An Atypical Presentation of Herpes Zoster

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Introduction

Herpes zoster (HZ), also known as Shingles, results from the reactivation of the latent varicella-zoster virus (VZV) within sensory ganglia, typically presenting as a unilateral, painful vesicular rash in a dermatomal distribution. Reactivation risk factors include immunosuppression, increasing age, recent illness, malignancy, trauma such as sunburn or surgery, and psychological stressors. Incidence increases with age, with an incidence of 1.2 to 3.4 per 1000 persons per year among younger, healthy individuals and 3.9 to 11.8 per 1000 persons per year in those over the age of 65. While most cases of HZ involve the thoracic, cervical and trigeminal dermatomes, nasopalatine zoster is a rare and often underrecognized manifestation affecting the maxillary division of the trigeminal nerve (V2). Trigeminal involvement occurs in up to 20% of cases, and atypical presentations may delay diagnosis. We present a unique case of herpes zoster affecting the maxillary division of the trigeminal nerve (V2), particularly in the distribution of the nasopalatine nerve.

Case Presentation

A 58-year-old white male presented with intermittent headaches localized to the glabellar region and nasal root for a duration of four days. His past medical history includes mild idiopathic thrombocytopenia, depression on escitalopram, and hypertension controlled on lisinopril and amlodipine. The pain was severe enough to occasionally wake the patient at night but was not exacerbated by activity. He also reported a burning sensation on the hard palate following ingestion of hot food. He denied any visual disturbances, nausea, or vomiting. Neurological exam was unremarkable, but erythema to the left hard palate was noted without vesicles, pustules or bullae, and without pharyngeal involvement. Physical exam was otherwise normal. Differential diagnosis included cluster headache, tension headache, thermal burn, odontogenic infection, and viral infection. Nasopalatine zoster was ultimately diagnosed given clinical presentation and exam findings. The patient was started on oral valacyclovir 1 g TID for 7 days, and gabapentin 100-200 mg TID for pain control. At one-week follow-up, the patient's headaches had nearly resolved, and the burning sensation had significantly improved.

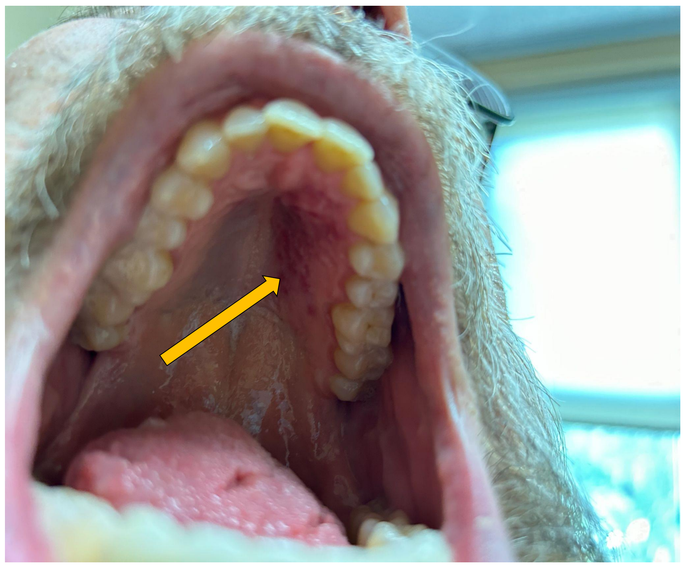

Image 1. Erythema localized to the left hard palate in the distribution of the nasopalatine nerve, as observed in the current case.

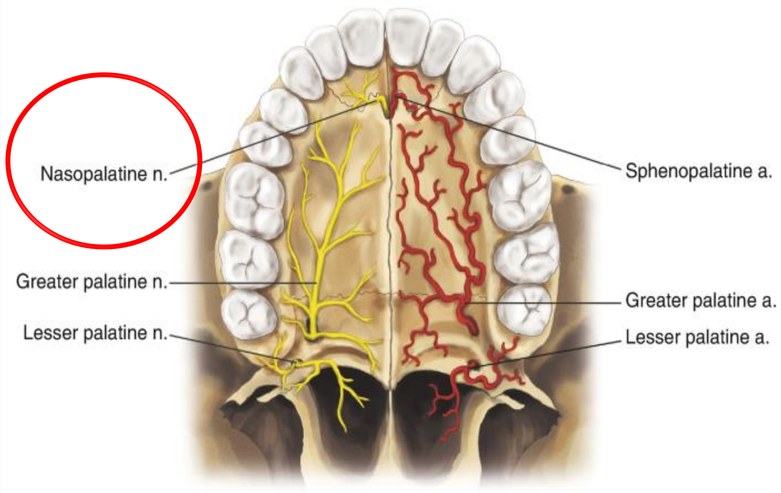

Figure 1. Diagram of the innervation and blood supply of the hard palate, with the nasopalatine nerve circled for emphasis.

Discussion

Nasopalatine herpes zoster is a rare manifestation of varicella-zoster virus (VZV) reactivation, with only a few cases reported in the literature. While the lifetime risk of developing herpes zoster (HZ) is approximately 30%, involvement of the nasopalatine nerve—a branch of the maxillary division (V2) of the trigeminal nerve—is uncommon. Classic HZ typically presents with prodromal neuralgia followed 2–4 days later by grouped erythematous macules that evolve into vesicles in a dermatomal distribution. However, our patient presented with headaches, burning pain localized to the hard palate, and a non-vesicular erythematous eruption, making the clinical picture atypical and potentially misleading. The headaches with absence of vesicles can delay diagnosis, as the differential may initially include cluster headache, sinus infection, aphthous ulcers, candidiasis, trauma, and thermal burn. The localization and quality of pain and the dermatomal distribution of the erythematous eruption ultimately supported the diagnosis of HZ involving the nasopalatine nerve. Notably, the patient was immunocompetent and vaccinated with Shingrix within the last two years, which highlights the need to consider HZ even in otherwise healthy individuals. Complications of HZ can include secondary bacterial infection, cranial nerve palsies, scarring, post-herpetic neuralgia and encephalitis in severe cases. Though our patient did not exhibit definitive extraoral involvement, HZ has been known to affect multiple trigeminal branches, with herpes ophthalmicus (V1 involvement) representing up to 20% of cases and carrying a risk of vision loss. Early recognition and initiation of antiviral therapy—such as with valacyclovir—are therefore essential, especially in elderly or immunosuppressed individuals, to reduce symptom severity and minimize complications.

Conclusions

This case underscores the importance of recognizing herpes zoster in patients presenting with localized neuropathic pain, even in the absence of classic cutaneous or mucosal lesions. The patient's burning pain localized to the hard palate supports trigeminal nerve involvement, specifically implicating the nasopalatine nerve, a branch of the maxillary division (V2). Herpes zoster should be included in the differential diagnosis for patients with isolated headaches, unilateral facial or palatal pain of unclear etiology, or a combination thereof—even when papular or vesicular eruptions are absent. While maintaining a broad differential is essential, clinicians must remain vigilant for atypical presentations of herpes zoster, particularly in elderly or immunocompromised patients. Prompt diagnosis and treatment are crucial to alleviating symptoms and preventing long-term complications, thereby reducing overall morbidity and mortality.

References

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