A 50 years old female presented with skin lesion over left upper limb since one and half months and left upper limb weakness since one month. History revealed that she had neck pain radiating to left upper limb one and half months before and she consulted orthopedic doctor, cervical spine x-ray done which revealed only degenerative changes in cervical vertebrae, managed with oral analgesic medications. After four days, she developed red vesicular skin eruption over left arm, forearm and hand and after consulting dermatologist she was diagnosed a case of herpes zoster. She was managed with acyclovir, analgesics, topical and rehabilitative measures to prevent complications like contractures and atrophy.

Due to persistent weakness she approached our hospital. On General Examination, vitals are normal and there were healing herpetic lesions over C5-6 dermatome involving left shoulder, arm, forearm and hand. Neurological examination revealed weakness in left supraspinatus, brachioradialis, biceps and supinator muscles. There was hypotonia, reduced reflexes involving affected dermatome. Pain is usually develops first following by involvement of other extremities, slurring of speech or diminution of conscious sensation. CSF analysis reported in 7% of ophthalmic zoster cases (4). In series involving 1432 cases of herpes zoster only 11(0.8%) cases developed lower motor neuron paralysis (5). Motor neuropathy after zoster infection is uncommon and occurs about 5% cases. However it involves cranial nerves more than spinal nerves. Ocular paralysis reported in 13% and facial paresis reported in 7% of ophthalmic zoster cases (6). In series involving 1432 cases of herpes zoster only 11(0.8%) cases developed lower motor neuron paralysis (5). Motor involvement occurs probably due to spread of infection from dorsal root ganglion to anterior horn cells of same spinal segment. Prognosis of this disease is fairly good with 55 % of cases shows complete recovery and 30% with significant improvement in three weeks to six weeks time.

Conclusion
Segmental paresis is a rare complication of herpes zoster. The exact pathogenesis is uncertain.

The facial nerve is commonly involved, followed by the upper extremities but Clinical symptomatology may vary greatly. The sensory ganglion, spinal cord, the roots, plexus, and the peripheral nerves may be affected. Diagnosis depends mainly on medical history and clinical findings. This case presented to emphasize though zoster infection may rarely complicated by motor paresis, it should be considered in differential diagnosis of acute painful asymmetrical motor weakness involving extremity to avoid unnecessary interventions as well as early determining treatment and rehabilitative measures to prevent complications like contractures and atrophy.
References


