Fast and furious: A case of deep neck abscess in pregnancy

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SUMMARY

Deep neck space abscess in pregnancy is uncommon and may lead to serious morbidity and mortality. Management of such infections in pregnancy depicts a difficult challenge, simply due to the fact that it is a possible life-threatening condition to both the mother and the fetus. We report a case of a 35 year-old gravid female at 32 weeks gestation, who presented with 3 days history of fever, change of voice and right neck swelling. Clinical examination revealed trismus and muffled voice, with left level II neck swelling. Intraorally there was medialization of the peritonsillar region and left lateral pharyngeal wall. Patient was subjected to intraoral I&D after which she showed initial improvement, but her condition worsened after 3 days with worsening neck swelling and spiking temperature. Emergent CT Neck was done revealing multiloculated collection involving the left parapharyngeal space, extending to involve the retropharyngeal and right parapharyngeal space, the superior and anterior mediastinum. A multidisciplinary team consensus was made and patient was subjected to an emergency Cesarean section, transcervical I&D of right parapharyngeal abscess and right Chamberlain mediastinotomy drainage of mediastinal abscess. She was nursed in the ICU postoperatively and was given broad-spectrum antibiotics (IV Ceftriaxone). Intraoperative pus cultures were reported as Kleibsella pneumoniae. She recovered well post-operatively and was discharged home after completing 4 weeks of IV Ceftriaxone. In conclusion, deep neck space infection, in patients with co-morbidities and immunocompromised states may lead to high mortality and morbidity. Early diagnosis, prompt initiation of appropriate antibiotics, adequate airway management, together with surgical drainage, remains the mainstay of management. A multidisciplinary team approach involving ORL surgeons, fetomaternal specialists, cardiothoracic surgeons, anesthetists and clinical radiologists is also paramount in managing a case of severe deep neck space infection in pregnancy.

Ramsay Hunt Syndrome: Where are the vesicles?

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SUMMARY

Ramsay Hunt syndrome (RHS), a variant of herpes zoster (HZ) is a rare cause of facial nerve palsy in children. This is a case report of a child with unusual non-vesicle RHS. A one-year-10 months old boy developed sudden onset left facial weakness with no otologic symptom. There was no history of trauma, insect bite, upper respiratory tract infection or skin rash. He had a history of varicella infection a month ago. On examination, he had left facial nerve palsy House Brackmann grade V. External ears and otoscopic examinations were unremarkable with no rash. Varicella zoster antibodies were detected. He was diagnosed as RHS without a vesicle and treated with a total of 2 weeks of corticosteroid. Antiviral therapy was not initiated as the onset of the symptoms was more than 72 hours. His facial nerve palsy improved to grade II 2 weeks later. Classic RHS symptoms are facial nerve palsy and vesicular rash at auricle. Otologic symptoms may present in the form of tinnitus, hearing loss, nystagmus or vertigo. It is caused by reactivation of varicella zoster virus at geniculate ganglion. If the infection does not involve sensory neurons, it will not produce classical dermatomal vesicular rash. This is called Zoster sine herpete (ZSH) that produces atypical neuropathic pain, cranial or spinal nerve palsy. This rare condition is often missed and requires a high level of suspicion to diagnose. Diagnosis is confirmed via detection of VZV-DNA via polymerase chain reaction test (PCR) or VZV antibody in serum. Combination of antiviral therapy and corticosteroid has been shown to have some benefit in treating RHS. Varicella vaccination is effective at lowering the overall risk of HZ and it's variant RHS in children. RHS may present without vesicle, predisposing clinician to misdiagnosis.