



Herpes Zoster Oticus in a Previously Healthy Child

Önceden Sağlıklı Bir Çocukta Gelişen Herpes Zoster Otikus

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Cite this article as: Çiftçi E, Arga G, Penezoğlu DN, Akat H, Somuncu E, Yıldırım AE, et al. Herpes zoster oticus in a previously healthy child. J Pediatr Inf 2025;19(4):e302-e303.

A five-year-old boy was brought to the hospital with a rash on the upper left side of his face, around his eyes, and on his ear. Five days earlier, he had presented to another healthcare center with fever, earache, and sore throat. A diagnosis of acute otitis media was made, and amoxicillin-clavunate therapy was initiated. On the third day of antibiotic therapy, severe earache and pinna redness developed. Physical examination revealed an exudative membrane on the left tonsil, a vesicular rash on the left side of the hard palate, a swollen left eardrum, bullous skin lesions in the external auditory canal, hyperemia and edema in the pinna, and a vesicular rash around the left eye. The patient had no prior history of chickenpox and had received all vaccinations appropriate for his age, including one dose of varicella vaccine. Herpes zoster oticus was suspected. The patient was admitted to the Pediatric Infectious Diseases Clinic. Polymerase chain reaction (PCR) tests were performed to identify infectious agents associated with vesicular rashes in bullous skin lesions. The patient was started on acyclovir (30 mg/kg/day, divided into three doses), and since concurrent bacterial perichondritis could not be excluded, piperacillin-tazobactam was started. There was no growth in the patient's bullae culture, and his throat culture was negative for *Streptococcus pyogenes*. Varicella zoster virus (VZV) PCR was positive in a sample taken from the bullous lesion located in the center of the auricle. The patient's hearing and



neurological examination were normal. Following negative culture results, the patient's antibiotics were discontinued. After a total of seven days of acyclovir treatment, skin lesions were observed to dry and heal significantly.

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Received: 15.11.2025 Accepted: 09.12.2025

Available Online Date: 25.12.2025

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Data Sharing Statement: The data that support the findings of this study are available from the corresponding author upon reasonable request.

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Patients without a history of chickenpox may also acquire VZV infection in utero. Children who receive a single dose of varicella vaccine may develop asymptomatic or undiagnosed mild VZV infection. Rarely, the vaccine strain can cause herpes zoster. Herpes zoster usually develops as a result of reactivation of latent virus as a result of immunosuppression, stress, or systemic illness, but it can also occur in healthy children. Herpes zoster oticus develops as a result of reactivation of VZV latent in the geniculate ganglion. Herpes zoster oticus is a rare form of herpes zoster. The combined occurrence of facial paralysis, vesicular rash around the ear and oral mucosa, and otalgia is called Ramsay Hunt syndrome. In herpes zoster oticus, the 7th and 8th cranial nerve may be affected. Edema and inflammation can cause compression of narrow bony canals, deepening facial paralysis. Some patients may also experience vertigo, tinnitus, or hearing loss as a result of 8th cranial nerve palsy. Clinical diagnosis is often sufficient. Diagnosis can be confirmed by the presence of VZV DNA in the vesicle fluid by PCR. Nucleoside analogs such as acyclovir are used as antivirals for treatment. Steroids should be added to treatment in the presence of facial paralysis. Early initiation of treatment accelerates recovery.

