported previously in Korea. Here, we describe the first case of RHS diagnosed and treated with antiviral agents and glucocorticoids in a 35-year-old kidney transplant recipient in Korea.

Case report

A 35-year-old kidney transplant recipient presented to the nephrology outpatient clinic because of left otalgia and periauricular vesicles. He underwent deceased-donor kidney transplantation because of hypertensive end-stage renal disease about 2 months before the first symptoms appeared and had been using immunosuppressive medications. His regimen included tacrolimus 3 mg, mycophenolic acid 720 mg twice daily, and prednisolone 20 mg once daily. At the time of transplantation, we checked his viral markers as a protocol, and the patient did not recall his vaccination status. He underwent emergency surgery before we checked the final result of the viral markers. Later, we found out that his serum VZV immunoglobulin (Ig)-G was positive and IgM was negative (Fig. 1).

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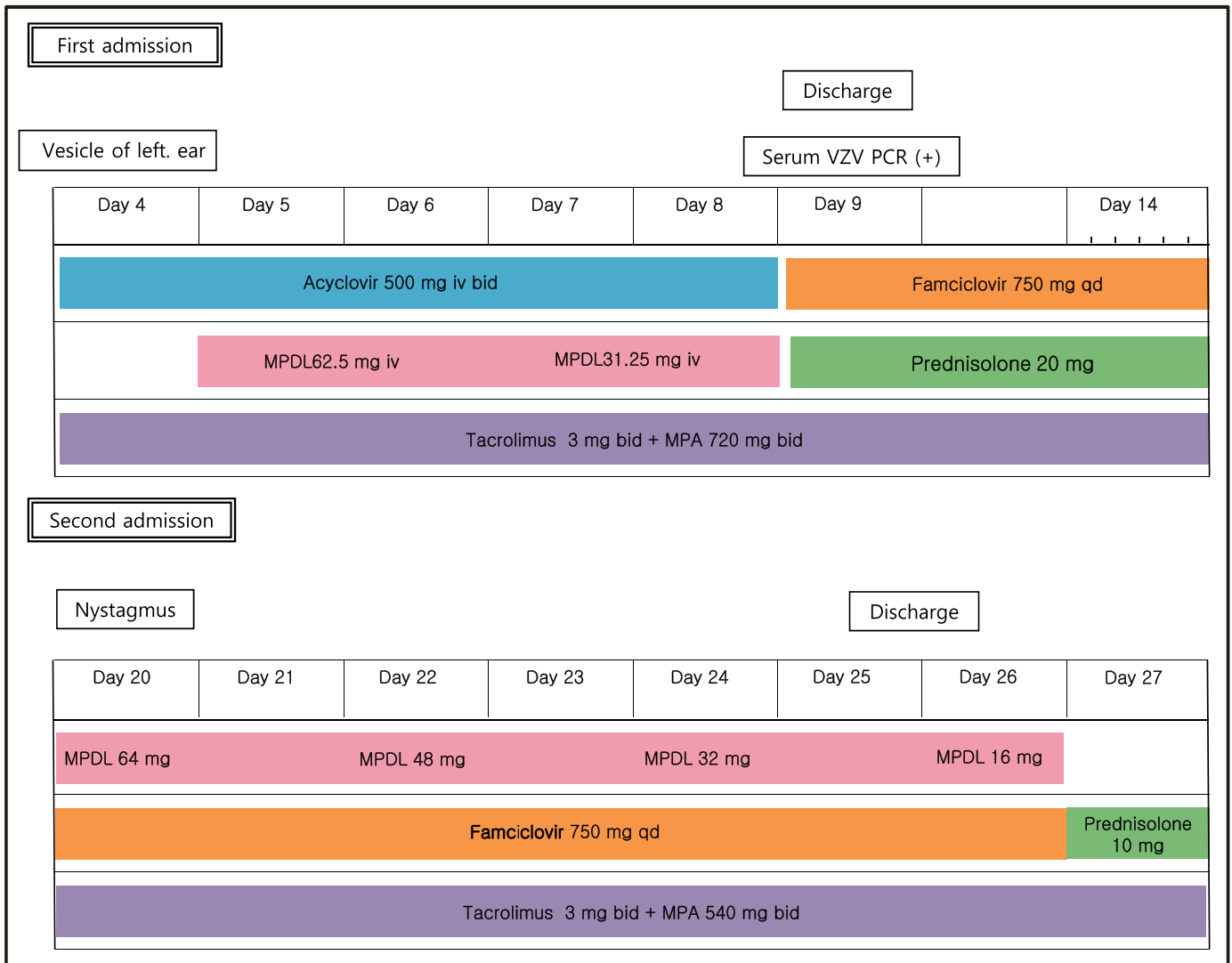


Figure 1. Clinical course of the patient. Bid, twice a day; Day, days from the onset of otalgia; IV, intravenously; MPA, mycophenoleic acid; MPDL, methylprednisolone; PCR, polymerase chain reaction; qd, once a day; VZV, varicella-zoster virus.

Initial vital signs were stable. In addition to pain and vesicular rash around the left ear, he complained of numbness of the left half of his face, but neurologic examination revealed no abnormal findings. Routine laboratory tests were conducted and revealed a serum creatinine level of 1.9 mg/dL. Estimated

glomerular filtration rate was calculated using the Modification of Diet in Renal Disease equation, and the value was 48 mL/min. The tacrolimus level was measured immediately before ingestion, and the result was 4.8 ng/mL, which was slightly below the target range.

In addition, serum VZV IgG/IgM was measured, and serum VZV polymerase chain reaction (PCR) was performed (Fig. 2). However, his symptoms were sufficiently clear to make a diagnosis of RHS with or without serologic confirmation of VZV infection, and we were not reluctant to administer intravenous (i.v.) antiviral agents and steroids in this case. Acyclovir was administered at a dose of 500 mg i.v. (5 mg/kg, 95 kg) twice daily for 5 days. The preferred dose of acyclovir in patients with normal renal function is 5–12.4 mg/kg twice daily. However, considering his renal impairment, dose reduction was performed. To administer steroids via the i.v. route and considering an anti-inflammatory effect, methylprednisolone was chosen. Methylprednisolone 62.5 mg was given i.v. and then tapered out. Although serum VZV IgM was negative, a positive result

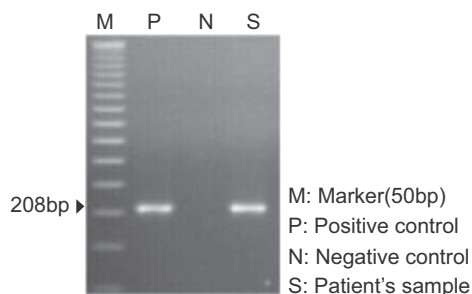


Figure 2. Result of varicella-zoster virus polymerase chain reaction from the serum of the patient.

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